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Psychologists' perceptions of occupational therapy and the treatment of eating disorders

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PSYCHOLOGISTS' PERCEPTIONS OF OCCUPATIONAL THERAPY AND THE TREATMENT OF EATING DISORDERS

by

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An Abstract

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ABSTRACT

From the literature, it appears that occupational therapists have been less actively involved in the treatment of clients with eating disorders in the last 10 years than previously. With the job markets changing for occupational therapists, it is important to understand some of those issues by investigating whether psychologists perceive occupational therapists provide beneficial treatments for clients with eating disorders and if they would refer those clients to occupational therapists. This study also aims to identify if there are similar treatment models and techniques utilized by both occupational therapists and psychologists in treating this population.

To gather data for this study, surveys were sent to 75 members of the New York State Psychological Association who treat eating disorders with an effective return rate of 44% achieved. The results of this study show that psychologists currently address many of the same treatment modalities occupational therapists use with individuals with eating disorders and they view those treatments as beneficial for this population. Furthermore, they would refer to occupational therapy for all of the modalities except for assertiveness training. Additionally, the results show that psychologists are not aware of occupational therapy's role with this population and that they may need to be educated about occupational therapy. If occupational therapists network and publicize for the profession, the amount of referrals they receive from other health care professionals, including psychologists, may increase and OT can once again take an active role in treating individuals with eating disorders.

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A Thesis Presented to the Faculty

of the School of Health Sciences and Human Performance

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Amy K. Robinson

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School of Health Sciences and Human Performance

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CERTIFICATE OF APPROVAL

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This is to certify that the Thesis of

Amy K. Robinson

Submitted in partial fulfillment of the requirements for the degree of
Master of Science in the Department of Occupational Therapy, School of Health Sciences and Human Performance at Ithaca College has been approved.

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CHAPTER I: INTRODUCTION

Eating disorders, particularly anorexia nervosa and bulimia nervosa, are extremely prevalent within our society today, occurring in up to 4% of adolescent and young adult students (Kaplan & Sadock, 1998). According to the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), a diagnosis of anorexia nervosa can be made if an individual fails to maintain body weight at or above a normal weight for age and height (specifically, body weight must be less than 85% of that expected), has an extreme fear of gaining weight, has body image distortions, and in women, has amenorrhea (American Psychiatric Association, 1994). Characteristics of bulimia nervosa include frequent episodes of binge eating, or consuming large amounts of food in a short amount of time, followed by purging behaviors such as self-induced vomiting, laxative or diuretic use, fasting, or vigorous exercise (American Psychiatric Association, 1994).

Many risk factors lead to the development of these disorders and the disorders significantly impact many areas in the lives of the affected individuals. According to Reed (2001), some conditions commonly associated with the disorders include: poor problem solving and decision making, participation in compulsive or ritualistic behaviors, poor self-concept, avoidance of some self-care tasks, and poor social skills. Additionally, the individual may neglect previous leisure interests, taking an active interest in food, bingeing, dieting, or exercise instead (Reed, 2001).

Background

There are many treatment options available to individuals with eating disorders, such as psychotherapy, nutritional counseling, and family therapy. These treatments are usually conducted by a psychologist or nutritionist. Physicians, social workers, and nurses commonly treat individuals with eating disorders as well. Through the search of occupational therapy literature, it was found that occupational therapy (OT) was frequently utilized in the treatment of this population during the 1980s and early 1990s. However, the literature published in occupational therapy on eating disorders has become scarce in the past ten years, suggesting that few occupational therapists are currently treating this population.

In treatment, occupational therapy addresses many areas in the daily lives of this population. The goal of treatment is not to cure, but to work towards achievement of the individual's highest level of psychosocial functioning (Giles & Allen, 1986). Some of the specific treatment modalities occupational therapists use are anxiety-reducing activities such as stress management and relaxation, cooking practice, clothes shopping, social skills training, expressive media, crafts, and assertiveness training (Giles & Allen, 1986; Rockwell, 1990).

Because occupational therapy focuses on the daily functioning of individuals and eating disorders affect many areas in the lives of this population, occupational therapists could be more involved in the treatment of these individuals. However, no research has been conducted on whether other professions (specifically psychologists) view occupational therapy's treatments as valid and beneficial. Since psychologists are one of

the primary professionals to treat individuals with eating disorders, it is important to know their perceptions of occupational therapy with this population. The intention of this study is to answer these questions as well as whether psychologists would refer this population to an occupational therapist for treatment. In the past, physicians and psychologists typically referred individuals with eating disorders to occupational therapy as part of inpatient hospitalization. Eating-disordered individuals are now more commonly treated in schools and in the community. We do not have hard-core data on whether psychologists have emerged as a referral source in the community.

Problem Statement

The literature in occupational therapy on eating disorders has become scarce in the past 10 years. This implies that the referral to occupational therapy and treatment by occupational therapists with the eating-disordered population has decreased. No research has been conducted to assess whether occupational therapists and psychologists use similar treatment modalities in the treatment of this population or whether occupational therapists are receiving referrals from primary referring professionals, including psychologists. Both of these scenarios could account for the decline in treatment of individuals with eating disorders by occupational therapists.

Purpose and Significance

The primary purpose of this study is to discover whether psychologists use similar treatment modalities to those occupational therapists use in the treatment of eating disorders. A second purpose is to discover whether psychologists view occupational therapy services as being beneficial to individuals with eating disorders. The third purpose

is to ascertain if psychologists would refer eating-disordered clients to occupational therapy. If psychologists are not performing the treatments occupational therapists provide but they believe the treatments would be beneficial to their clients, then psychologists will need to be educated in the role occupational therapy plays in the treatment of individuals with eating disorders. This would probably increase the number of referrals psychologists make to occupational therapists, thus allowing this profession to take a more involved role in treating this population. More importantly, individuals with eating disorders could greatly benefit from receiving occupational therapy services.

Limitations

- A major limitation in this study is the inability to select a random sample. This is because a national list of psychologists is not available and it is not cost-effective for the purposes of this study. A convenience sample of psychologists who work with individuals with eating disorders obtained from the New York State Psychological Association have been sent this survey.
- Choosing only psychologists from this association may be a biased way of choosing psychologists who have a particular set of beliefs or values or increased knowledge or value on the profession.
- Another limitation is that the sample is quite small, with only 75 psychologists being sent the survey.
- A limitation is that the survey is only being distributed to psychologists and not other professionals who treat individuals with eating disorders.

- Another limitation is that the psychologists listed in the database provided by the New York State Psychological Association may not be the only psychologists in New York State treating individuals with eating disorders. Other psychologists may treat this population but do not list this as their specialty treatment area.
- Another limitation is that the response rate from the survey may be low.

Delimitations

- The survey is only being sent to psychologists in New York State who are listed in the New York State Psychology Association's database and who treat individuals with eating disorders as part of their specialty.
- This study is only concerned with psychologists who treat clients with anorexia, bulimia, or both.
- This study excludes the following: psychologists in states other than New York, those not working with individuals with eating disorders, those working with individuals who are not diagnosed with anorexia nervosa or bulimia nervosa, and other professionals who work with this population.

Assumptions

- It is assumed the survey measures the variables defined in the study.
- It is assumed the psychologists will respond to the survey.
- It is assumed the respondents treat individuals with diagnosed eating disorders.
- It is assumed the psychologists are licensed in New York State and are clinical psychologists.

- It is assumed the respondents will accurately and honestly respond to the survey questions.

Research Questions

1. Do psychologists use similar treatment modalities as those typically used by occupational therapists in treating individuals with eating disorders?
2. Do psychologists view typical occupational therapy modalities as having benefits for their clients with eating disorders?
3. Would psychologists refer an individual with an eating disorder to occupational therapy for typical OT treatment modalities?

Summary

Eating disorders affect up to 4% of adolescent and young adult students (Kaplan & Sadock, 1998). Since eating disorders are so prevalent in our society and they profoundly affect the lives of the individuals with the disorders, it is a population that could benefit from occupational therapy services. In the past, occupational therapy was one of the multidisciplinary services provided in treating eating disorders. This seems to have markedly decreased in the past 10 years. It is important to assess other professionals' (specifically psychologists') perceptions of occupational therapy with this population in order to increase the number of referrals to occupational therapy. The following chapter will review the occupational therapy and psychology literature pertaining to the treatment of individuals with eating disorders.

CHAPTER II: LITERATURE REVIEW

The purpose of this study is to determine whether psychologists use similar treatment modalities to those occupational therapists use in the treatment of individuals with eating disorders and whether they view occupational therapy (OT) as being beneficial to individuals with eating disorders. Another purpose is to ascertain whether psychologists would refer eating-disordered clients to OT for treatment. The literature will be reviewed pertaining to this topic. This chapter will review the following topics: definition of eating disorders and associated risk factors; the role and involvement of psychologists with individuals with eating disorders; the role and involvement of occupational therapy with individuals who have eating disorders. Finally, the limitations of OT literature in this area will be addressed and a comparison between the treatment of eating disorders in OT and psychology will be discussed.

Definitions/Types of Eating Disorders

An eating disorder is defined by Christopher G. Fairburn and B. Timothy Walsh as "a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning" (1995, p.135). There are many eating disorders including anorexia nervosa, bulimia nervosa, eating disorder not otherwise specified, binge eating disorder, and obesity (American Psychiatric Association, 1994). However, for the purposes of this study only anorexia nervosa and bulimia nervosa will be included. According to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), anorexia nervosa is a refusal to maintain body weight at or above a

normal weight for age and height requirements by restricting food intake. The individual also has a fear of gaining weight, has body image distortions, and, in women, has amenorrhea (American Psychiatric Association, 1994).

To be diagnosed with bulimia nervosa, an individual must experience frequent episodes of binge eating, or consuming a large amount of food in a short period of time, followed by purging behaviors such as self-induced vomiting, laxative or diuretic use, fasting, or vigorous exercise. These behaviors must occur at least twice a week for three months to be diagnosed with bulimia (APA, 1994).

Risk Factors For Eating Disorders

Introduction

Although the exact etiology of eating disorders is unknown, many risk factors have been proposed that lead to the development of anorexia and bulimia. According to Jane H. White (2000), there are four major areas of classification of risk factors for developing eating disorders. These include: biological, psychological/developmental, family/parent, and sociocultural.

Biological Risk Factors

In her review of the literature, Jane H. White (2000) found dieting and obesity to be the most thoroughly studied biological risk factors. Furthermore, she states that dieting and food restriction are serious behaviors that may lead to the development of eating disorders. This restraint of food provides some individuals with a sense of control, which can encourage dieting and sometimes can lead to starvation. In today's society, dieting is thought of as normal and is often practiced regardless of body weight (White, 2000).

According to White, obesity is increasing rapidly in the United States. This obesity may be connected with unhealthy dieting and the development of eating disorders. Individuals who are encouraged to lose weight and to exercise are at an increased risk for the development of an eating disorder, especially if they choose an unhealthy means to lose weight (White, 2000). Individuals who diet and/or are obese will not necessarily develop an eating disorder; there are many other risk factors as well.

Psychological & Developmental Risk Factors

Many psychological risk factors for eating disorders have been identified. Body image distortion has been identified by White (2000) to be a major risk factor for the development of an eating disorder. Poor self-esteem has also been identified as a possible risk factor (Button, Sonuga-Barke, Davies, & Thompson, 1996; White, 2000). Button et al. (1996) conducted a longitudinal study to investigate the role of self-esteem in the cause of an eating disorder prior to the disorder's development. A self-esteem questionnaire was given to 11 and 12 year olds and a questionnaire about eating and psychological problems was given to the same individuals at ages 15 and 16. The results revealed that girls with low self-esteem at age 11 and 12 were much more likely to develop an eating disorder and other psychological problems at a later age. While these results were significant, other variables such as difficulties at school and cultural background could have played a part in the development of the eating disorders as well (Button et al., 1996).

