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Evaluation of Parental Stress and Appointment Satisfaction in a Feeding Disorders Clinic

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Evaluation of Parental Stress and Appointment Satisfaction
in a Feeding Disorders Clinic

by

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Presented to the Faculty of the
Graduate Department of Clinical Psychology
George Fox University
in partial fulfillment
of the requirements for the degree of
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in Clinical Psychology

Newberg, Oregon

February 2018

Evaluation of parental stress and appointment satisfaction in a feeding disorders clinic

by

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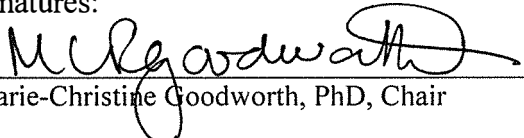
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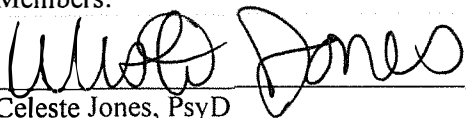
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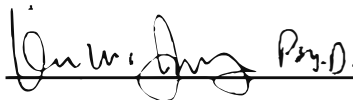


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Evaluation of Parental Stress and Appointment Satisfaction
in a Feeding Disorders Clinic

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Abstract

More than one-quarter of the pediatric population in the United States struggles with feeding or swallowing challenges, many of which become chronic, lifelong disorders. Diagnosis and treatment of feeding and disorders can be challenging due to the interplay of behavioral and medical factors that create food refusal by the child. Treatment of feeding disorders is difficult, as it requires comprehensive involvement of parents and caregivers, which can be demanding and stressful. Parental stress may include anxiety, fear, and frustration with the child(ren) with feeding or swallowing disorders and can negatively affect health outcomes for children. Specialty clinics designed to address treatment needs for children diagnosed with a feeding disorder can provide tools necessary to improve the child's health outcomes (e.g., feeding plans implemented by parents/caregivers). This study examined the perspectives of 81 parents/caregivers within the feeding clinic at a large children's hospital in the Pacific Northwest. Parents/caregivers reported on their clinic experience and how their needs were met,

with specific attention to stress and motivation for implementation of treatment plans outside of clinic appointments. Overall, participants were largely satisfied with the clinic operations, typically scored within higher levels of activation (knowledge, skills, and confidence in managing their child's healthcare). Most endorsed "child resistance to eating" as a main barrier to successful mealtime interactions. Recommendations for future research included a focus on implementation of stress reduction/management techniques, incorporation of outcome measures for the clinic, and incorporation of health literacy measures within the clinic.

Keywords: diagnosis of feeding disorders, interventions, treatment of feeding disorders, parental stress, feeding disorders, feeding therapy, mealtime behaviors, feeding disorder clinic, parent patient activation, program evaluation, stress management techniques, health management, caregivers of chronic health conditions, severity

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Chapter 1

Introduction

More than one-quarter of the pediatric population in the United States currently struggles with feeding problems, many of which become chronic, life-long disorders (Chatoor, Ganiban, Surlis, & Doussard-Roosevelt, 2004). For children with developmental disabilities, feeding problems are more prevalent, affecting up to four-fifths of the population (Greer, Gulotta, Masler, & Laud, 2008). Though feeding disorders often resolve within a child's early years of life, many do not and instead require intensive treatment (Greer et al., 2008). Feeding disorders involve a variety of problems regarding a person's eating ability. As noted by Didehbani, Kelly, Austin, & Wiechmann (2011), feeding problems can include refusal to eat, gagging or vomiting (dysphagia), eating severely limited foods and/or textures, or the necessity of a gastrostomy tube. Those with feeding disorders struggle to consume the proper amount or variety of foods to sustain proper nutritional status, which can lead to medical conditions that can become life-threatening (Greer et al., 2008). Often, families seek medical care for children with feeding disorders, including diagnosis, treatment, and other medical support. In fact, children diagnosed with feeding disorders experience more physician visits than typically developing children (Bandstra, Crist, Napier-Phillips, & Flowerdew, 2011). With the high occurrence of health care visits, feeding clinics provide a medically-specialized and interdisciplinary opportunity to meet the needs of children with feeding disorders and their families (Janicke, Finney, & Riley, 2001; Sharp, Jaquess, Morton, & Herzinger, 2010).

