REGULAR ARTICLE

Evaluating the Real-World Effectiveness of Cognitive-Behavior Therapy Efficacy Research on Eating Disorders: A Case Study from a Community-Based Clinical Setting

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ABSTRACT

Objective: There is a growing consensus that there is a need to test the real-world effectiveness of eating disorder therapies that show promise in efficacy research. This article provides a narrative account of an NIMH-funded study that attempted to apply efficacy findings from CBT research to an Intensive Outpatient Program (IOP) at the largest community-based eating disorder program in the United States.

Method: We describe the study as originally envisioned as well as the various challenges that the researchers and the IOP staff encountered in implementing this study.

Results: The different training, assumptions, and "ways of knowing" of the research team and the treatment staff in regard to the nature of eating disorders and their treatment created multiple challenges for both groups during the study period. We describe valuable lessons learned about how to—and how not to—implement effectiveness designs in clinical settings that are relatively unfamiliar with empirically-based research findings.

Discussion: It is hoped that our experience in attempting to apply efficacy-based research findings on eating disorders treatment in a community-based clinical setting will prove helpful to other researchers and service providers engaging in such translational research. © 2010 by Wiley Periodicals, Inc.

Keywords: cognitive behavior therapy; intensive outpatient program; efficacy research; effectiveness research; clinical settings; translational research

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Introduction

The vast majority of controlled psychotherapy outcome studies for eating disorders have used efficacy designs, leaving open the question of the real-world applicability of their findings. Efficacy studies have found cognitive-behavior therapy (CBT) to be the treatment of choice for bulimia nervosa (BN). It may hold promise for anorexia nervosa (AN) as well.[1–3] The present paper describes our attempt to translate CBT findings from efficacy studies on bulimia nervosa to a community-based intensive outpatient program. This study was supported by a NIMH R34 grant that was designed to promote such translational studies. The reason that we wrote this narrative account is that the attempt to apply findings from well-controlled efficacy studies to a clinical setting using an effectiveness design creates a number of novel challenges that must be identified and overcome to facilitate this kind of translational research in the future.

Two goals of the R34 grant that funded this research were to "encourage research on 1) the development and/or pilot testing of new or adapted interventions, [and] 2) pilot testing interventions with demonstrated efficacy in broader scale effectiveness trials. . . . ".[4] This rationale is in line with several researchers who have suggested that there is a substantial need within eating disorder treatment outcome research for the transmission of empirically supported treatments that are utilized in efficacy studies into real-world clinical treatment settings.[5,6,3] For example, Mussell et al.[6] noted that "considerable effort has been devoted to developing and empirically testing manual-based treatments for individuals with eating disorders. To make a meaningful impact on service delivery,

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dissemination efforts are clearly needed" (p. 236). Such lab-to-field translational research is particularly timely within the field of eating disorders. For example, Wilson et al.[3] pointed out that substantial progress has been made within the fields of both anxiety and mood disorders in demonstrating that the results of efficacy studies are generalizable to real-world clinical settings, whereas the evidence for such dissemination within the eating disorders field is lacking.

The overarching goal of the NIMH-funded study was to evaluate (1) the feasibility of adapting therapeutic procedures developed in efficacy studies to The Renfrew Center's intensive outpatient program (IOP), and (2) whether adapting the therapeutic treatment in a real-world setting enhances treatment outcome. To accomplish this task, we implemented an effectiveness paradigm to evaluate the usefulness of CBT treatment components in two of Renfrew's IOP sites (the two sites were merged into one site during project but this did not affect the implementation of the research study). Treatment outcome research is rarely conducted in such real-world clinical treatment settings and yet the vast majority of eating disordered patients are treated in these settings.