A proposed risk factor for the development of bulimia is interpersonal skill deficits (Keel, Mitchell, Miller, Davis, & Crow, 2000). In their study of the psychosocial adjustment of a sample of women diagnosed with bulimia 10 years prior to the study, Keel

et al. (2000) determined that while other factors improved in these women over time, the social adjustment in interpersonal relationships did not change. Keel et al. suggests that these findings may reflect that these interpersonal skill deficits initially led the women to be vulnerable to the development of bulimia and that training in interpersonal skills may benefit this population.

Childhood sexual and physical abuse have also been identified in the literature as psychological risk factors for an eating disorder (Waller, 1998; White, 2000; Neumark-Sztainer, Story, Hannan, Beuhring, & Resnick, 2000). In Glenn Waller's (1998) study of perceived control in eating disorders, he found that women with eating disorders have a more external locus of control, or a belief that they have limited control over events in their lives, if they were sexually abused as a child. He believes treatment of this population should include discussing perceived control as well as the sexual abuse.

Neumark-Sztainer et al. (2000) studied the associations between sexual and physical abuse and disordered eating among adolescents. The authors found both sexual and physical abuse to be related to disordered eating among both girls and boys, indicating that abuse is a risk factor. They also concluded that strong, positive family relationships may decrease the risk of developing disordered eating. A positive family relationship is beneficial, but many dysfunctional family patterns can become risk factors.

Family/Parent Risk Factors

Parental attitudes and behaviors towards their children have become a primary focus of research on family as a risk factor for eating disorders (White, 2000). Parents' attitudes about their children's appearance and weight may manifest themselves in the development of an eating disorder in the child. Schwartz, Tantleff-Dunn, and Thompson (1999) studied the effect parental feedback about physical appearance has on a child's body image and psychological functioning. The researchers hypothesized that appearance-related comments from parents is a major factor in disturbances in body image and psychological functioning. Through the use of a questionnaire, the results showed that women received more feedback than men about their physical appearance. This feedback was related to poorer body image for these women and negatively affected psychological functioning. Furthermore, White (2000) identified having an eating-disordered mother as another possible risk factor. Although receiving negative feedback from family members is a risk factor, there are many sociocultural risk factors as well.

Sociocultural Risk Factors

Our society and culture has a major impact on the development of eating disorders. Peer pressure regarding weight and physical appearance has been identified as a sociocultural risk factor in the literature (Barr Taylor et al., 1998; White, 2000). Barr Taylor et al. (1998) identified significant risk factors in both older children and younger adolescents and the association these risk factors have with excessive weight concerns in these children. The results revealed that in both the elementary-aged and middle school

students included in the study, the importance peers put on weight and eating was the most important risk factor. Other risk factors identified in this study included body mass index, confidence, and, for the girls, trying to look like women in the media.

Physical attractiveness has also been suggested as a possible risk factor in the etiology of an eating disorder (Davis, Claridge, & Fox, 2000). In a study investigating "the combined role of physical beauty and perfectionism in predicting weight preoccupation in young women," Davis et al. found that physical attractiveness was positively related to weight preoccupation (2000, p. 69). This research suggests that weight and diet concerns are greater in beautiful women than in less attractive women. The subjective rating of physical attractiveness by the researchers decreases the validity of the study; so further research is needed to confirm these results.

There are many biological, psychological, familial, and sociocultural risk factors that put individuals at risk for the development of an eating disorder. Although it is not clear which risk factor puts individuals at greatest risk or whether many combine to cause the disorder, it is clear that these disorders impact the individual's life greatly. For example, according to Peter J. Cooper (1995), thoughts of suicide are often present in individuals with eating disorders, and suicide is one of the most common causes of death in those who die of anorexia.

Eating disorders impact many areas of the affected individual's life including: self-care, productivity, leisure, and cognition (Reed, 2001). According to Reed, the individual may avoid performing some activities of daily living or they may be obsessed with hygiene and grooming. He or she may avoid home-management tasks, may be an over-achiever in school in the case of anorexia nervosa, or may have a history of underproductivity in the

case of bulimia nervosa (Reed, 2001). The individual may have few leisure interests and may avoid previously enjoyed leisure activities. Additionally, he or she may have difficulties with problem solving and decision-making and may have difficulty concentrating on a task (Reed, 2001). For this reason, it is important to review the treatment approaches and modalities used with this population. Both psychologists' and occupational therapists' involvement with this population will be reviewed.

Psychologists' Involvement With Individuals With Eating Disorders

Frames of Reference/Models Used in Treatment

In the treatment of individuals with eating disorders, psychologists use various frames of reference to guide their treatment. They may choose to follow one specific frame of reference or instead choose to combine two or more models. Mussell et al. (2000) conducted a study to assess the primary models used by psychologists in treating individuals with eating disorders. Cognitive-behavioral therapy was found to be the most commonly used frame of reference followed by eclectic, family systems, psychodynamic, interpersonal psychotherapy, and narrative frames of reference. Psychologists often work in collaboration with psychiatrists and physicians who provide pharmacotherapy as part of their treatment of this population (Profinsky & Marek, 1997).

Cognitive-behavioral therapy (CBT) has been identified as the most commonly used frame of reference by psychologists for the treatment of individuals with eating disorders (Mussell et al., 2000; Profinsky & Marek, 1997). The overall purpose of CBT is to "help patients understand the inaccuracy of their cognitive assumptions and learn new strategies and ways of dealing with issues" (Kaplan & Sadock, 1998, p. 922). The

individual's types of thinking processes are examined in detail by the psychologist and the individual is asked to monitor his or her thoughts during times of distress (Barlow & Durand, 1995). A focus is placed on changing people's maladaptive behaviors that have been learned or conditioned and replacing those behaviors with more adaptive behavior through various behavioral tasks such as relaxation techniques (Barlow & Durand, 1995).

According to this model, all behavior has been learned and can therefore be unlearned. Kaplan and Sadock (1998) report that a cognitive-behavioral approach should be used with anorexic patients to monitor weight gain and to address maladaptive eating behaviors. The approach should be used by psychologists in treating a patient with bulimia to address specific behaviors leading to the binge/purge cycles (Kaplan & Sadock, 1998) and to change those maladaptive behaviors.

Family therapy is another frame of reference used often by psychologists in the treatment of individuals with anorexia and bulimia, and is used to examine interactions among family members (Kaplan & Sadock, 1998). As mentioned previously, there are many familial risk factors for the development of an eating disorder. These factors can be explored and examined in family therapy. Family members' roles and interpersonal relationships are examined with the goal of conflict resolution (Kaplan & Sadock, 1998).

Interpersonal psychotherapy (IPT) has been identified as another commonly used frame of reference by psychologists (Mussell et al., 2000). The goal of IPT is "improvement in current interpersonal skills" (Kaplan & Sadock, 1998, p. 896). This form of therapy focuses on resolving interpersonal conflicts in relationships or building interpersonal skills to form new relationships (Barlow & Durand, 1995). In treatment, the patient is taught to evaluate his or her interactions with other people and to identify

problematic behaviors. The therapist should offer advice, help the patient with decision-making, and help identify areas of conflict (Kaplan & Sadock, 1998). According to Barlow and Durand (1995), interpersonal psychotherapy is brief in that it lasts only from 10 to 15 sessions.

Pharmacotherapy, or the prescription of medicines by a psychiatrist or a physician in combination with psychotherapy with a psychologist, is used often with the eating disordered population (Profinsky & Marek, 1997; Kaplan & Sadock, 1998). According to Kaplan and Sadock, psychotherapy and medication often provide the best treatment when used in combination. Joan E. Martin (1990) reports that in eating disordered individuals, antidepressants are used to treat their depressive symptoms. Through her review of the literature she found that bulimic patients have been shown to respond to antidepressants whether they were clinically depressed or not (Martin, 1990), indicating that this form of medication is beneficial in treating bulimia.

Psychologists use many frames of reference while treating patients with eating disorders. It is also important to review the major therapeutic modalities associated with these frames of reference that are used by psychologists in order to determine if their treatment approaches vary from those of occupational therapists.

Treatment Modalities

The cognitive-behavioral model is a treatment approach commonly used by psychologists in treating individuals with eating disorders (Mussell et al., 2000). Mussell et al. found that the CBT techniques psychologists report to be used most often include: cognitive restructuring, or examining one's own thinking and changing those thoughts to change behavior, self-monitoring, and written homework assignments. Relapse prevention strategies are also used in treatment. These are strategies to focus on the client's perceptions of him or herself and food and how his or her eating behaviors are determined by those perceptions (Mussell et al., 2000). Self-control strategies must be taught as well to help the client control his or her disordered eating and to prevent any relapses of binges or food restriction from occurring. Introduction to a strict eating pattern is a CBT technique used with individuals with bulimia to eliminate the binge/purge cycles that are common with this disorder (Barlow & Durand, 1995).

Mussell et al. (2000) identified formal problem solving, prescribing distracting activities such as hobbies, and stimulus control techniques to be used as well. Relaxation training, behavioral contracts, and desensitization to the thoughts and feelings leading to an eating binge are also used in the treatment of individuals with eating disorders (Kaplan & Sadock, 1998).

According to Barlow and Durand (1995), the most important goal of treatment with anorexia nervosa is to restore the individual's weight to a normal range. Once weight has been restored, the focus of treatment should shift to address the individual's attitudes about body image in order to prevent relapse. Barlow and Durand (1995) contend that the individual's family should be included in treatment to address any dysfunctional

communication within the family and to change any negative attitudes toward body shape and weight. The family also needs to be educated so that they can provide positive reinforcement and support to the eating disordered individual.

Although psychologists often treat individuals with eating disorders, occupational therapists can become involved in treatment as well. It is important to review the frames of reference and modalities used in the treatment of this population by occupational therapists.

Occupational Therapists' Involvement With Individuals With Eating Disorders

Frames of Reference/Models Used In Treatment

In reviewing the literature, it is evident that occupational therapists use a variety of frames of reference in the treatment of individuals with eating disorders. Similar to those used in psychology, the psychoanalytic and cognitive-behavioral frames of reference are the most commonly used by occupational therapists (Rockwell, 1990; Henderson, 1999). Rockwell (1990) also identified the familial and developmental frames of reference as being used by occupational therapists. The model of human occupation (MOHO) is another frame of reference occupational therapists use (Barris, 1986; Cull, 1990). In her review of the current occupational therapy literature, Sarah Henderson (1999) found a lack of empirical evidence with all frames of reference and treatment approaches. This indicates a need for further research to justify the use of these frames of reference and treatment approaches with this population.

Two studies have been conducted to determine the frames of reference and modalities being used by occupational therapists in treating individuals with eating

disorders. In Rockwell's 1990 study, questionnaires were sent to 204 registered occupational therapists working with patients with eating disorders. The questionnaire addressed theoretical etiologies, frames of reference, and modalities used. Although the return rate was low (21%) and there were some questionnaire problems, the results showed the majority of occupational therapists use the psychoanalytic, cognitive-behavioral, familial, and developmental frames of reference.

A pilot study by Lim and Agnew (1994) was conducted to determine if occupational therapists use a specific frame of reference in treating those with eating disorders and which are used most often. Like Rockwell's study, they used a questionnaire to collect their data. The questionnaires were distributed to all occupational therapists (n=80) working in psychiatric settings in the eastern states of Australia. Although 40 questionnaires were returned for a return rate of 50%, only 26% of the questionnaires could be included in the study because 19 of the respondents acknowledged a lack of experience in treating this population. Because of this poor return rate, the results should be examined with caution. Similar to Rockwell's study, the results revealed that the cognitive-behavioral and psychoanalytic frames of reference are used most often by occupational therapists.