Structure of the Feeding Clinic

Within the specialty feeding clinic involved in this study (and common in other feeding clinics), children engage with an interdisciplinary treatment team, often comprised of a pediatrician, psychologist, speech language pathologist, nutritionist, and occupational therapist. The treatment team typically collects weight and measurement, followed by a clinical interview to collect information regarding mealtime behaviors, parent concerns, and history of the child. The clinical interview also addresses family functioning, family mental health history, the child's developmental history, the child's medical history, and the family's economic needs. Often, the child is provided a snack and observed to evaluate eating functioning from a physical, medical, and behavioral standpoint. Diagnosis is clarified upon team collaboration, and information is provided to the family regarding treatment options (Greer et. al, 2009; Sharp, et al., 2010).

The parent-professional collaboration process is vital for parents to feel understood and supported, as well as invest in their diagnosis and treatment of their child's feeding disorder, and ultimately impacts the parents' trust of the treatment providers and satisfaction with their clinic experience (Cowpe, Hanson, & Smith, 2014; Wu, Franciosi, Rothenberg, & Hommel, 2012). This collaboration process also impacts treatment outcomes for the child, so understanding the process from the parental perspective is important for feeding clinics to ensure quality care and overall satisfaction with the clinic program (Cowpe et. al., 2012; Greer et al., 2009).

Diagnosis and Treatment of Feeding Disorders

Diagnosis and treatment of feeding disorders can be challenging due to the interplay of behavioral and medical factors that create food refusal by the child. Children who have a feeding disorder will often struggle with an unwillingness to try new foods, they may prefer to drink their

meals rather than eat solid foods, and they may experience a poor appetite compared to children without a feeding disorder (Piazza-Waggoner, Driscoll, Gilman, & Powers, 2008). These feeding patterns can make it difficult to distinguish “picky eating” from a feeding disorder. Many children with feeding disorders fall below the fifth percentile for height and/or experience weight loss greater than two growth percentiles. When this is the case, doctors diagnose failure to thrive or FTT (Bauchner, 2016; Gueron-Sela, Atzaba-Poria, Meiri, and Yerushami, 2011), and more intensive intervention is often needed. When other cognitive or psychological limitations co-occur, they often negatively impact the feeding process for children with feeding disorders, exacerbating symptoms such as food refusal (Kerzner et al., 2015). The impacts of these co-occurring conditions highlight the importance of the interdisciplinary treatment team. The physician can work to address associated medical conditions that exacerbate feeding symptoms (e.g., acid reflux, constipation, or respiratory issues). The speech and language pathologist or occupational therapist can address any oral motor, pharyngeal, and esophageal problems, which can include problems with suckling in infants, tongue movement, and difficulty with swallowing when food gets stuck or enters the airway (Pressman & Berkowitz, 2003). After medical/physical concerns are addressed, parent and caregiver involvement become vital, as they are important to the advancement of proper feedings. The psychologist considers family and cultural issues to adapt feeding plans and create patient-specific treatment goals that are appropriate in the family context.

Intervention for feeding disorders. Intervention for feeding concerns most often involves behavioral programming, with a focus on nutrition. Parents are given specific instruction for family mealtimes and snacks. For instance, parents and caregivers are typically

instructed to provide preferred food for the child at mealtimes, with new foods introduced at snack times. In addition, it is typically recommended that both mealtimes and snack times occur in a setting with minimal distractions for the child. Third, children and families are taught the division of responsibility at an age-appropriate level for the child, meaning that each person in the family has a role in the child's feeding process. The child and siblings may assist with food selection at the grocery store, setting the table, or helping parents or caregivers in meal preparation and cooking (Pressman & Berkowitz, 2003).

Systematic changes are then incorporated one at a time, with parents and caregivers providing foods that the child readily accepts, then working to modify taste, texture, or quantity (Fishbein, M., Benton, K., & Struthers, W., 2016). When new foods become readily accepted, they are then implemented in regular mealtimes with the child. In cases where children are not yet able to accept foods by mouth, sensory-based experiences are often incorporated into treatment, such as sitting at the table, feeling utensils, smelling new foods, or touching/licking foods (Pressman & Berkowitz, 2003). Appropriate rewards are utilized to facilitate child participation.