Our intervention was referred to as "Normalization of Eating" (NOE), which is a central component of CBT. Research has indicated that a change in dietary restraint that involves patients adopting a regular pattern of flexible eating early in treatment mediates improvement in both binge eating and vomiting at post treatment.[7] The original goals of the NOE intervention were to: (a) promote and maintain a regular pattern of food intake that would reduce dieting and maintain or increase body weight; (b) identify specific fear-based practices or beliefs that underlie avoidance of food and eating; (c) design behavioral tasks to be implemented during supervised meals and at home via homework assignments to gradually expose patients to feared foods and behaviors; and (d) teach cognitive therapy techniques so patients could learn how to challenge their own extreme and irrational thoughts about food, eating, and weight. Additionally, patients were gradually exposed to their feared foods both inside the IOP during evening meals as well as at home. We also incorporated a pre- and postmeal check-in within the already existing IOP groups to check on the progress of patients' food-related goals at home and their food-related goals for the IOP meal each evening (premeal group) as well as the progress on their food-related goals during the IOP meal (postmeal group).

The research design was a simple A-B design with repeated measures (intake/discharge assessments) during both phases. The first phase (A) was referred to as "Treatment as Usual (TAU)." During TAU, the therapists within the IOPs continued to administer the treatment approach that is implemented within Renfrew IOPs generally. The TAU phase lasted for one year and was followed by the NOE approach (B). The original design called for the research team to train staff for two months prior to and for two months during the beginning of the NOE phase. However, for a variety of reasons that we describe below, our research team continued to hold weekly training sessions with the IOP staff throughout the year-long NOE phase. These meetings involved presenting the overall conceptualization of CBT, training staff in the implementation the NOE procedures, and providing feedback to staff based on the observations the researchers made during their observations of IOP sessions. Within these training sessions, the researchers often engaged in role-playing strategies as a way of illustrating the techniques to be adopted. The clinical realities and demands of the existing program meant that there was sometimes backsliding on our recruitment procedures, which meant that we captured patients for our study at a slower rate than originally anticipated. Therefore, both the TAU and NOE phases lasted several months longer than originally planned.

Overview of the Prestudy IOP

The Renfrew nonresidential treatment centers provide a continuum of treatment services that range from consultation and traditional outpatient clinical services up to a five day per week Day Treatment Program. The IOP provides three nights of services designed for two particular groups of patients—those stepping down from residential or day treatment levels of care and those for whom straight outpatient management proved to be inadequate. Each IOP session consists of two psychotherapy or psychoeducational groups and a structured and supervised dinner. The mealtime protocol includes a systematic review of patient mealtime goals and of their experience of the meal. Each patient is assigned to an individual case manager who is responsible for developing specific treatment goals. The case manager also coordinates contact and therapy with family members, when appropriate, and maintains contact with the patient's existing outpatient treatment providers. A registered dietitian meets with each patient to develop her nutritional treatment plan. All patients are evaluated and monitored by the staff psychiatrist

while enrolled in the IOP. In most cases, patients are expected to continue their psychotherapy, family therapy, psychiatric management, and medical monitoring while enrolled in the IOP. The treatment goals for most patients focused on restoration of nutritional and physical health, the stabilization of co-morbid mood and impulsivity issues, and the development of a personal commitment to ongoing treatment and recovery.

The structured dinner meal is a core component of the IOP. From a nutritional perspective, the meal provides an opportunity to help each individual patient meet her specific nutritional and weight goals. Many of the symptoms, behaviors and thoughts of patients with eating disorders reflect the influence of inadequate nutrition. The structure of the meal and the mealtime support therapy plays an important role in helping to moderate these effects. From a psychotherapeutic perspective, the meal groups also provide opportunities to address food rituals and, perhaps more importantly, they provide support to help minimize the anxiety and tension most patients experience around meals.

The prestudy IOP focused on the negative emotional precipitants of restricting, binge eating and purging behaviors. The group and individual psychotherapy sessions commonly addressed the relational precipitants for eating disorder behaviors, seeking to link interpersonal disruptions and disconnections with the individual's feelings about her body, her weight, and her relationship to food. In this model, the treatment community offers a set of secure relationships which provide the safety necessary to risk new behaviors with food. The groups and the individual therapies provided informal, nonsystematic directives regarding some of the cognitive and emotional antecedents to eating disordered behaviors. The clinical emphasis was the therapeutic alliance and on the links between negative emotional reactions and eating disordered behaviors.