The literature reveals that the psychoanalytical, cognitive-behavioral, familial, and developmental frames of reference, and the model of human occupation are commonly used by occupational therapists. Psychologists use many of these frames of reference in the treatment of this population as well, although they do not often use the model of human occupation. A brief review of each will be presented.

Psychoanalytic

The psychoanalytical frame of reference has been identified by Rockwell (1990) as the most commonly used approach to the treatment of individuals with eating disorders by occupational therapists. Lim and Agnew (1994) found it to be the second most common frame of reference. This frame of reference is based on the belief that eating disorders are the "manifestation of underlying problems and self-doubts" (Rockwell, 1990, p. 49). Rockwell also states that the individual tries to gain self-control by controlling his or her body weight and eating patterns. According to Breden, treatment within this framework should "focus on providing positive experiences to improve self-esteem and identification and expression of feelings" (1992, p. 53). This can be accomplished by such activities as crafts, dance, movement therapy, and body image work.

Cognitive-Behavioral

The cognitive-behavioral frame of reference has been identified by many as a common treatment approach (Rockwell, 1990; Cull, 1990; Martin, 1990; Breden, 1992; Lim & Agnew, 1994). According to Martin (1990), this frame of reference is based on the assumption that dysfunctional beliefs and values concerning body shape and weight are major issues in the development of an eating disorder. It is also based on the theory that eating disorders are learned behaviors which can be unlearned through positive and negative reinforcement (Rockwell, 1990). Furthermore, if the individual learns the appropriate methods of weight regulation, the binge/purge cycles will discontinue in bulimic individuals. Although this frame of reference is similar to that used by psychologists, the treatment modalities used by the two professions differ.

Familial

Those in occupational therapy that use the familial frame of reference believe that the eating disorder is caused by a dysfunctional and maladaptive family structure (Rockwell, 1990; Breden, 1992; Lim & Agnew, 1994). Treatment within this frame of reference should focus on underlying family problems and attitudes of overprotectiveness and overemphasis on thinness and attractiveness (Rockwell, 1990; Lim & Agnew, 1994).

Developmental

The developmental frame of reference follows the theory that eating disorders develop as a result of irregular appropriate responses to a child's needs or a failure to receive a satisfactory response by a caregiver (Rockwell, 1990; Lim & Agnew, 1994). In turn, the child is unable to distinguish between biological feelings and emotional or interpersonal experiences. Within this framework, "treatment attempts to acknowledge inaccurate conceptualization and provides a conducive environment in which developmental delays can be corrected" (Lim & Agnew, 1994, p. 311).

Model of Human Occupation

In Barris' review (1986) of the model of human occupation (MOHO) in the treatment of eating disorders, she found that these individuals are dysfunctional in their attitudes and habits related to eating as well as in their pursuit of meaningful occupations. The occupational therapist should focus treatment on the individual's dysfunction in occupational behavior (Barris, 1986).

Despite the frame of reference an occupational therapist chooses to use in the treatment of individuals with eating disorders, many of the activities remain the same. The major treatment modalities identified through a review of the literature will be identified and discussed.

Treatment Modalities

According to Giles and Allen (1986), the major aim of treatment in occupational therapy is maximizing the individual's level of psychosocial functioning. In order to accomplish this, occupational therapists use an activity-oriented approach (Giles & Allen, 1986). Under this approach, the occupational therapist chooses activities that will meet the client's needs and facilitate recovery. However, according to Harris (1992) occupational therapy by itself will not achieve recovery. It can be helpful, however, in treating many aspects of the illness such as self-awareness, self-esteem, expression of feelings, and independence. It is important to treat this population using a team approach, with the occupational therapist bringing the unique perspective of function to the team (Harris, 1986; Barris, 1986; Rockwell, 1990; Breden, 1992; Cull, 1990).

Throughout the literature, two major categories of treatment have been identified. Giles and Allen (1986) describe the functional and expressive techniques to treatment. Similarly, Levens and Duncan (1987) believe treatment can be divided into reality-oriented therapies and creative therapies. Functional or reality-oriented therapies include: relaxation, menu planning, cooking, shopping, social skills training, exercise, and body image work (Giles & Allen, 1986; Levens & Duncan, 1987). Expressive or creative therapies include: creative media, art therapy, creative movement, psychodrama, and

creative writing (Giles & Allen, 1986; Levens & Duncan, 1987). These activities will be described in further detail below.

Rockwell (1990) determined the treatment modalities most often used by occupational therapists with this population through the use of a questionnaire. The questionnaire results showed that occupational therapists often use projective media, menu planning, crafts, stress management training, relaxation therapy, and assertiveness training. Occupational therapists also use education, discussion groups, cognitive-behavioral groups, social skills training, movement therapy, and clothes shopping. Behavioral strategies education, vocational training, weight and exercise training, dining out, and nutrition classes are sometimes used as well. The results of this study should be used with caution, however, because the return rate of questionnaires was low (32%).

Some of the most commonly used treatment modalities used by occupational therapists include projective media, cooking skills, crafts, stress management, assertiveness training, movement therapy, and clothes shopping (Rockwell, 1990). Each of these will be further explored below.

Projective Media

This form of therapy includes many media such as art, clay modeling, music, puppetry, dance, and drama (Martin, 1991). It is based on the assumption that people respond to situations based on past experience. These responses contain information on how inner feelings and relationships are organized into one's life (Martin, 1991). The use of projective media provides a healthy method of expressing thoughts and feelings (Harris, 1992). When used in a group format, the group is instructed to draw, paint, or sculpt on a given topic. Each member then speaks about his or her creation and how it relates to him

or herself (Harris, 1992). In this way, it "encourages insight and self-awareness in the patient" (Martin, 1991, p. 49). This treatment modality is commonly used within a psychoanalytic frame of reference in occupational therapy.

Cooking Skills

Much has been written in the OT literature about the use of cooking in the treatment of this population. In OT treatment, all aspects of cooking are evaluated and treated including menu planning, preparing a shopping list, food shopping, cooking practice, and eating with others for socialization (Giles & Allen, 1986; Baily, 1986; Levans & Duncan, 1987; Rockwell, 1990; Martin, 1991; Harris, 1992; Breden, 1992). While the client's knowledge of cooking and nutrition are usually normal or above average, a lack of knowledge about normal-sized portions and eating behaviors need to be addressed (Martin, 1991). Also, meals should be eaten in groups to develop and use interpersonal socialization skills (Levens & Duncan, 1987).

This treatment modality can be used within the cognitive-behavioral frame of reference or MOHO. Under the cognitive-behavioral frame of reference, reinforcement would be used to shape the individual's behavior. If the individual is taught and practices healthy behaviors surrounding food preparation and eating, his or her unhealthy behaviors can be unlearned. Within MOHO, cooking skills practice would focus on the individual's dysfunction and his or her unhealthy attitudes and habits surrounding food.

Crafts

Because treatment with this population focuses on activities, crafts are used often in occupational therapy. According to Rockwell (1990), it is the third most common treatment modality identified by occupational therapists working with the eating disordered population. Craft activities can be addressed within the cognitive-behavioral frame of reference "to provide the patient with an arena to improve cognitive abilities" (Breden, 1992, p. 60) such as problem solving and decision-making skills and to change the negative behaviors associated with an eating disorder. In Meyer's case study (1989), her client reports craft activities as a source of self-control.

Crafts can be used as a projective technique if used within the psychoanalytic frame of reference. If used in this manner, they allow the individual to deal with issues such as body image and self-esteem. This treatment modality can be used within the developmental frame of reference to analyze and address developmental delays in the individual's thinking.

Stress Management and Relaxation

Most individuals with eating disorders become anxious and stressed before and after meals (Giles & Allen, 1986). Relaxation is viewed as a loss of control by some of these individuals, so they try to avoid this activity (Levens & Duncan, 1987). It is important to teach individuals with eating disorders relaxation and stress management techniques so that they can decrease their anxiety and avoid the eating behaviors that seem to depend on stress, such as an eating binge (Giles & Allen, 1986). Yoga has been identified as a beneficial activity for stress reduction (Martin, 1991) as has time management (Breden, 1992). This treatment modality is often used in a cognitive-

behavioral frame of reference because it teaches the individual alternative behaviors to deal with stress. It is also used in preparation for high stress in the environment to be used in conjunction with other treatment modalities.

Assertiveness Training

This treatment modality is used to develop self-expression and self-awareness (Harris, 1992). Often individuals with eating disorders have low self-esteem and control issues. This form of therapy addresses these issues and allows the individual to gain control of his or her life, which should in turn increase his or her self-esteem (Baily, 1986). Assertiveness training allows the individual to test out assertive comments and attitudes within a safe environment (Martin, 1991) and is often conducted in groups by an occupational therapist.

This treatment modality could be addressed within a cognitive-behavioral frame of reference to change the individual's perceptions of self-esteem and self-control and to teach the individual more assertive behaviors. Assertiveness training could also be used in a psychoanalytic frame of reference to increase self-esteem and expression of feelings. The expression of feelings may lead to an increased sense of self-control and may help to decrease the negative eating patterns associated with an eating disorder (Rockwell, 1990). If a dysfunctional family pattern is causing the eating disorder and the family is present in treatment, assertiveness training can be used in the familial frame of reference to teach the individual how to express his or her wants and needs to the family in a constructive manner.

Movement Therapy/Creative Movement

Movement therapy is another modality utilized by occupational therapists when working with the eating disordered population within the psychoanalytic frame of reference (Rockwell, 1990). Within this technique, the individual is encouraged to creatively use movement and dance to express him or herself (Levens & Duncan, 1987). This movement can help the individual realize feelings which have been hidden or defended against by the individual (Levens & Duncan, 1987) and then to share those feelings with others.

Clothes Shopping

Shopping for new clothes is an area of treatment occupational therapists address with individuals with eating disorders. This activity has many therapeutic benefits to the individual such as: promoting better body image and self-esteem (Martin, 1991) and focusing on self-awareness and self-expression (Harris, 1992). In this way, it can be addressed within many frames of reference including psychoanalytic, cognitive-behavioral, developmental, or MOHO. Giles and Allen (1986) believe it is important for an occupational therapist to go shopping for clothes with his or her client to watch how the individual selects the correct size as well as for moral support. The authors feel it is very traumatic for the hospitalized patient to try on their old clothes after a weight gain, so an OT should address this in treatment.

Occupational therapists use many treatment modalities when working with individuals with eating disorders. However, there is a lack of empirical evidence on their efficacy (Henderson, 1999). The limitations of the occupational therapy literature in regards to eating disorders will be discussed.

Limitations of Occupational Therapy Literature

There are many limitations in the literature about eating disorders in occupational therapy. The majority of the literature on this topic is outdated, with the largest number of articles having been written in the 1980s. There has been very little OT literature published in the early 1990s and only one article, written by Henderson (1999), in the latter part of the 1990s. In order for occupational therapy to take an active role in the treatment of this population and to receive referrals from other professionals such as psychologists, it is crucial for research to be conducted and published in occupational therapy in the treatment of these disorders.

Another limitation is that there have been few published research studies about individuals with eating disorders in the occupational therapy literature. Only two research studies were found by the researcher for this study (Rockwell, 1990; Lim & Agnew, 1994) along with one case study (Meyers, 1989). Most of the literature included in this chapter are either therapists' descriptions of the eating disorder clinics or wards in which they work, or a literature review. Of the two studies that have been conducted, both had poor return rates in their survey research and questionnaire difficulties that decreased the reliability and validity of the studies and caused the results to be questionable.

In her review of the OT literature about eating disorders, Henderson (1999) found a lack of empirical evidence with all frames of reference and treatment modalities. She feels that more research is needed within the field of occupational therapy to validate this profession's role in the treatment of this population.