Parental Stress in Feeding Disorder Intervention

There are many stressors that tax parents/caregivers of children with feeding disorders. First, parent involvement in the implementation of feeding treatment plans is comprehensive and essential, with factors such as feeding disorder onset, severity, and prognosis further influencing the demands on parents/caregivers (Didehbani et al., 2011). Similar to other populations of children with chronic, complex medical issues, parents and caregivers of children with severe and chronic feeding disorders have caregiving duties that extend through the night (i.e.,

medication administration, tube feeds, or checking breathing ventilator functioning; Monaghan, Hilliard, Cogen, & Streisand, 2009). Relatedly, these parents/caregivers have been found to report disrupted sleep, fatigue, depression, and an overall negative quality of life (Monaghan et al., 2009). In turn, parenting stress negatively impacts family functioning, relating to poorer social and medical outcomes (e.g., greater post-treatment disease activity among patients with Crohn's disease, poor expressive language development, and increasing children's behavioral problems; Wu et al., 2012).

Parent emotional control. The relationship between parent/caregiver stress and severity of the child's feeding disorder is bidirectional, in that parents of children with increased severity experience more stress, and unmanaged parent-caregiver stress can negatively impact symptom severity. Didehbani et al. (2011) reported that caregivers who were unable to provide their child with appropriate nutrition experienced rejection, stress, decreased self-efficacy, and increased parenting-related self-doubt. These experiences are heightened for parents of children with severe feeding disorders (those children who associate feeding with pain), resulting in increased intensity of feeding challenges and increased familial stress (Greer et al., 2008). At the same time, Didehbani et al. (2011) endorse the importance of parent and caregiver emotional monitoring and control when working with their children with feeding disorders. Where effective parent/caregiver emotional monitoring and control is related to better eating behaviors and improved nutrition in children with feeding disorders, parent/caregiver emotional arousal or stress influences the development of anxiety, fear, and frustration in children with feeding disorders, negatively affecting health outcomes (Didehbani et al., 2011). Also, parental worry and anxiety may lead to maladaptive parenting responses surrounding the feeding process, such

as being too rigid or controlling of the feeding process for their child (Mitchell, Brennan, Hayes, & Miles, 2009). Finally, coupled with the demands of the child's feeding disorder intervention, the heightened level of parental stress can negatively impact marital relationships (Bluth, Roberson, Billen, & Sams, 2013), further demonstrating the need for parent support for this population.

Parent-child relational factors in feeding disorders. Similar to the bidirectional relationship between parent stress and symptom severity, researchers have noted that familial stress is cyclical among the parents and the child with a feeding disorder (Davies et al., 2006). This pattern describes impacts of feeding disorders on the parent-child relationship due to the interplay of behaviors between children and parents during feeding. Some of these dynamics are explored here, in the context of Baumrind's parenting styles (Baumrind, 1966).

Authoritarian parenting. Associated with an authoritarian parenting style (Baumrind, 1966), parents may become too rigid or controlling with the feeding process, engaging in too much coaxing, food pushing, or force-feeding behaviors. This controlling type of engagement by parents during the feeding process can be reflective of overall parenting style. Collins, Duncanson, and Burrows (2014) found that an authoritarian parenting style was linked to pressuring their child to eat, as well as engaging in restrictive food behaviors as parents. This type of parenting style is associated with a parent's belief that the child is self-indulgent and strong-willed. Parents with this belief often utilize control through coercion and power (Collins et al., 2014).