This emphasis reflected Renfrew's overall conceptualization of eating disorder psychopathology. The psychotherapy components of the IOP were designed to help patients stabilize their eating disorder symptoms and to engage them in a self-directed course of treatment. In contrast to a more formal cognitive behavioral model, the Renfrew model focuses on the role of the eating disorder symptoms in managing relationships, internal distress, and the challenges of maturation. Specifically, symptoms are assumed reflect difficulties in self-assertion, and the identification and articulation of emotions. Therefore, considerable therapeutic attention is paid to the profound ambivalence many patients experience when contemplating the surrender of their eating disorder. In the IOP, normalization of eating, be it cessation of binge/purge behaviors or increased caloric intake, is seen as a necessary but insufficient first step in treatment. A restoration of nutritional health allows the IOP patient to start to address the relational and self-regulating functions of her eating disorder. With the support of a relationally focused therapeutic community, patients can develop a curiosity about the role of their eating disorder in their relational and psychological lives. This emerging curiosity helps build an internal motivation to commit to treatment. The bulk of this deeper psychological work is expected to take place in the post-IOP psychotherapy and family therapy.

The prestudy IOP did make use of certain cognitive and directive techniques. However, in contrast to the NOE study protocol, the original program was much less focused on the cognitive and/or behavioral antecedents to food restriction. For instance, the opening groups of each session served as a basic check in for patients. They were encouraged to discuss any significant developments since their last IOP session but there was no particular emphasis on food related behaviors. Therapists were trained to look for links between negative emotional experiences and eating disordered behaviors but the priority was the development of strategies for containment of distress and increasing the commitment to recovery. The core features of a cognitive behavioral approach, particularly the normalization of eating, blocking of food rituals, experimentation with specific changes in behaviors and thoughts, were part of this more general therapeutic approach, but they were not systematically applied in the prestudy IOP. Similarly, although there was an implicit encouragement for patients to take the risk of trying new behaviors, there was no explicit push for experimentation.

Patient Population

Over the duration of the study, patient ages ranged from 14 to 55 years. IOP patients received DSM-IV Axis I diagnoses from Renfrew psychiatrists. Exclusively female, there was considerable diagnostic variability. Approximately one third of the IOP patients met diagnostic criteria for AN, one third for BN. The remaining patients were diagnosed with EDNOS. Virtually every patient had multiple comorbid psychiatric diagnoses, particularly affective and anxiety disorders. Many patients had histories of physical or sexual trauma. At least

one quarter had co-morbid substance abuse diagnoses.

Given the wide range in ages and developmental levels, it was common to find a wide range in the availability of social and relational support. While many patients lived with their families of origin, others were living independently for the first time. Still, others were now living with their spouses, their partners and, less frequently, with their own children. Although patients were expected to be in ongoing outpatient individual psychotherapy during their IOP admission, many, in reality, entered the program without an existing outpatient treatment team. These patients needed quick referrals to a new team of clinicians. This variability also affected the degree of support and limited opportunities for patients to process and work through issues that arose in the course of the group sessions.

This demographic and diagnostic diversity complicated treatment planning. In addition, patients in the IOP came into treatment with a wide range of levels of motivation and ambivalence. Managing motivation and ambivalence in a group format is a therapeutic art. Although some patients within any given group were eager to address specific strategies for symptom and behavior management, many others had not achieved that level of commitment to change. At any given time, the IOP cohort included patients who were "stepping up" from outpatient treatment and patients who were "stepping down" from residential and partial hospital levels of care. Patients had different levels of experience with treatment, goal setting, and self-awareness. These differences had considerable impact on patients' willingness to participate treatment, especially in the more directive CBT interventions.

Staff Background and Training

The core members of the IOP treatment staff were in place prior to the start of this study. With the exception of the program psychiatrist, all staff members were female, masters level clinicians. Most were drawn to work at Renfrew by their interest in this particular patient population. While many had some prior treatment experience with this population, most clinicians joined the staff with general clinical training but without formalized training in the treatment of eating psychopathology. The Renfrew orientation and training protocols emphasize general eating disorder knowledge and treatment information but did not, at the time of this study, include formal training on specific therapeutic approaches such as CBT, DBT, IPT, or EMDR. The clinical and administrative directors of this program did, however, have more than five years of clinical experience with eating disordered women.