After reviewing the literature on eating disorders in the fields of psychology and occupational therapy and how each addresses the disorders, it is important to make comparisons between the two to see how they differ and how occupational therapy has a unique perspective with this population.

Comparison of the Treatment of Eating Disorders in Psychology and Occupational Therapy

Although psychologists and occupational therapists may use similar frames of reference when treating individuals with eating disorders, the treatment approach and modalities they use may differ. In many cases, the psychologist focuses on discussing the individual's self-defeating thoughts, feelings, and behaviors (Breden, 1992) in order to achieve psychological functioning whereas an occupational therapist focuses on achieving an optimal level of psychosocial functioning using an activity-oriented approach (Giles & Allen, 1986). Occupational therapists bring to the rehabilitation team a "unique knowledge of how to assist people to gain optimal interpersonal, psychological, and physical functioning" (Breden, 1992, p. 50). In this way, an occupational therapist focuses treatment on all aspects of the individual, not just the psychological aspect.

Most of the literature that was collected for this literature review was written during a time when treating individuals with eating disorders shifted from inpatient psychiatric settings to outpatient and community-based settings. Since that time, deinstitutionalization has occurred in psychiatric settings and health maintenance organizations (HMO's) have risen (Stein & Cutler, 1998; Scaffa, 2001). This has changed the way individuals with eating disorders are treated. Occupational therapists had been

very involved members of the multidisciplinary team in the treatment of individuals with eating disorders in psychiatric settings. As treatment is now more outpatient and community-based, occupational therapy's unique role in the treatment of this population has changed and may be lost (Stein & Cutler, 1998; Scaffa, 2001).

Some of the treatment modalities used in occupational therapy differ from those used in psychology, and some modalities are used in both professions. With an emphasis on function in daily living skills (Breden, 1992), occupational therapy uses many functional activities in treatment (Levens & Duncan, 1987). Rockwell's (1990) study shows the most common modalities used by occupational therapists in the treatment of individuals with eating disorders. Those activities that are unique to the field of OT include menu planning, crafts, social skills training, movement therapy, clothes shopping, vocational training, and dining out. Those activities which may be addressed by both professions include projective media, stress management and relaxation training, assertiveness training, education, cognitive-behavioral and discussion groups, and behavioral strategies education.

Occupational therapy has a holistic focus in that treatment is aimed at the entire person including physical, cognitive, and psychosocial aspects of the individual. Psychology places a focus on the psychological, emotional, and social aspects of the individual and often does not address the physical spectrum in treatment. It is occupational therapy's functional treatment focus and holistic perspective that makes this profession unique to that of psychology in the treatment of individuals with eating disorders.

In Lim and Agnew's study, many respondents to their questionnaire commented that there is much an occupational therapist can offer within the treatment of individuals with eating disorders, but other health care professionals "are unaware of the value of occupational therapy for these patients" (1994, p. 313). This may be because the role of OT is not clear to other professionals, in which case education about OT is critical. The respondents of the study also said there is not much definition of roles among the team members in their setting and there is an overlap of many responsibilities. Lim and Agnew (1994) believe further studies need to be conducted to obtain the views of other health professionals about OT and eating disorders, which is the purpose of this study.

Since there are so many risk factors for the development of eating disorders, and since these disorders impact the daily lives of these individuals and their ability to function in life, it seems logical that occupational therapists could be more involved in the treatment of this population. Do psychologists believe this is true? This study aims to answer this question.

Summary

The frames of reference psychologists and occupational therapists use to guide their treatment of individuals with eating disorders have a common ground between them. However, it is the modalities these professionals use in treatment that may set the professions apart. Occupational therapy's functional emphasis and the unique treatment modalities of this profession are not just associated with inpatient treatment, but can be used in the community setting as well. Through the literature review, there appear to be 13 treatment modalities that occupational therapists typically use in both inpatient and community-based treatment (Rockwell, 1990; Lim & Agnew, 1994). Are psychologists aware of this? The following chapter will describe the methodology the researcher went through to answer this and other questions.

CHAPTER III: METHODOLOGY

The aim of this study is to determine whether psychologists use treatment techniques that are similar to those an occupational therapist would use in treatment. In addition, the purpose is to determine whether psychologists perceive occupational therapy as a beneficial treatment for individuals with eating disorders and whether psychologists would refer to an occupational therapist. In the previous chapter, a review of the literature pertaining to this topic was conducted. This chapter will describe the methodology of the study and the process the researcher underwent in order to answer the research questions.

Population and Sample

Population

The population for this study is all licensed psychologists who work with individuals with eating disorders. The population that is accessible for the purposes of this study is 75 psychologists who are registered in the New York State Psychology Association's database of psychologists who work with individuals with eating disorders. In order to be included in this study, the participants must be licensed psychologists, must practice psychology within New York State, and must identify that they treat individuals with eating disorders, specifically anorexia and bulimia on question 4 of the survey.

Sample

Recipients of the survey were the 75 psychologists listed in the New York State Psychology Association's database of psychologists who list eating disorders as a specialty area of treatment. Only surveys of those who met the inclusion criteria were analyzed for this study.

Operationalization of Concepts Into Variables

The following is the list of variables being analyzed in this study. Refer to Appendix A for the definition of each term and Appendix B for the coding.

1. Demographics about Psychologists
    - Years Worked as a Licensed Psychologist
    - Treat Individuals With Eating Disorders
    - Percentage of Clients Treated in Past Year With Anorexia and/or Bulimia
    - Currently Treating Individuals With Eating Disorders
    - Type of Setting Currently Working In
    - Referred to an Occupational Therapist
    - Number of Clients Referred to an Occupational Therapist
    - County Practice Psychology In
2. Frame of Reference
    - Primary Frame of Reference Used in Treatment of Eating Disorders
    - Other Frames of References Used in Treatment of Eating Disorders
3. Treatment Modalities
    - Expressive Media
    - Cooking Skills

Meal Planning

Food Shopping

Dining Behaviors

Crafts

Coping Skills

Relaxation Techniques

Assertiveness Training

Movement Therapy

Clothes Shopping

Social Skills Training

Discussion Groups

Measurement Instrument

Research Design

This study is a survey research design (see Appendix D for a copy of the survey). Because the type of data being gathered (e.g. opinions, knowledge base and referral practices) and the geographic location of the psychologists who treat individuals with eating disorders, survey research is the most appropriate design to use.

Subject Participation

The 75 psychologists listed in the database were sent a survey with a cover letter and pre-addressed stamped envelope (see Appendix C). Each participant was assigned a number and the surveys were numbered to correspond with the participant number. This allowed the monitoring of those responding to the survey in order to send a reminder

postcard and second survey if necessary. Respondents were asked to complete the survey and return it immediately. A follow-up reminder postcard (see Appendix E) was sent to the participants who had not returned the survey after two weeks. A second copy of the survey, cover letter, and pre-addressed stamped envelope was sent three weeks later to all participants who had not yet returned the survey.

An inducement was offered to increase participation. The respondents were given the choice of being entered in a drawing for a $20 gift certificate to Amazon.com, and the winner was notified by mail and sent a gift certificate. The names of the participants remained confidential throughout the study and the primary researcher remained blind to the names (see Data Gathering Procedures).

Data Gathering Instruments

The first part of the survey asks for demographic information such as number of years working as a psychologist, if the participant is licensed, if the participant treats individuals with eating disorders, and the type of setting in which the participant works (see Appendix D). Two questions ask for information about the frames of reference the psychologists use in treatment. All of the demographic and frames of reference questions are multiple choice. The next section of the survey is a table which asks questions about different treatment modalities that are typically used by occupational therapists with the eating disordered population. Four questions were asked in regards to each of the thirteen treatment modalities: (1) the question "do you address this?" targets research question #1; (2) the question "do you feel it would be beneficial to your clients?" targets research question #2; (3) the question "are you aware that an OT does this?" targets research

question #3; and (4) the question "would you refer to an OT for this treatment?" targets research question #3 as well. The participants were asked to answer each question with a dichotomous yes/no answer. Through this section the researcher gathered information to answer the research questions.

Sources

The information included in the survey is based on research in the fields of psychology and occupational therapy regarding the treatment of eating disorders. The frames of reference psychologists typically use are based on a study conducted by Mussell, Crosby, Crow, Knopke, Peterson, Wonderlich, and Mitchell (2000). The treatment modalities included in this survey were identified by Rockwell (1990) to be the most commonly used modalities of occupational therapists.

Reliability

A pilot survey was reviewed prior to the distribution of surveys to the participants. The survey was given to five psychologists who work with individuals with eating disorders in the Ithaca College Counseling Center. Three of the five surveys were returned to the researcher. The psychologists' suggestions and comments were used to make minor changes to the survey and cover letter to increase clarity. Additionally, three occupational therapy professors read and gave suggestions for minor changes to the survey and cover letter. While no specific tests of reliability were conducted, the review did not demonstrate a need for major revisions to the survey.

Validity

External Validity

There are some factors that may have affected the external validity of the study. The results obtained from the population may not be generalizable to all licensed psychologists who treat individuals with eating disorders. Also, the psychologists who returned the survey may be biased to the subject. For example, they may have strong opinions about the involvement of occupational therapists with this population or they may feel strongly about one or more of the treatment modalities. It is possible that those who returned the survey may have done so only because of the inducement to participate. Those who feel strongly about the inducement are more likely to have completed and returned the survey, which could threaten the external validity of the study as well.

Content Validity

The content validity of this survey was accounted for by the researcher. All information included in the survey was obtained from published research literature. The frames of reference and treatment modalities can also be found in textbooks. Additionally, the comments made by the psychologists who reviewed the survey for the pilot test and the three occupational therapy professors who reviewed the survey were used to determine face validity. They commented on the style and clarity of the survey but not on the content, which indicates the survey's validity.

Summary of Reliability and Validity

This is the first time the survey has been used. The survey has standard administration and scoring, but the precise reliability and validity have not been determined. However, a pilot review was conducted to determine the ease of use by participants and the basic content validity before the study was conducted. The results required minor changes in administration of the survey.

Data Gathering Procedures

The data were gathered from all of the completed surveys that were returned and that met the inclusion criteria. The first surveys were sent to 75 psychologists in the database. A reminder postcard was sent to the participants who had not returned the survey two weeks following the initial mailing. A reminder letter and copy of the survey were sent three weeks later to all participants who had still not returned the survey (Salant & Dillman, 1994).

To insure the confidentiality and anonymity of all participants, an administrative assistant was used to open the envelopes and record the participants' counties on the surveys. They also crossed out the name of the participant on the database list and changed the number on the survey to correspond with the order the surveys were returned. Therefore, the primary researcher and committee could not link the survey to a name and anonymity was ensured.

Data Analysis and Interpretation Procedures

Descriptive statistics were used to analyze this data using Statistical Package for the Social Sciences (SPSS) version 10. Multiple questions were answered in this study, including whether psychologists use similar treatments an occupational therapist would in treatment and if not, whether psychologists perceive these treatments as beneficial to their clients with eating disorders. Whether psychologists are aware of what an occupational therapist does in treatment and whether they would refer their clients to an occupational therapist were also answered.

Frequency tests were run to determine the demographic information of the psychologists, the frames of references used by the psychologists, and information on the treatment modalities.

In terms of the participants, the depth and breadth of their experience with eating disorders in the community and hospital settings may affect their knowledge of occupational therapy treatment and their referral to OT. Therefore, Chi-square cross tabulations and Cramer's V were run on demographic information and the answers to the research questions. These include: number of years practiced and would the psychologists refer to OT; percentage of clients with eating disorders and would the psychologists refer to OT; and whether the psychologists feel the treatment modality is beneficial and would they refer to OT. Chi-square cross tabulations and Cramer's V were also run for the following groups of variables: do the psychologists address the modality and would they refer to OT; number of years practiced and are they aware OT addresses the treatment modality; and do the psychologists address the modality and are they aware OT addresses the treatment modality. Additionally, a Chi-square cross-tabulation with Cramer's V using

one layer was used to identify the effect of whether the psychologists address the modality, whether they find the modality beneficial, and whether they would refer to OT. For this study the statistical significance level was set at $p = .05$.