Permissive parenting. Next, overly permissive parenting is also problematic for children with feeding disorders. With this style of parenting, when demands or rules are set, they are

inconsistently reinforced or not enforced by the parent. Baumrind (1966) reported that in this style of parenting, the parents engage with their child as a friend, making little to no demands on the child, instead, allowing the child to regulate his or her own activities. Children who receive permissive parenting also engage in more fussiness with the eating and feeding process, greater conduct problems, and hyperactivity challenges. Within this parenting style, mothers rated their child to have higher overall behavioral challenges (Blissett, J., Meyer, C., & Haycraft, E., 2010). Collins et al. (2014) reported that permissive parents of children with feeding disorders lack engagement in monitoring their child's dietary intake. Mealtimes may lack direction and structure or may lack appropriate food and support for the child. In these ways, learning is hindered for the child regarding self-regulation and social patterns surrounding eating.

Parent/Caregiver Activation

Parent/caregiver activation is much like patient activation, which is an individual's ability to manage their medical problems and maintain functioning. This involves collaboration with their healthcare providers, and increased access to quality care. When patients experience high levels of activation, they are more likely to obtain their healthcare needs, gain support from their providers, and obtain health care in a timely manner (Donald et al., 2011). Increasing patient activation has been found to improve management behaviors and health outcomes. For parents and caregivers, increasing levels of activation regarding their knowledge, skills, and confidence in being able to manage and care for their child diagnosed with a feeding disorder may lead to increased self-efficacy and positive health behaviors, comparable to other medical patients with higher activation (Hibbard, Stockard, Mahoney, & Tusler, 2004).

Depression. It is also important to note the impact that depression or other mental distress can have on patient activation. Research has shown that patients experiencing depression or mental distress can block helpful self-management behaviors, essentially stopping patient activation, and decreasing positive health outcomes (Greene & Hibbard, 2012). Parent/caregiver activation has been studied primarily regarding caregivers of geriatric patients with Alzheimer's Disease and/or dementia (Sadak, Wright, & Borson, 2016), with little existing research on parent/ caregiver activation on pediatric samples. However, based on the existing research on patient activation, parent/caregiver activation may be an important factor in how the parents of children with feeding disorders experience their child's symptoms and cope with the demands of the treatment. Furthermore, it is important to consider the increased likelihood of depression and mental distress in parent/caregivers of children with feeding disorders, and the relationship between those parent symptoms and decreased activation. As noted above, parent/caregivers of children with feeding disorders with depression or mental distress may also experience decreased or stagnant activation, resulting in decreased positive health outcomes for their child (Greene & Hibbard, 2012).

Purpose of the Study

The purpose of the evaluation was to examine if parents are stressed by their child's feeding disorder and to explore the level of activation regarding their caregiver role in managing their child's health/healthcare. Additionally, the evaluation was implemented to examine clinic operations, as this was an area of interest expressed by the feeding clinic director. Finally, it is hoped that this research informs the development of effective and supportive practices in intervention with parents and caregivers struggling with stress and activation challenges.

Chapter 2

Methods

Participants

The data collected in this study was collected through an interdisciplinary feeding and swallowing disorder clinic within a large teaching children's hospital in the Pacific Northwest. Data was collected from May 2017 through September 2017 during clinic days of Tuesdays and Thursdays each week. Every year this clinic serves 800-1100 patients, predominantly patients within the 0-5-year age range. The feeding disorders clinic sees patients who are either self-referred or referred by their primary care physicians due to severe picky eating, sensory challenges related to the eating process, or physical/medical challenges related to being able to eat and/or swallowing properly. Parents and caregivers come to the feeding clinic to seek diagnostic clarity for their child's eating or swallowing challenges, information on how to treat the challenges at home, and to engage in specific treatment regimens inside the clinic to address needs of the child. The data included in this study were collected through follow-up appointments only.

To date, this clinic has served over 5,100 patients with feeding challenges. Of the patients served, 922 patients attended one visit and 2,260 patients attended six or more visits for feeding therapy (EPIC database, 2016). The number of children with feeding challenges served in the clinic has risen in recent years, with 834 patients served in 2014 and 1,035 patients served in 2015 (EPIC database, 2016). All parents/caregivers attending their child's feeding clinic appointment were invited to participate in this study. The parents and caregivers included

consisted of 74 adults. 81 surveys were completed by parents in the feeding and swallowing disorders clinic. Seven surveys were discarded due to missing data, leaving 74 viable responses.