Many of the staff were drawn to this work by Renfrew's reputation for holistic, relational, and gender sensitive nutritional rehabilitation and psychotherapy. Historically, Renfrew's clinical programming has not emphasized CBT and other directive therapeutic techniques but has, instead, focused on issues of therapeutic engagement, social support, and increasing self assertion within the context of relationships. This relational focus has been a core Renfrew value and, in the recent past, was specifically integrated into a "feminist oriented" treatment philosophy. While this perspective has evolved into a more generalized approach based on the centrality of connection and inter-relatedness, it is likely that the "feminist" focus appealed to potential staff members who were especially drawn to this perspective.

Original and Adapted Goals of the NOE phase

The individuals who wrote and eventually received the R34 grant consulted with IOP staff early in the preparation of the grant proposal, but approximately two years transpired between these consultations and the receipt of NIMH funds. Thus the IOP staff (some of whom were new to the IOP) had little knowledge of or involvement in the study that was to be implemented in the IOP. Most of the IOP staff were not comfortable that they would have to learn how to implement a set of therapeutic procedures that were not of their choosing and that largely conflicted with their treatment philosophy and clinical experience. Because of this, training the staff in the NOE procedures was much more difficult than originally anticipated.

The original goals of the NOE intervention were to (a) promote and maintain a regular pattern of food intake that would reduce dieting and bingeing and maintain or increase body weight; (b) identify specific fear-based practices or beliefs that underlie avoidance of food and eating; (c) design behavioral tasks to be implemented during supervised IOP meals and at home via homework assignments to gradually expose patients to feared foods and behaviors, and (d) teach cognitive therapy techniques so patients could learn how to test and challenge their own extreme and irrational thoughts about food, eating, and weight. Additionally, patients were gradually and increasingly exposed to their feared foods both inside the IOP during

evening meals as well as at home. We also incorporated a pre- and postmeal check-in time within the already existing IOP groups to check on the progress of patients' food-related goals at home and their food-related goals for the IOP meal each evening (premeal group) as well as the progress on their food-related goals during the IOP meal (postmeal group).

The training process during the NOE phase of treatment took much more time than anticipated for several reasons. First, implementing the changes in focus required a change in scheduling and time devoted to traditional Renfrew treatment. Staff often felt that the time budgeted for goal setting and CBT based interventions was inadequate. There was considerable frustration with time management but also with the expectation that therapists limit or contain patients' emotional expression in order to focus on normalization of eating techniques. At times, therapists felt that the study protocols were academically disconnected from their patients' realities. For example, how was one supposed to challenge irrational food and weight concerns with a patient who was distressed and, at best, ambivalent about being in treatment in the first place? Also, the orientation of the IOP staff, as noted above, was primarily psychodynamic and feminist-relational, and the researchers were introducing CBT techniques, many of which the therapists had not utilized before, particularly in a group format. There were important differences between the feminist-relational treatment model that was in place and the cognitive-behavioral model that underlay the NOE intervention. These included different assumptions about the importance of focusing treatment on emotional and interpersonal factors that may be underlying disordered eating versus focusing on eating disordered behaviors and thought patterns themselves.

Perhaps most importantly, the IOP staff was not involved in the design of the study and therefore many staff members felt that the new treatment procedures involved in NOE were being externally imposed upon them. One Renfrew clinician pointed out that the study had been designed and implemented in a particularly hierarchical, that is masculine, manner that conflicted ironically with feminist principles of collaboration and consensus. Furthermore, as noted earlier, few of the staff had any formal training or background in CBT.

The more the research team learned about the IOP program, the more they realized that they needed to try to change aspects of the existing program that they didn't anticipate when designing the original grant application. Therefore, in realty some of the NOE procedures that were implemented took shape gradually throughout the intervention period. Thus, the research team was in the unfortunate position of continually shaping the independent variable of "normalization of eating" even as it was being administered. Given this multiplicity of challenging circumstances, it is our judgment that the level of fidelity to NOE procedures that was achieved by the end of the one-year NOE intervention was suboptimal. Discussed below are the most significant challenges the research team faced in trying to adapt the NOE intervention given the real world demands of a functioning clinical setting.