In order to ensure a high return rate, the researcher sent a reminder postcard and follow-up letter with a second survey. The participants had an option to obtain the results of the study through the mail and to be entered in a drawing for a gift certificate.

Scope and Limitations of the Study

- A major limitation in this study is the inability to select a random sample. A convenience sample of psychologists who work with individuals with eating disorders from the New York State Psychology Association were identified and sent this survey.
- Choosing only psychologists from this association may be a biased way of choosing psychologists who have a particular set of beliefs or values or increased knowledge or value on the profession.
- Another limitation is that the sample is quite small, with only 75 psychologists being sent the survey.
- A limitation is that the survey is being distributed to psychologists and not other professionals who treat individuals with eating disorders.
- Another limitation is that the psychologists listed in this database may not be the only psychologists in New York State treating individuals with eating disorders. Other psychologists may treat this population, but did not register it with the New York State Psychological Association as their specialty area in treatment.
- Another limitation is that the response rate from the survey may be low.

CHAPTER IV: RESULTS

The previous chapter described the methodology of the study and the process the researcher underwent to answer the research questions. This chapter will detail the results of the research study. The demographics of the participants will be presented, followed by the results of the research questions. The results will be presented by applying each research question to each of the 13 treatment modalities. The results of the crosstabulations and Cramer's V will then be presented for the demographic information and research questions that were run to determine if the participants' experiences affected their knowledge of OT treatment and their referral to OT.

Of the 75 participants, 36 surveys were returned for a return rate of 48%. However, three of the surveys could not be included in the analysis because the participants did not meet the inclusion criteria of being a licensed psychologist and treating individuals with diagnosed anorexia nervosa and bulimia. This dropped the return rate to 44% (N=33). All of the 33 participants included in the analysis treat individuals with eating disorders. Over 15% of the participants (n=5) have less than five years experience in the field of psychology, 18.2% (n=6) have between six and ten years of experience, and 15.2% (n=5) have between 11 and 15 years of experience. Seventeen (51.5%) of the participants have more than 16 years of experience in the field of psychology. Over 81% (n=27) have had less than 25% of their caseload consist of individuals with eating disorders in the past year. Five of the participants (15.2%) have had 26-50% of their caseload consist of individuals with eating disorders and only one participant (3.0%) had more than 50% of their caseload consist of clients with eating disorders.

Seventy-two percent (n=24) currently treat individuals with eating disorders. All of the participants (100%) practice psychology in a private practice and 18.2% also work in other settings outside of a private practice. Of the respondents, only one participant (3.0%) has ever referred a client to an occupational therapist. The most commonly used frames of reference reported by the participants are the cognitive-behavioral frame (33.3%) and an eclectic approach (33.3%). Two participants (6.1%) use family systems, six participants (18.2%) use interpersonal psychotherapy, and three participants (9.1%) use other frames of reference as their primary frame of reference in treating this population.

Of the participants, 30.3 % report that they use expressive media as a treatment modality (see Table 1). Of those who do not use this in treatment, 60.9% believe it would be beneficial, 13% believe it may be beneficial, and 26.1% believe it would not be beneficial (see Table 2). Thirty percent of the participants were aware and 51.5% were not aware that an OT uses expressive media in treatment, while 18.2% did not answer the question (see Table 3). Of the participants, 51.5% would refer to an OT for expressive media treatment, 27.3% would not refer, and 18.2% did not answer the question (see Table 4).

The majority (72.7%) of the participants address cooking skills in their treatment of individuals with eating disorders (see Table 1). Over 77% of those who do not address cooking skills believe it would be a beneficial modality and 22.2% do not think it would benefit their clients (see Table 2). Thirty-six percent of the participants were aware that cooking skills is addressed in occupational therapy, 48.5% were not aware, and 15.2% did not respond to the question (see Table 3). Over 51% of the participants would refer to an

OT for cooking skills treatment, 30.3% would not refer, and 18.2% did not answer this question (see Table 4).

Meal planning is addressed by 72.7% of the participants (see Table 1). Of those who do not address this in treatment, 85.7% feel this would be a beneficial treatment modality and 14.3% do not believe it would be beneficial (see Table 2). Of the participants, 45.5% were not aware that an occupational therapist uses meal planning as a treatment modality, 30.3% were aware, and 24.2% did not answer the question (see Table 3). While 45.5% would refer to an occupational therapist and 30.3% would not refer for this treatment modality, 24.2% did not respond to this question (see Table 4).

The majority of the participants (66.7%) use food shopping as a treatment modality with this population (see Table 1). Of those who do not use this modality in treatment, 90.0% feel this would benefit their clients and 10.0% do not feel it would be beneficial (see Table 2). Over 30% of the participants were aware an OT addresses food shopping in treatment, 51.5% were not aware, and 18.2% did not answer this question (see Table 3). Of the participants, 48.5% would refer to an occupational therapist for this treatment, 30.3% would not refer to an OT, and 21.2% did not answer the question (see Table 4).

Of the participants, 66.7% address dining behaviors in their treatment of individuals with eating disorders (see Table 1). Over 77% of those who do not address dining behaviors report this would be a beneficial treatment modality, 11.1% report it may be beneficial, and 11.1% report it would not be beneficial (see Table 2). Twenty-four percent of the participants were aware that an occupational therapist addresses dining behaviors in treatment, 57.6% were not aware, and 18.2% did not respond to this question

(see Table 3). Over 48% would refer to an OT, 3% report they may refer, and 24.2% would not refer to an OT for this treatment modality (see Table 4).

Over 45% of the participants use crafts as a treatment modality for eating disordered clients (see Table 1). Of those who do not use crafts, 50.0% feel they would be beneficial to their clients, 12.5% feel crafts may be beneficial, and 37.5% feel they would not be beneficial to use in treatment (see Table 2). Of the participants, 45.5% were aware that an OT uses crafts in treatment, 36.4% were not aware, and 18.2% did not answer the question (see Table 3). Over half (51.5%) of the participants report they would refer to an OT for the use of crafts for their clients, 30.3% report they would not refer to an OT, and 18.2% did not respond (see Table 4).

Of the participants, 97% address coping skills in their treatment of individuals with eating disorders (see Table 1). Because none of the participants who do not address coping skills answered this question, the cross tabulation could not be performed (see Table 2). Over 51% of the participants were not aware that an occupational therapist addresses coping skills in treatment while 27.3% were aware and 21.2% did not answer this question (see Table 3). Forty-two percent would refer to an OT for coping skills treatment, 39.4% would not refer to an OT, and 18.2% did not respond (see Table 4).

Over 84% of the participants use relaxation techniques in treating eating disorders (see Table 1). Of those who do not address relaxation techniques, 100.0% think they would be beneficial (see Table 2). Only 15.2% of the participants were aware that relaxation techniques are used in OT treatment while 66.7% were not aware of this, and 18.2% did not respond (see Table 3). Of the participants, 42.4% report they would refer

to an OT for relaxation techniques, 39.4% would not refer to an OT, and 18.2% did not answer the question (see Table 4).

All of the participants (100%) use assertiveness training as a treatment modality (see Table 1). Because this modality is addressed by all participants, a cross tabulation could not be performed (see Table 2). The majority (57.6%) were not aware that occupational therapists address assertiveness training in treatment while 18.2% were aware and 24.2% did not answer the question (see Table 3). While 36.4% would refer to an occupational therapist for assertiveness training for their clients and 36.4% would not refer, 27.3% did not respond to the question (see Table 4).

Of the participants, only 18.2% use movement therapy in treatment (see Table 1). Of those participants that do not use movement therapy, 63.6% think this treatment modality would benefit their eating disordered clients, 13.6% think this may be a beneficial modality, and 22.7% do not see movement therapy as beneficial (see Table 2). Over 45% were not aware that this treatment modality is addressed in occupational therapy, 39.4% were aware, and 15.2% did not answer the question (see Table 3). The largest group of respondents (48.5%) would refer to an occupational therapist for movement therapy, 33.3% would not refer, and 15.2% did not respond (see Table 4).

Over 48% of the participant's address clothes shopping as a treatment modality with their eating disordered clients (see Table 1). Of those participants that do not use this modality, 76.9% think this treatment would be beneficial to their clients and 23.1% do not think it would be beneficial (see Table 2). The majority (63.6%) were not aware that occupational therapists use clothes shopping in treatment, 24.2% were aware, and 12.1% did not answer this question (see Table 3). Over 60% report they would refer to OT for

this treatment modality, 3% report they may refer to OT, 21.2% would not refer, and 15.2% did not respond (see Table 4).

Of the participants, 75.8% use social skills training with their eating disordered clients (see Table 1). Of the 24.2% that do not address social skills in treatment, all (100%) of those participants believe this would be a beneficial treatment modality (see Table 2). The largest group of respondents (48.5%) was not aware that social skills training is conducted in occupational therapy while 33.3% of the participants were aware and 18.2% did not respond (see Table 3). Over 45% of the participants would refer to occupational therapy for social skills training, 30.3% would not refer, and 21.2% did not answer the question (see Table 4).

Over 57% of the participants use discussion groups in the treatment of individuals with eating disorders (see Table 1). However, 100% of those that do not use discussion groups believe they would be beneficial for their clients (see Table 2). Over 63% of the participants were not aware that discussion groups are used in occupational therapy while 24.2% were aware and 12.1% did not answer the question (see Table 3). Forty-two percent reported they would refer to occupational therapy for discussion groups, 39.4% would not refer, and 18.2% did not respond (see Table 4).

To summarize the results of the first research question, this study found that psychologists address many similar treatment modalities that occupational therapists address with individuals with eating disorders. The majority of participants in this study address cooking skills, meal planning, food shopping, dining behaviors, coping skills, relaxation techniques, assertiveness training, social skills training, and discussion groups.

The OT treatment modalities that were not used by the majority of the participants include expressive media, crafts, movement therapy, and clothes shopping (see Table 1).

The results of research question #2 can be summarized as follows: of the participants that did not address the treatment modalities, the majority feel all of the modalities would be beneficial for the eating-disordered population (see Table 2). To summarize the results of the third research question, the majority of participants would be willing to refer their clients with eating disorders to occupational therapy for all treatment modalities except for assertiveness training (see Table 4).

Chi-square crosstabulation and Cramer's V were used to try to identify statistically significant differences between psychologists with different years of experience and their awareness that OT addresses each treatment modality. Assertiveness training was the only treatment modality that approached significance (see Table 5).

Chi-square crosstabulation and Cramer's V were used to try to identify statistically significant differences between whether or not the participants address each modality and whether or not they are aware that occupational therapists address the modality. The only difference that approached significance was for discussion groups (see Table 6).

Chi-square crosstabulation and Cramer's V were used to try to identify statistically significant differences between the percentage of the participants' caseloads with diagnosed eating disorders and whether or not they would refer to occupational therapy for each treatment modality. Discussion groups were the only modality that approached significance (see Table 7).

The statistically significant difference between whether or not the participants address a treatment modality, whether or not they find it beneficial, and whether or not

they would refer to occupational therapy was determined for each of the thirteen treatment modalities using a chi-square cross tabulation and a Cramer's V test with one layer. The only difference approaching significance was for clothes shopping (see Table 8).

No significant differences were found between psychologists with varying years of experience and if they would refer to occupational therapy for any of the treatment modalities. Furthermore, no significant differences were found between whether the participants address the treatment modality and whether they would refer to OT for any of the treatment modalities. In an analysis of whether the participants find the treatment modalities beneficial and whether they would refer to OT, no significant differences were determined. All of these results were determined using a cross tabulation chi-square and a Cramer's V test.