Procedures

Recently the child development and rehabilitation center (CDRC) (within which the feeding clinic is housed) underwent a system-wide evaluation to examine operations and improve efficiency in a variety of ways. The program evaluation addressed the overall process of referrals, scheduling, and how rooms were being utilized. The outcome of that evaluation specifically for the feeding clinic did not change clinic operations, therefore further providing a basis for this current assessment of the feeding clinic and ways to improve patient/family care.

Prior to recruitment, this research project was reviewed and approved by the hospital's internal review board (IRB). As noted above, this data was collected during feeding therapy appointments. Verbal consent to participate in the evaluation was all that was required of the clinic since the IRB process outlined all the benefits/risks and rationale for the evaluation to participants. After being weighed and measured by nursing, each patient and family waited for medical providers in an exam room. During this time, a research assistant entered the exam room and reviewed the consent information (risks/benefits of participation) with the parent. Parents were then provided the measures to complete, taking approximately ten minutes. In addition to the measures, parent demographic data were collected including: who was filling out the surveys, marital status, level of education completed, and occupation. Child demographic data were also collected, including: age, gender, number of siblings, and additional diagnoses accompanying the feeding disorder. This information provided more information regarding the family structure and dynamics.

Instruments

Parent-Patient Activation Measure (Insignia Health, 2013). Parents and caregivers completed the Parent-Patient Activation Measure (P-PAM), a 13-item questionnaire which evaluates a parent's skills, confidence, and knowledge to manage and support the patient they are caregiving (Insignia Health, 2013). Each item was rated on a four-point Likert scale, with the following response options: *Disagree Strongly*, *Disagree*, *Agree*, *Agree Strongly*, or *N/A (not applicable)*. Scores combined to determine the level of caregiver activation. This measure groups people into one of four levels of activation, each progressively higher in activation than the prior level. The first level, *disengaged and overwhelmed*, represents individuals who struggle with knowing how to take an active role in their child's healthcare and tend to approach healthcare in a passive manner. The second level, *becoming aware but still struggling*, represents individuals who have some knowledge regarding their child's healthcare but do not know how to engage further in their child's healthcare. The third level of activation, *taking action*, represents individuals who are able to work toward achieving goals and view themselves as part of their child's healthcare team. The highest level of activation, the fourth level, *maintaining behaviors and pushing further*, represents individuals who have adopted new behaviors regarding managing their child's healthcare, though they may struggle during times of stress. These individuals view themselves as integral advocates for their child's healthcare needs (Insignia Health, 2013). The P-PAM has demonstrated reliability ($\alpha = .81$) and has been successfully utilized in a variety of settings (Hibbard, J.H., Mahoney, E.R., Stockard, J., & Tusler, M., 2005). Reliability was slightly improved in the current study ($\alpha = .88$).

About Your Child's Eating- Revised. The second measure, About Your Child's Eating -Revised (AYCE-R), is a 25-item questionnaire which looks at parent perceptions regarding family mealtime interactions and assesses both satisfaction and concern regarding their child's nutrition (Davies, Ackerman, Davies, & Noll, 2008). The AYCE-R has questions such as "My child hates eating," "There are arguments between me and my child over eating," and "Mealtime is pleasant, family time" which are rated using a five-point Likert scale, with responses ranging from 1 (*Never*) to 5 (*Nearly Every Time*). This measure explores family functioning at mealtimes, grouping responses into three composite scores: "Child Resistance to Eating," "Positive Mealtime Environment," and "Parent Aversion to Mealtime." This measure has demonstrated reliability ($\alpha = .81$) and has been utilized in studies of chronically ill as well as healthy children in assessment of the parent-child feeding relationship (Davies et al., 2008). In the current sample, the measure was found to be reliable ($\alpha = .74$).

Patient satisfaction and stress questions. Specific to this study, parents/caregivers completed a short questionnaire assessing their satisfaction with the feeding clinic appointments. These questions were developed in consultation with the feeding clinic director. Parents responded to satisfaction items regarding length of appointment, amount of information provided to them, intervention strategies provided, and time spent on information gathering. This questionnaire also incorporated specific questions that inquired about parental stress. Items that assessed parent stress included: "My child's eating challenges are stressful for me (with response to indicate how often)," "My child's eating challenges are severe (with response to indicate how often)," and "I find it difficult to manage my child's feeding challenges and behaviors surrounding the feeding process (with response to indicate how often)."