Essential Differences Between the Two Treatment Approaches

The conflicts between the existing program philosophy and the research protocols clustered around several essential areas.

Dietary Intake

One unique therapeutic opportunity of the IOP was a standardized meal, which ensured that patients consumed a balanced meal while preventing purging or other compensatory behaviors after the meal. Patients work with a nutritionist to decide on the caloric and nutritional content of their meal plan based on diagnosis and weight level. However, for many patients, the size of the meal is significantly larger than meals they ate outside the IOP. From a behavioral perspective, this had two undesirable consequences. First, the principle of successive approximations (where patients would begin with a meal that was moderately challenging and gradually increase the size of the meal and the number of "forbidden foods" contained in it) was not followed. This could have had the effect of resensitizing some patients to normal eating by expecting them to eat too much too quickly. Second, it soon became clear that nearly all patients were restricting their intake at home the day of and the day after IOP groups and that this was done in part in anticipation of, or as a consequence of, needing to consume the "large" meal at the IOP. The staff were clearly aware of this pattern and worked to establish structure for patients at home for evenings and weekends. For underweight patients, the nutritional goals often focused on weight restoration, with a premium placed on maximizing caloric intake during the IOP structured meals. The unintended consequence, however, was that the required meal, though designed to be therapeutic, was having unanticipated negative effects in promoting food restriction among both anorexic and bulimic patients.

A somewhat similar issue existed in regard to the staff's expectations for patients' food intake at home. Individualized meal plan requirements were developed by a nutritionist and patients reported in at each session on the percentage of their meal plan they were consuming. However, most patients reported that they were consuming well below 100% of their meal plan, sometimes throughout their six-week IOP stay. The IOP worked on the assumption that the therapy and support patients received would help to establish a platform of symptom stability and therapeutic engagement, thereby leading to gradual increases in the percentage of the meal plans that were actually consumed. However, this assumption often was not borne out by experience and the staff did not have a system of detecting and responding to sub-optimal intake of food plans when this occurred.

Directive vs. Nondirective Nature of Intervention

The model of psychotherapy at the Renfrew Center was based on the premise that if a patient is given sufficient opportunity to express their struggles in a supportive environment, they will begin to build commitment and motivation to make specific changes in their eating and thinking. An essential goal of IOP treatment is to establish this sense of community, connection and empowerment which patients can use as a safe and stable platform. Reduction of emotional distress would lead, in this view, to eating disorder symptom reduction. In practice, this could also lead to therapist avoidance of emotionally charged topics that might "trigger" increased weight, shape, and eating concerns. In the existing protocols, therapists would focus on containment and distress reduction. The NOE intervention, however, required staff to take a much more directive stance with patients to get them to focus on and gradually challenge specific pathological beliefs and behaviors surrounding eating disordered symptoms. Most of the staff had little experience implementing the much more directive NOE approach and many were uncomfortable practicing it. From the perspective of NOE, the nondirective stance of supportive-expressive therapy inadvertently allowed many patients to avoid directly confronting and challenging the beliefs and practices that were maintaining their disordered eating. In sum, it was not only the substance of the NOE treatment but the relatively directive style required to implement it that was difficult for most staff to accept and adhere to.

Nature of Therapeutic Process

On a more specific level, the NOE phase called for therapists to change their typical inquiries and discussion prompts in the group therapy sessions. Staff were more likely to push for patient associations and would attempt to link eating disorder symptom use to changes in the patients' emotional states and interpersonal functioning. If a patient, for instance, reported that she had eaten 50% of her meal plan outside of program hours, therapists would typically attempt to identify disruptions in relationships and support that may have prompted the restriction. Questions such as "what does that make you think or feel?", "what do you think you needed at that moment?", or, generally, "Can you tell us something more?" or "Can anyone else in the group relate to what she's saying?" were used to facilitate group exploration and support for the patient in question.