CHAPTER V: DISCUSSION

Through an analysis of the data, all of the research questions can be answered. This study found that psychologists address many similar treatment modalities that occupational therapists address with individuals with eating disorders. The majority of participants in this study address cooking skills, meal planning, food shopping, dining behaviors, coping skills, relaxation techniques, assertiveness training, social skills training, and discussion groups. The OT treatment modalities that were not used by many of the participants include expressive media, crafts, movement therapy, and clothes shopping (see Table 1).

One of the reasons that could be postulated for psychologists not using these treatment modalities may be that they do not view them as beneficial with this population. However, this is not suggested by the research findings of this study. Of the participants that did not address the treatment modalities, the majority felt all of the modalities would be beneficial for this population (see Table 2). Possible explanations of this finding may be that the psychologists would like to use these modalities but do not have enough time to address the modalities themselves, do not have the training to use these modalities, or may not be able to receive reimbursement for the modalities. Further research may clarify the reasons behind this.

Of the 13 treatment modalities addressed in this survey, assertiveness training is the only modality for which the majority of psychologists would not refer to OT. This shows that a majority of psychologists in this study are even willing to refer to OT for treatment modalities they currently address themselves. This may be due to several

reasons. First, it may be that the psychologists realize that occupational therapists address these modalities from a different perspective that may be beneficial for the client. It is also possible that psychologists are only using these media because they are unable to find anyone else who addresses those issues, but they may feel that these are important services for their clients. If these psychologists are willing to refer to OT, why is it that only one participant reported referring to an OT? The psychologists simply do not know what occupational therapists do.

Of all the modalities, crafts was the only one these psychologists recognized as being addressed by occupational therapists. This suggests that in order to receive referrals from psychologists, occupational therapists need to market themselves to this profession and educate psychologists and other health care professionals about the profession of occupational therapy and its role in the treatment of individuals with eating disorders. This is supported by a comment made by one of the participants in this study who said, "I can tell you that there is very little connection between OT and psychology and there ought to be. Psychologists pretty much just don't know what OT's do. OT's should network and publicize more." Another participant commented that they usually refer to nutritionists and dietitians as a "result of lack of education regarding OT."

As well as being educated about occupational therapy and its role in the treatment of eating disorders, psychologists may need to be taught about the educational preparation of occupational therapists to work in this area. One participant said, "I'm not sure that OT's have the training to work with severely psychiatrically disturbed patients." In fact, several mental health courses are included in most occupational therapy programs. Another participant commented, "I have been totally unaware of referral to OT as an

option." Again, if more psychologists were better educated on the role of OT and what the profession can do with eating disordered individuals, the frequency of referral to OT by psychologists could increase.

Other possible explanations for psychologists not referring to occupational therapists may be the lack of availability of occupational therapists in the psychologists' geographic locations or the lack of knowledge about the occupational therapists practicing within their geographic area. Another reason psychologists may not refer to occupational therapy is because the locus of settings for the treatment of this population has moved from hospital-based to community-based settings (Scaffa, 2001). Since 100% of these psychologists work in private practices and only 18.2% also work in other settings, a lack of exposure to treatment teams in the community setting may be a factor that reduces the number of referrals psychologists make to occupational therapists for the treatment of individuals with eating disorders. Although this study only examined the awareness level of psychologists, further research needs to be conducted to investigate other possible explanations for the lack of referrals to occupational therapy by psychologists for individuals with eating disorders. This information could provide important marketing information for occupational therapists.

The results of this study are consistent with Lim and Agnew's study (1994) that found that health care professionals were not aware of the value of OT. The authors felt that education about occupational therapy is critical and that studies need to be conducted to obtain the views of health professionals about OT and eating disorders. This was supported by this study. With the majority of psychologists being unaware of occupational therapy's role in the treatment of eating disorders for all treatment modalities

except crafts (see Table 3), the need for education of this profession about the role of OT is highlighted.

While it was suggested in a comment by a participant in this study that psychologists may not believe that occupational therapists are qualified to treat the eating disordered population, occupational therapists may have some of the same perceptions themselves. They may feel they did not receive a sufficient amount of training in their OT educational program about treating individuals with eating disorders and may not have the skills to provide these treatment modalities. It is critical to determine the occupational therapists' level of knowledge about treatment of clients with eating disorders. If further research findings suggest that occupational therapists are not comfortable with treating this population, continuing education courses and further inclusion in occupational therapy curricula may be needed.

Professional discussion about the skills necessary to work with these clients and whether these skills should be learned within the undergraduate educational curricula or in post-professional education would also be beneficial. Further research to support this discussion would focus on the number of OT's working in this area, the skills perceived as necessary, the number of educational curricula currently addressing those skills, those skills perceived by the profession as post-graduate skills and the perceived benefits of continuing education courses, and the perception by psychologists of the skills needed to work in this area. Public discussion within the profession and the formation of a network may increase the support available for therapists wanting to work in this area and may increase the profession's awareness of practice opportunities in the area of eating disorders.

A difference approaching significance was found between the number of years experience in the field of psychology and the participants' awareness that occupational therapists address assertiveness training in treatment (see Table 5). With closer inspection of the cross-tabulation table for number of years experience and awareness that occupational therapists address assertiveness training, it appears that the majority of those psychologists with more than 16 years of experience in psychology were not aware that assertiveness training is addressed in OT (see Table 5). This suggests that education about occupational therapy may not have been included in the educational curriculum of psychologists 16 years ago. However, two of the three participants with less than five years experience in psychology were aware that occupational therapists address assertiveness training in treatment, which suggests that psychologists may be educated about occupational therapists' use of assertiveness training in the current educational curricula.

A difference approaching significance was also found between whether or not the participants use discussion groups in treatment and whether or not they are aware that occupational therapists use discussion groups (see Table 6). As seen in Table 6, there are more participants that are not aware of occupational therapists' use of discussion groups in treatment than those that are aware. Of those who are not aware of OT's use of this modality, more use discussion groups themselves in treating individuals with eating disorders (n=13). Therefore, the majority use discussion groups in treating this population, but are not aware that occupational therapy uses this modality. A possible explanation for this is that the participants may either be too busy or satisfied with conducting discussion groups themselves to look elsewhere for professionals who conduct

these groups. They may also have to run these groups themselves because they are not aware that other professionals conduct discussion groups with this population. Amongst those who address discussion groups in treatment, 15 participants would refer to OT and 15 would not refer to OT. This may support the conclusion that psychologists were conducting the groups themselves because they were unaware that other professions used this modality. Education of psychologists about the skills of occupational therapists may increase the referrals occupational therapists receive. Further research to validate this conclusion may be useful.

A significant difference was also found between the percentage of the participants' caseload with diagnosed eating disorders and whether they would refer to occupational therapy for discussion groups (see Table 7). On investigating the cross-tabulation distribution table (see Table 7), it appears that the participants with the smaller number of clients with eating disorders on their caseload are not willing to refer to occupational therapy for discussion groups (n=12). It is unclear why this may be, so further investigation is needed.

A difference approaching significance was found between whether the participants address clothes shopping, whether they find it beneficial, and whether they would refer to OT for this modality (see Table 8). However, the cross tabulations between whether they find clothes shopping to be beneficial and whether they would refer to OT, whether they use clothes shopping in treatment and whether they would refer, and whether they use clothes shopping and whether they feel it is beneficial found no significant relationships. This may suggest it is the interplay between all factors, and not between any two of the variables that results in the significance. This may not be a significant factor overall and

may be a result of the small numbers in the study. Further research to look at the factors influencing the decision to refer to occupational therapists may be useful.

Limitations

Some limitations were found in the survey instrument. The directions were not very clear on the second page of the survey (see Appendix D). The directions should have instructed the participants to complete every box. Some surveys were returned with many of the boxes empty, which may have skewed the data. Another limitation was that there should have been another answer choice besides yes and no on the second page of the survey. Some of the participants answered "maybe" for some of the questions, so this was included in the analysis. However, if all participants were given this option more may have chosen this answer, which may have changed the results of the study.

Another limitation in the study is the fairly small sample size. Thirty-three out of 75 surveys were returned for a return rate of 44%, but with a larger sample size the results may be more reliable and the conclusions more appropriately generalized. Because of this fairly small sample size, the results should be interpreted with caution. This sample was also limited by the participants being restricted to members of the New York State Psychological Association, which would limit the ability to generalize these results to psychologists in other states. Additionally, only those psychologists who chose to join the state association were included in this sample. There may be the influence that these psychologists are more aware or educated as they voluntarily joined this professional association. Additionally, there may be more psychologists who treat individuals with eating disorders in New York State but are not members of this association. There are

factors in each state that may affect these outcomes and further studies would be needed across geographic areas to ascertain those differences.

CHAPTER VI: CONCLUSION

Eating disorders affect up to 4% of adolescent and young adult students (Kaplan & Sadock, 1998). Since eating disorders are so prevalent in our society and they affect the lives of the individuals with the disorders, it is a population that could benefit from occupational therapy services. Individuals with eating disorders were referred to occupational therapists often in the past, but the number of referrals has not continued within the past 10 years. It is important to assess other professionals' (specifically psychologists') perceptions of occupational therapy with this population, which is the aim of this study. This may help explain how and why referrals are made to occupational therapists.

The primary purpose of this study is to discover whether psychologists and occupational therapists use similar treatment modalities in the treatment of eating disorders. A second purpose is to discover whether psychologists view occupational therapy services as being beneficial to individuals with eating disorders. The third purpose is to ascertain if psychologists would refer eating-disordered clients to occupational therapy.

The results of this study show that while psychologists currently address many similar treatment modalities to those occupational therapists use with individuals with eating disorders and they view those treatments as beneficial for this population, the majority would refer to occupational therapy for all of the modalities except for assertiveness training. Additionally, the results show that psychologists are not aware of occupational therapy's role with this population. This could imply a need for education about occupational therapy. If occupational therapists network and publicize for the

profession, the number of referrals they receive from other health care professionals, including psychologists, may increase. This is especially true as the treatment of individuals with eating disorders moves from a hospital-based to community-based setting (Scaffa, 2001). If OT receives more referrals, the profession can once again take an active role in treating individuals with eating disorders.

Future Research

It is recommended that this study be replicated with a larger sample size in the future. Instead of only including psychologists from New York State, other states could be included or the sample could be from a national database of psychologists. Other professionals such as physicians, nurses, and social workers could also be assessed using a similar survey instrument to determine their perceptions of occupational therapists' treatment of individuals with eating disorders. This would determine if other health care professionals would be willing to refer to OT and whether occupational therapists need to educate other professions to increase the number of referrals to OT for treatment of this population.

A study could also be conducted to determine if occupational therapists are available to treat individuals with eating disorders. Occupational therapists may not be available to provide treatments to meet referrals of this population. Their level of comfort and knowledge about treating this population could be assessed to determine what impact they have on occupational therapists choosing to treat individuals with eating disorders.

The reasons why psychologists do not refer to occupational therapy could be studied as well. This study looked at lack of awareness as a possible cause, but other reasons could be investigated as well. Further investigation could also be conducted to

determine why these participants do not address expressive media, crafts, movement therapy, and clothes shopping more often. These were the treatment modalities that were not used by the majority of participants in this study. Those media could be investigated to see if they are effective treatment modalities to use with this population. Additionally, the relationships approaching significance that were found in this study could be further investigated, such as the percentage of psychologists' caseloads with eating disorders and whether they would refer a client to occupational therapy for discussion groups. The results of all of these studies could provide important marketing information for occupational therapists.