In the NOE phase, therapists were now instructed to shift their focus of inquiry to specific conditions surrounding instances of food restriction or binge eating and purging along with possible cognitive distortions and unwarranted assumptions thought to underlie these behaviors. Staff were encouraged to shift focus from the patient's emotional dysregulation to a focus on the ways in which the patient made specific decisions about eating or symptom use and how behavioral practices and thought patterns contribute to the self-perpetuation of disordered eating symptoms. At times, staff felt pressured to use NOE inquiries such as "What made it difficult for you to eat lunch yesterday?" or "When you decided to restrict yesterday, what thoughts were running through your head?", even if they believed that the clinical focus needed to remain on the patient's emotional distress. This conflict between therapists' initial instincts and the responses required as part of the NOE implementation was a persistent source of difficulty between the staff and the research consultants.

Goal Setting

Patients were expected to generate treatment goals on a weekly basis. In the TAU phase, these goals most often addressed issues of emotional regulation, avoidance of distress, and use of interpersonal support when struggling with eating disorder impulses. Staff would explore goals in individual and group sessions with a focus on exploration of feelings, anxieties, and relationship dynamics. For instance, if a patient set a goal of "Not obsessing about calories," a therapist might explore this by

asking "What are you afraid will happen to you if you can't account for all the calories?" During the NOE phase, the research team trained staff to help patients set more specific, behavioral, and measurable goals such as "I will use my list of distracting activities to help me shift out of my obsessive thoughts about calories". Therapists were expected to help patients identify specific and concrete tactics for managing anxieties. A NOE appropriate response, for example, would be something like "What can you do when you start to obsess about the calories?" The staff was also instructed to avoid exploration of how the anxiety developed or what the patient thought it signified unless it was connected to presumed proximal contributors to symptoms (e.g., food restriction or strict eating rules). The staff, again, struggled with this shift, often expressing concerns that the specificity of the goals felt mechanical, unempathic, and excessively concrete. Some staff felt that this mode of response was somehow nonhumanistic, judgmental, and patronizing. They also felt that the patient's level of emotional distress precluded a focus on the specific cognitive antecedents of eating symptoms.

Triggering

A staff concern in using a directive approach like NOE with a vulnerable population such as eating disordered individuals is the risk that the treatment might sometimes create anxiety and trigger some of the very behaviors that the treatment is designed to remediate. Prior to being trained in NOE, the IOP staff was reluctant to induce thoughts, emotions, or behaviors in the patients that might trigger greater restriction, bingeing, or purging during or after IOP sessions. However, from the NOE perspective, this reluctance on the part of the therapists could inadvertently reinforce patients' avoidance of feared stimuli and eating behaviors. The CBT-based NOE approach viewed "triggering"' (i.e. asking patients to intentionally do things that generated anxieties related to their eating disorder) as a therapeutic opportunity to help the patient examine, challenge, and alter, in a supportive environment, the thoughts, feelings, and behaviors that are maladaptive or distorted.

This distinction was most noticeable during a "Challenge Group" that was begun as part of the NOE treatment. In this group, patients were expected to taste enough of a "forbidden food" to begin to generate anxiety about the consequences of doing so. Staff initially had a difficult time encouraging patients to try some of the challenge foods. They were uncomfortable with patient reports of anxiety during this exercise and worried that exposure to anxiety would promote increased symptom use when patients left for the evening. The NOE trainers had to reinforce that intentionally inducing anxiety was therapeutic for patients because—not in spite of—its potentially "triggering" effects. That is, it would be beneficial to demonstrate to patients that the feared consequences were not inevitable or, if they occurred, catastrophic. Moreover, therapists were encouraged to assist patients to verbalize the specific fears that tasting these foods generated. The NOE trainers needed to repeatedly emphasize to staff that progress meant taking actions that were difficult or unpleasant for patients to take.

Approach to Comorbidity

Many of the IOP patients had previously been in a higher level of treatment and had a variety of comorbid problems that complicated the treatment of their eating disorder. When the NOE phase was introduced, the IOP staff was particularly reluctant to directly target eating disordered behaviors for treatment in those who were also struggling with other major emotional or interpersonal issues. Therefore, IOP staff felt that coexisting problems should be one of the primary focuses of treatment and that making progress with comorbid issues would facilitate the resolution of the eating disorder symptoms. The research team was in agreement that some issues are so serious or overwhelming (e.g., severe depression, hostility toward treatment staff) that a patient cannot be expected to engage in specific NOE treatment for their eating disorder. Otherwise, the assumption of CBT is that eating disorder behaviors should continue to be directly targeted, even as attention is directed toward co-occurring problems. The conflict between these goals was particularly apparent with patients who were not especially motivated for treatment and the staff often struggled to focus on discrete CBT goals and interventions with patients who were highly ambivalent about treatment. This difference in perspective about comorbid features seemed grounded in the staff's belief that some eating disorder patients "need" their disorder to help them cope with other significant problems they face; staff had been trained to address the adaptive function of patient's symptoms and to address the ambivalent attachment to their disorders. The CBT perspective does not make such an assumption and, if a patient is sufficiently engaged in treatment, would proceed with a focus on remediating specific eating disordered behaviors. Indeed a possible outcome of making progress with the eating

disorder is that it could improve the co-occurring problems or make working on them more feasible.

Approach to Training and Supervising Staff

A final difference between the IOP staff and the research team was their attitudes about training and supervision. The research team was accustomed to working from detailed treatment manuals, training graduate students in their implementation, and providing feedback both about what trainees were doing well and what they needed to improve. Between their educational backgrounds, clinical experience, and exposure to the Renfrew treatment model, IOP staff adopted a treatment model that was less clearly defined and much less prescriptive and specific in its application. Similarly, although there was a clinical director of the IOP staff, treatment approaches and clinical decision making was made in a much more decentralized manner—that is, using more of a collaborative "bottoms-up" rather than an expert-based, "top-down" approach. Therefore, when the research team observed IOP sessions and later provided feedback to therapists on their degree of adherence to NOE procedures, many of the staff experienced this as too authoritarian and direct in its approach. Tension sometimes arose because the staff was not accustomed to thinking in terms of there being a "right" and "wrong" way of implementing treatment.

The Staff Perspective

As noted earlier, it is likely that the process involved in implementing this project had as much, if not more, of an impact on staff receptivity than the actual content of the changes in treatment approaches. The design of the study and the grant application itself were developed with very limited input from the actual clinical staff at the study site. This was due in part to the amount of time that typically transpires between the time a grant is written and the time it is started. Renfrew Center administrators had approved the study and the study site administrator was aware of the project but had little sense of the timeline. With the grant in hand, the research team approached the clinical staff with protocols that, to the clinicians, reflected little awareness of the nuts and bolts of the clinical program. Even prior to the study, it was hardly unusual for staff at a satellite outpatient site to perceive the centrally based administration as unappreciative and unaware of the challenges faced by front line staff. The introduction of a demanding study, led by a highly regarded male academic noted for his work in CBT and bulimia, intensified this dynamic.

At the same time, the site leadership and clinicians felt pressure from the administration to maximize patient census, admission rates, and, where clinically appropriate, patient lengths of stay. They were concerned about patient reactions to the study parameters, fearful that patients would leave the program due to the study demands. This concern, while certainly valid at one level, probably also represented a projection of the staff's discomfort with the process and content of the protocols. The inclusion of the research consultants in the actual group sessions (as silent observers) was particularly challenging. Many therapists seemed to resent the intrusion of the academic, vigilant, compliance-monitoring "other" into the therapeutic community. For therapists trained to focus on relational influences, the inclusion of the researchers seemed incompatible with "good" therapy. Over the course of the study, therapists, researchers, and patients needed to address issues such as the researchers' note taking in sessions and the lack of therapeutic interaction with the researchers. For patients, who are prone to experience themselves as deficient, unworthy, and imperfect, the presence of a note taking, vigilant rater was a ripe set-up for projections of low self esteem and inadequacy. Some staff experienced similar reactions.

These perceptions and possible projections often came to a head in the weekly training sessions. In these sessions, the research consultants would review their observations of the IOP sessions. While the researchers struggled to respectfully and empathically push for greater adherence, the staff often complained that they were not getting enough concrete explanations about how to respond to certain clinical situations. They often felt criticized, at times patronized, and devalued. At the worst moments, training sessions seemed to have two distinct communities, one speaking a clinical language while the other spoke about clinical performance and adherence to the CBT perspective. This disconnect was resolved to some degree by the addition of a senior Renfrew clinician to the weekly sessions. Usually attending telephonically, this clinician was able, to some extent, to translate each group's concerns and helped to develop a working consensus.