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Table 1

Treatment Modalities Addressed By Psychologists (N=33)

Treatment Modality	Yes % n	No % n
Expressive Media	30.3 10	69.7 23
Cooking Skills	72.7 24	27.3 9
Meal Planning	72.7 24	21.2 7
Food Shopping	66.7 22	30.3 10
Dining Behaviors	66.7 22	27.3 9
Crafts	45.5 15	51.5 17
Coping Skills	97.0 32	3.0 1
Relaxation Techniques	84.8 28	12.1 4
Assertiveness Training	100.0 33	0 0
Movement Therapy	18.2 6	81.8 27
Clothes Shopping	48.5 16	51.5 17
Social Skills Training	75.8 25	24.2 8
Discussion Groups	57.6 19	42.4 14

Table 2

Would OT Treatment Modalities Be Beneficial According To Psychologists Who Do Not Use The Modality (N=33)

Treatment Modality	Yes % n	Maybe % n	No % n
Expressive Media	60.9 14	13.0 3	26.1 6
Cooking Skills	77.8 7	0 0	22.2 2
Meal Planning	85.7 6	0 0	14.3 1
Food Shopping	90.0 9	0 0	10.0 1
Dining Behaviors	77.8 7	11.1 1	11.1 1
Crafts	50.0 8	12.5 2	37.5 6
Coping Skills	0 0	0 0	0 0
Relaxation Techniques	100.0 3	0 0	0 0
Assertiveness Training	0 0	0 0	0 0
Movement Therapy	63.6 14	13.6 3	22.7 5
Clothes Shopping	76.9 10	0 0	23.1 3
Social Skills Training	100.0 5	0 0	0 0
Discussion Groups	100.0 11	0 0	0 0

Table 3

Psychologists' Awareness of OT Treatment Modalities: Are You Aware That OT Does This? (N=33)

Treatment Modality	Yes % n	No % n	No Response % n
Expressive Media	30.3 10	51.5 17	18.2 6
Cooking Skills	36.4 12	48.5 16	15.2 5
Meal Planning	30.3 10	45.5 15	24.2 8
Food Shopping	30.0 10	51.5 17	18.2 6
Dining Behaviors	24.2 8	57.6 19	18.2 6
Crafts	45.5 15	36.4 12	18.2 6
Coping Skills	27.3 9	51.5 17	21.2 7
Relaxation Techniques	15.2 5	66.7 22	18.2 6
Assertiveness Training	18.2 6	57.6 19	24.2 8
Movement Therapy	39.4 13	45.5 15	15.2 5
Clothes Shopping	24.2 8	63.6 21	12.1 4
Social Skills Training	33.3 11	48.5 16	18.2 6
Discussion Groups	24.2 8	63.6 21	12.1 4

Table 4

Would Psychologists Refer To An OT? (N=33)

Treatment Modality	Yes % n	Maybe % n	No % n	No Response % n
Expressive Media	51.5 17	3.0 1	27.3 9	18.2 6
Cooking Skills	51.5 17	0 0	30.3 10	18.2 6
Meal Planning	45.5 15	0 0	30.3 10	24.2 8
Food Shopping	48.5 16	0 0	30.3 10	21.2 7
Dining Behaviors	48.5 16	3.0 1	24.2 8	24.2 8
Crafts	51.5 17	0 0	30.3 10	18.2 6
Coping Skills	42.4 14	0 0	39.4 13	18.2 6
Relaxation Techniques	42.4 14	0 0	39.4 13	18.2 6
Assertiveness Training	36.4 12	0 0	36.4 12	27.3 9
Movement Therapy	48.5 16	3.0 1	33.3 11	15.2 5
Clothes Shopping	60.6 20	3.0 1	21.2 7	15.2 5
Social Skills Training	45.5 15	3.0 1	30.3 10	21.2 7
Discussion Groups	42.4 14	0 0	39.4 13	18.2 6

Table 5

Cross-Tabulation Table For Relationship Between Years of Experience as Psychologist and Awareness That OT Addresses Assertiveness Training (N=25)

Number of Years	Aware OT Addresses	Not Aware OT Addresses
0-5	2	1
6-10	0	3
11-15	2	2
16 +	6	19

Using the Cramer's V test, Chi-Square is 6.360, Cramer's V is .504, and p = .095.

Table 6

Cross-Tabulation Table For Relationship Between Whether Psychologists Address Discussion Groups and Whether They Are Aware OT Addresses Discussion Groups (N=29)

	Aware OT Addresses	Not Aware OT Addresses
Address Discussion Groups	2	13
Do No Address Discussion Groups	6	8

Using the Cramer's V test, Chi-Square is 3.160, Cramer's V is .330, and p = .075.

Table 7

Cross-Tabulation Table For Relationship Between Percentage of Caseload With Eating Disorders and Referral to OT For Discussion Groups (N=27)

Percent With Eating Disorders	Would Refer to OT	Would Not Refer to OT
0-25%	10	12
26-50%	4	0
51-75%	0	1
76-100%	0	0

Using the Cramer's V test, Chi-Square is 5.152, Cramer's V is .437, and p = .076.

Table 8

Relationship Between Whether Psychologists Address Each Treatment Modality, Whether They Find The Treatment Modalities Beneficial, and Whether They Would Refer To OT (N=33)

Treatment Modality	χ^2	Cramer's V	p
Expressive Media [1]			
Cooking Skills	.016	.039	.898
Meal Planning	.178	.149	.673
Food Shopping	.032	.060	.858
Dining Behaviors	.321	.189	.852
Crafts	.476	.218	.490
Coping Skills [1]			
Relaxation Techniques	1.215	.417	.270
Assertiveness Training[1]			
Movement Therapy [1]			
Clothes Shopping	4.950	.671	.084 *
Social Skills Training	1.742	.467	.187
Discussion Groups	.014	.033	.906

[1] Unable to calculate statistically due to data distribution
* Data approaches significance at p = 0.05

Appendix A

Basic Definitions of Terms

Eating Disorders: The term eating disorders will include diagnosed anorexia nervosa and bulimia nervosa. It excludes overeating associated with other psychological disturbances, vomiting associated with other psychological disturbances, and eating disorders unspecified (Kaplan & Sadock, 1998).

Anorexia Nervosa: According to DSM-IV, a diagnosis of anorexia nervosa can be made if an individual fails to maintain body weight at or above a normal weight for age and height (specifically, body weight must be less than 85% of that expected). Additionally, the individual must have an extreme fear of gaining weight and of becoming fat, a disturbed body image, and in women, amenorrhea or the absence of 3 consecutive menstrual cycles (American Psychiatric Association, 1994).

Bulimia Nervosa: To be diagnosed with bulimia nervosa, the DSM-IV criteria include recurrent episodes of binge eating (consuming large amounts of food in a short amount of time with a sense of lack of control during the binge) and repeated compensatory behaviors such as vomiting, misuse of laxatives, fasting, or exercise. These binge/purge cycles must occur at least twice a week for three months. To be diagnosed, an individual must also be overconcerned with body shape and weight (American Psychiatric Association, 1994).

The Diagnostic and Statistical Manual (DSM-IV): This is a classification system for psychiatric disorders. It is used by professionals who work with individuals with psychiatric disorders to give definitions and diagnostic criteria for various conditions. The criteria for anorexia nervosa and bulimia nervosa used in this study originate in the DSM-IV.

Psychologist: For the purposes of this study, a psychologist will practice in the state of New York, have a Ph.D. or Psy.D., and be a member of the New York State Psychological Association.

Occupational Therapy: Occupational therapy refers to "the art and science of helping people do the day-to-day activities that are important to them despite impairment, disability, or handicap" (Neistadt & Crepeau, 1998, p. 5). The goal of OT services is to return the individual to their highest level of functioning.

Expressive Media: Includes a variety of media such as art, clay modeling, music, dance, and drama. It is used to encourage insight and self-awareness in the individual.

Cooking Skills: Issues such as lack of knowledge about normal-sized portions and eating behaviors are addressed. Socialization and problem-solving are addressed if used in group format.

Meal Planning: Planning a nutritious meal can be addressed in a group or individually.

Food Shopping: Includes planning a grocery list and shopping for food, while emphasizing the purchase of only those foods on the list and avoidance of binge foods.

Dining Behaviors: Eating in group situations and in public is practiced. Support and encouragement are needed to reduce anxiety caused by eating in public and to allow the individual to eat comfortably in public. Proper dining behaviors should be evaluated and emphasized in treatment.

Crafts: An activity that is not essential but produces some kind of useful product as the outcome. Provide the individual with the opportunity to improve cognitive abilities such as problem-solving, decision-making, creativity, and self-control.

Coping Skills: Cognitive reframing and social techniques taught to decrease anxiety before and after meals, and to avoid eating behaviors that depend on stress and anxiety.

Relaxation Techniques: Techniques such as yoga and visualization are taught to decrease anxiety and stress.

Assertiveness Training: Allows the individual to test out assertive comments and attitudes within a safe environment, and is used to develop self-expression and self-awareness. Examples of assertive comments include giving and receiving compliments and identifying and stating needs.

Movement Therapy: The individual creatively uses movement and dance to express themselves and then discusses the experience with others.

Clothes Shopping: This activity promotes better body image and self-esteem while focusing on self-awareness and self-expression. Moral support is needed as the individual selects larger-sized clothing.

Social Skills Training: Because many individuals with eating disorders have deficits in this area, a social skills group provides a safe environment to test newly gained skill such as identifying routine daily social interactions and individual deficits for training and practice.

Discussion Groups: Group members speak about any topics or concerns they may have. It provides a safe environment for speaking about sensitive topics.

Appendix B

Coding of Variables

1. Demographics about Psychologists

Licensed Psychologist

1=Yes 2=No

Years Worked as a Licensed Psychologist

1=0-5 yr. 2=6-10 yr. 3=11-15 yr. 4=16+ yr.

Treat Individuals With Eating Disorders .

1=Yes 2=No

Treat Individuals With Anorexia Nervosa and/or Bulimia

1=Yes 2=No

Percentage of Clients Treated in Past Year With Anorexia and/or Bulimia

1=0-25% 2=16-50% 3=51-75% 4=76-100%

Currently Treating Individuals With Eating Disorders

1=Yes 2=No

Type of Setting Currently Working In

1=Private Practice 4=High School

2=Hospital 5=College/University

3=Community Agency 6=Other

Referred to an Occupational Therapist

1=Yes 2=No

Number of Clients Referred to an Occupational Therapist

1=1-5 2=6-10 3=11-15 4=16+

County Practice Psychology In

1=Albany	8=Onondaga
2=Bronx	9=Queens
3=Dutchess	10=Richmond
4=Erie	11=Rockland
5=Kings	12=Suffolk
6=Nassau	13=Westchester
7=New York	

2. Frame of Reference

Primary Frame of Reference Used in Treatment of Eating Disorders

1=Cognitive-Behavioral	4=Eclectic
2=Family Systems	5=Narrative
3=Interpersonal Psychotherapy	6=Other

Other Frames of References Used in Treatment of Eating Disorders

1=Cognitive-Behavioral	4=Eclectic
2=Family Systems	5=Narrative
3=Interpersonal Psychotherapy	6=Other

3. Treatment Modalities

Expressive Media (EM)

Cooking Skills (CS)

Meal Planning (MP)

Food Shopping (FS)

Dining Behaviors (DB)

Crafts (CR)

Coping Skills (COP)

Relaxation Techniques (RT)

Assertiveness Training (AT)

Movement Therapy (MT)

Clothes Shopping (CLO)

Social Skills Training (SST)

Discussion Groups (DG)

Do You Address This? (ADD)

If No, Would it be Beneficial? (BEN)

Are You Aware That OT Does This? (OT)

Would You Refer to an OT? (REF)

1=Yes 2=No

Appendix C

What Do You Think About Occupational Therapy in the Treatment of Individuals With Eating Disorders?

I am a graduate student in the Occupational Therapy Department at Ithaca College. As part of my Master's thesis, I am conducting research about psychologists' perceptions of occupational therapy in the treatment of individuals with eating disorders. Because psychology is a key discipline in treating these disorders, I have targeted your profession. I ask that you take approximately 10-15 minutes of your time to complete this survey.

This survey will ask demographic questions such as number of years working as a psychologist, setting in which you currently work, and whether you have referred clients to an occupational therapist in the past. The survey also asks about the frame of reference and modalities you use in the treatment of individuals with eating disorders. In treating eating disorders, you will find modalities that could be provided by psychologists but are typically addressed by other professionals such as physicians and nutritionists. The survey will ask you to evaluate the benefits of these modalities for your clients with eating disorders and whether you would refer to an occupational therapist to provide these treatments.

After completing the survey, please return it in the pre-addressed stamped envelope. Once returned, the participants who elect to participate will be entered into a drawing for a $20 gift certificate to Amazon.com. The winner will be notified by mail. You may also elect to receive the results of the study by mail.

To ensure your anonymity, please do not write your name on this survey. If you choose to be included in the gift drawing, your name will be linked to a number which will remain confidential and protected. Check the line below if you choose to be included in the gift drawing, and write the number that is on the top of the survey on the appropriate line.

Thank you very much for your participation. If you have any questions, feel free to contact me at (607) 273-4577 or my thesis advisor Marilyn Kane at (607) 274-1737.

Sincerely,

Amy K. Robinson

Please check if applicable.

_____ Please enter me in the drawing for a $20 gift certificate to Amazon.com.
The number on my survey is: _____

_____ Please send me the results of the study by mail.

Appendix D

Eating Disorder Survey

1. Are you a licensed psychologist in New York State?
   ____Yes ____No

2. How many years have you worked as a licensed psychologist?
   ____0-5 years ____ 6-10 years ____11-15 years ____16 + years

3. Do you treat individuals with eating disorders?
   ____Yes ____No

4. Do you treat individuals diagnosed with anorexia nervosa and/or bulimia?
   ____Yes ____No

5. What percentage of the clients you have treated in the past year have been diagnosed with anorexia nervosa and/or bulimia?
   ____0-25% ____26-50% ____51-75% ____76-100%

6. Are you currently treating any individuals with eating disorders?
   ____Yes ____No

7. In what type of setting do you currently work?
   ____ Private Practice ____ High School
   ____ Hospital ____ College/ University
   ____ Community Agency ____ Mental Health Clinic
   ____ Other Please specify_____

8. Have you ever referred a client to an occupational therapist (OT)?
   ____Yes ____No _____ Go on to question 10

9. If yes, approximately how many clients have you referred to an OT?
   ____1-5 ____6-10 ____11-15 ____16 +

10. What is the primary frame of reference/treatment model you use in the treatment of individuals with eating disorders? (Please mark only one answer)
    ____Cognitive-behavioral ____Eclectic
    ____Family systems ____Narrative
    ____Interpersonal psychotherapy ____Other Please specify_____

11. What other frames of reference do you use with this population? (Mark all that apply)
    ____Cognitive-behavioral ____Eclectic
    ____Family systems ____Narrative
    ____Interpersonal psychotherapy ____Other Please specify_____

Please fill out the following chart. Note that OT means Occupational Therapy. Mark the appropriate box using:

Y= Yes N= No

TREATMENT MODALITIES	DO YOU ADDRESS THIS?	IF NO, WOULD IT BE BENEFICIAL?	ARE YOU AWARE THAT OT DOES THIS?	WOULD YOU REFER TO AN OT?
Expressive Media: Includes many media such as art, clay modeling, music, dance, and drama. It is used to encourage insight and self-awareness in the individual.				
Cooking Skills: Issues such as lack of knowledge about normal-sized portions and eating behaviors are addressed. Socialization and problem-solving are addressed if used in group format.				
Meal Planning: Planning a nutritious meal can be addressed in a group or individually.				
Food Shopping: Includes planning a grocery list and shopping for food, while emphasizing the purchase of only those foods on the list and avoidance of binge foods.				
Dining Behaviors: Support and encouragement are needed to reduce anxiety caused by eating in public. Proper dining behaviors should be evaluated and emphasized in treatment.				
Crafts: Provide the individual with the opportunity to improve cognitive abilities such as problem-solving, decision-making, creativity, and self-control.				
Coping Skills: Taught to decrease anxiety before and after meals, and to avoid eating behaviors that depend on stress and anxiety.				
Relaxation Techniques: Techniques such as yoga and visualization are taught to decrease anxiety and stress.				
Assertiveness Training: Allows the individual to test out assertive comments and attitudes within a safe environment, and is used to develop self-expression and self-awareness.				
Movement Therapy: The individual creatively uses movement and dance to express themselves and then discusses the experience with others.				
Clothes Shopping: This activity promotes better body image and self-esteem while focusing on self-awareness and self-expression. Moral support is needed as the individual selects larger-sized clothing.				
Social Skills Training: Because many individuals with eating disorders have deficits in this area, a social skills group provides a safe environment to test newly gained skills.				
Discussion Groups: Group members speak about any topics or concerns they may have. It provides a safe environment for speaking about sensitive topics.				

***** Thank you very much for your participation. Please return the survey as soon as possible.**

Appendix E

February 7, 2001

Two weeks ago you were mailed a survey about psychologists' understandings of occupational therapy and eating disorders. You are one of a small number of psychologists chosen for this study and your response is vitally important. Please return the survey by February 28, 2001. If you have lost your copy of the survey and would like a new one, please call me at (607) 273-4577.

I would like to take this opportunity to thank you for your participation in this research project.

Sincerely,

Amy K. Robinson, OTS

Appendix F

ITHACA

Ithaca College
350 Job Hall
Ithaca, NY 14850-7012
(607) 274-3113
(607) 274-3064 (Fax)

Office of the Provost and
Vice President for
Academic Affairs

DATE: December 12, 2000

TO: Amy K. Robinson
Department of Occupational Therapy
School of Health Sciences and Human Performance

FROM: Garry L. Brodhead, Associate Provost
All-College Review Board for Human Subjects Research

SUBJECT: Psychologists' Perceptions of Occupational Therapy with Eating Disorders

The All-College Review Board for Human Subjects Research has received your request for review of the above named proposal. The proposal has been reviewed and the Board authorizes you to begin the study. This approval will remain in effect for a period of one year from the date of authorization. Future proposals should be submitted to the Board on the published deadlines.

The Board did, however, have the following consultative comment:

Reference to self-addressed stamped envelope should be revised to pre-addressed stamped envelope.

After you have finished the project, please complete the attached Notice-of-Completion Form and return it to my office for our files.

Best wishes for a successful study.

Attachment

c: Marilyn Kane, Faculty Advisor

ALL-COLLEGE REVIEW BOARD
FOR
HUMAN SUBJECTS RESEARCH

COVER PAGE

Investigators: Amy K. Robinson

Department: Occupational Therapy

Telephone: 273-4577 (Campus) (716) 763-0162 (Home)

Project Title: Psychologists' Perceptions of Occupational Therapy With Eating Disorders

Abstract:

The purpose of this study is to determine whether psychologists perceive occupational therapy as a beneficial treatment for individuals with eating disorders. In addition, the purpose is to discover whether psychologists use the same treatment techniques an occupational therapist would use in treatment and whether psychologists would refer a client to an occupational therapist for a treatment they do not provide themselves.

Surveys will be sent to psychologists in New York State who treat individuals with eating disorders to gather data for this study. The names of these psychologists have been obtained from the New York State Psychological Association. The surveys will be sent in January of 2001. The information gathered from this study will be analyzed using descriptive statistics and its results may help increase psychologists' awareness concerning occupational therapists' role with this population. This may add to the number of referrals psychologists make to occupational therapists, thus allowing this profession to take a more active part in the treatment of individuals with eating disorders.

Proposed Date of Implementation: January 2001

Amy K. Robinson Marilyn Kane, MA, OTR
Print or Type Name of Principal Investigator and Faculty Advisor

Signature (Use blue ink) Principal Investigator and Faculty Advisor

1. General Information about the Study

The purpose of this study is to determine whether psychologists view occupational therapy (OT) as being beneficial to individuals with eating disorders. In addition, the purpose is to determine whether psychologists use the same treatment techniques an occupational therapist would use in treatment and whether psychologists would refer a client to an occupational therapist for a treatment they do not provide themselves.

a. Funding

Data will be gathered using a survey that has been developed for this study (see Appendix B).

b. Location

The funding for this study will come from the Occupational Therapy Department at Ithaca College.

c. Timeline

The surveys will be sent to psychologists in New York State beginning in January of 2001.

2. Related Experience of the Researcher

The research experience of the primary researcher is limited to the occupational therapy curriculum at Ithaca College. Related courses include Biostatistics (670-39000), Research Seminar (672-49500), and Research Methods (672-67000). The primary researcher has written two literature reviews on eating disorders from an occupational therapy perspective. The faculty advisor for this study is Marilyn Kane. She has over 25 years of experience in occupational therapy specializing in mental health, administration, and home health care. She has experience treating the eating disordered population in both a community and hospital setting. She is a professor in the occupational therapy department, teaching classes such as Clinical Psychiatry in OT, Activity Group Process, and OT with Adults.

3. Benefits of the Study

Since there is a lack of literature on psychologists' perceptions of the benefits of OT intervention with individuals with eating disorders, this study could benefit the scientific community by adding to the literature. Psychologists may feel the treatments an occupational therapist would provide are important to address in treatment and are not being covered by themselves. If this is the case, psychologists would need to be educated in the role an occupational therapist can play in the treatment of individuals with eating disorders. This would increase the number of referrals psychologists would make to occupational therapists, and more importantly, individuals with eating disorders could potentially benefit from receiving occupational therapy services.

4. Description of Subjects

Surveys will be sent to 71 licensed psychologists in New York State who treat individuals with eating disorders. These psychologists are listed in a database from the New York State Psychological Association. All subjects must be licensed psychologists who practice within the state of New York. Only those who treat individuals with eating disorders will

be included in the study. In order to be included in the analysis, the survey must be 100% complete.

5. Description of Subject Participation

The subjects will voluntarily complete and return the self-addressed stamped survey, which should take approximately 10-15 minutes to complete. This survey will ask demographic information, information about their practice, information about their clients with eating disorders, and treatment options used (see Appendix B). The survey will be sent to the subjects with an introduction page which explains the purpose of the study (see Appendix A). All subjects will receive a reminder letter and follow-up survey after one month to increase the return rate.

6. Ethical Issues- Description

There are no identifiable risks involved in this study. An informed consent form is not necessary for participation. By completing and returning the survey, it is assumed the subject gives his or her consent to participate in the study.

7. Recruitment of Subjects

The participants in this study will be chosen from a list of psychologists who treat individuals with eating disorders. This list has been obtained from the New York State Psychological Association. As an inducement to participate in this study, the participants will be given an option to be entered in a drawing for a $20 gift certificate to Amazon.com. The winner will be notified by mail. In addition, the participants will be offered the opportunity to receive the study results by mail.

8. Confidentiality/Anonymity of Responses

Since there is no identifying information included in the survey besides general practice information and type of setting in which he or she currently works, anonymity will be secured. The subjects will be instructed not to include any other identifying information. Each survey will be coded with a number which corresponds to each participant. If they elect to be included in the gift drawing or wish to receive results from the study, the coded number will be used. Participants' names will remain confidential, however. They will voluntarily complete and return the survey by mail.

9. Debriefing

The subjects will be given the option to receive a report of the results of the study. No other debriefing is necessary.

10. Compensatory Follow-up

Not applicable to this study.