The staff also expressed their frustration that the consultants undervalued the significance of procedures that interfered with their preferred treatment, lack of patient motivation and affective variability, and the slow pace of change for many patients. From their perspective, the IOP was designed to

help stabilize patients' symptoms and to help engage them in longer term treatment. The researchers had a shorter time frame in mind and were measuring symptom change in the four- to six-week course of IOP treatment. So, while the staff may have been relatively content with small changes in soft signs like motivation and commitment, the research perspective focused on more measurable short-term behavioral changes. This disconnect reinforced mutual perceptions; the staff saw the researchers as academic idealists while the researchers were prone to see therapists as overly wedded to their traditional approach and dismissive of evidence-based treatments and research-based approaches. These perceptions could surface in times of stress.

Lessons Learned

Many of the study limitations, in retrospect, stemmed from the process through which the study was implemented as much as the actual content of the evidence based NOE protocols. The inability to involve key supervisory and clinical staff in the original design of the project fueled the perception that the study was an imposition and that the researchers and administration had little respect for the real world clinical complications in the IOP. Future projects will need to work collaboratively from the outset to enhance staff "buy-in" to the use of empirically supported treatments. As we learned, subsequent studies will also need to include formal measures of therapist and patient adherence to the treatment interventions. The researchers came to appreciate the enormous challenges of sustaining patient motivation and commitment to treatment in a real world clinical setting. Future research in this area needs to address the essential issue of ambivalence. We may have increasingly useful evidence based treatments but they can't work for patients who find the treatments unacceptable or irrelevant to their realities.

Yet, despite the many complexities, false starts, and revisions, the study has had lasting impact on the IOP, both at the study site and throughout other Renfrew programs. The staff have enthusiastically incorporated certain NOE techniques and assumptions, particularly in regards to challenge foods and challenge meals. On a more conceptual level, there is increasing appreciation for the power of therapeutic exposure to fearful foods and situations and a marked movement away from the notion that treatment should focus on the avoidance of psychological and dietary "triggers". Although ongoing training has led to a more sophisticated appreciation for the usefulness of specific behavioral goals and the use of CBT derived and directive interventions, the core approach has retained a distinctly relational and psychodynamic conceptualization of eating disorder symptoms and experiences. What has changed, though, is the open embracement of the use of directive techniques in the context of this relational focus. Normalization of Eating, CBT, and a dynamic relational approach are not irreconcilable and, in fact, may be synergistic. The most recent revision of the Renfrew Center Treatment Philosophy now incorporates many of the fundamental assumptions of NOE and CBT approaches.

Discussion

This NIMH funded study ended in July, 2008. Outcome data comparing the TAU and TAU+NOE phases will be reported in a separate article.

The clinical supervisor at the study site was a psychotherapist with a background in creative arts. She wrote a summary of her experience of the research project that, with a bit of a twist, captures much of this experience.

On a cold December afternoon, both sets of parents, NIMH and Renfrew, made arrangements for a blind date. Both parties were anxious and excited to embark on an experience that had potential to be mutually beneficial. The moment arrived, eyes met, expectations and needs for this new relationship were discussed. Some doubts and questions were raised. Others were not expressed at all to ensure that this relationship would have a successful start.

As the relationship progressed, both parties became more acquainted with each other; quirks became evident, resistance to change regarding philosophical beliefs also emerged, frustration ensued but never once was a break up discussed. Instead, both parties continued to build a strong foundation.

After nearly two years of dating, the time had come to celebrate the union. Both parties then worked independently to write their vows, which included compiling all of the information obtained throughout the years, reflecting on the memories; what worked, what didn't work, lessions learned and capturing the emergence of a deep respect for each other, ensuring a partnership for years to come.

Although it was 2 [1/2] years in the making, during the early summer of 2008, Renfrew and the researchers were proud to announce the birth of

the "Food Challenge Group". Over the past several months, with proper nurturance and guidance, the group continues to develop, trying new techniques and introducing a multitude of challenges. The parents are proud of what they have accomplished, both clinically and professionally.

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