Participants completed a questionnaire that assessed stress related to their child's feeding challenges, specifically regarding level of stress perceived by parents due to their child's feeding disorder, their perception of the severity of their child's feeding challenges, and management of their child's behaviors and feeding issues during feeding.

Chapter 3

Results

Demographics

Parent demographics. Demographic data explored included visit type (initial vs. follow-up), caregiver type (parent vs. foster parent), marital status, and education level. Regarding caregiver type, 93.2 % of respondents were parents and 6.8 % were foster parents of patients in the clinic. Next, parent relationship status was collected to illustrate the support that parent may have in the home that may impact caregiver stress and activation. In terms of marital status, 65.3% were married, 1.4 % were in a domestic partnership, 18.9 % were single, 6.8 % were divorced, 2.7 % were separated, and 4.1 % of respondents selected their relationship status as *other*. Two respondents did not report their marital status. Finally, parent education level was collected to explore impact on activation. Regarding participant education, 45.2 % of respondents completed a high school diploma, 11 % completed an associate degree, 5.5 % completed a trade or technical degree, 19.2 % completed a bachelor's degree, 13.7 % completed a graduate degree, and 5.5 % of respondents selected *other*. One respondent did not answer regarding educational level completed (See Table 1).

Table 1

Parent Demographic Information

Demographics	<i>n</i>	Percentage
Visit Type		
Initial	38	51.4
Follow-Up	36	48.6
Caregiver Type		
Parent	69	93.2
Foster Parent	5	6.8
Relationship Status ^a		
Married	47	65.3
Domestic Partnership	1	1.4
Single	14	18.9
Divorced	5	6.8
Separated	2	2.7
Other	3	4.1
Caregiver Education ^b		
High School	33	45.2
Associate Degree	8	11
Trade/Technical	4	5.5
Bachelor Degree	14	19.2
Graduate Degree	10	13.7
Other	4	5.5

Note. a = 2 Missing Values. b = 1 Missing Value.

Child demographics. Demographic data explored included age, number of siblings, gender, and co-occurring diagnoses. Age within the evaluation sample ranged from less than one

year to 14 years old, with the mean reported age being 4.5 years old. The average number of siblings was 1.5 with a standard deviation of 1.3. Regarding gender, 61.6% of the patients were male and 38.4 % were female, with one patient's gender not reported. In regard to co-occurring diagnoses, 1.4 % of patients were diagnosed with ADHD, 4.3% were diagnosed with an intellectual disability, 14.3% were diagnosed with a physical or medical disorder, 2.9 % were diagnosed with a mental health disorder, 28.6 % were diagnosed with multiple or a combination of disorders (either neurodevelopmental, medical/physical, or mental health), and 34.3 % of patients had no other accompanying diagnosis. Four patients' parents did not answer this item (See Tables 2 through 4).

Table 2

Child Age and Siblings

	Minimum	Maximum	Mean	Std. Deviation
Age	0.5	14	4.49	3.47
Number of Siblings	0	4	1.49	1.33

Table 3

Gender of Child

Gender ^a	<i>n</i>	Percentage
Male	45	61.6
Female	28	38.4

Note. a = 1 Missing Value

Table 4

Other Diagnoses

Diagnosis ^a	<i>n</i>	Percentage
ADHD	1	1.4
ID	28	38.4
Medical/Physical	10	14.3
Mental Health	2	2.9
Other	10	14.3
Multiple/Combination	20	28.6
No Diagnosis	24	34.3

Note. a = 4 Missing Values

Parent Stress

Table 5 lists the results of the three parent stress items. Of the 74 participants, 4.1 % responded *never* to the question “my child’s eating challenges are stressful for me,” while 24.3 % selected *once in a while*, 37.8 % selected *sometimes*, 17.6 % selected *often*, and 13.5 % selected *always*. There were 9.5 % of participants who reported that their child’s eating/feeding challenges are *never* severe, 24.3 % reported the challenges to be severe *once in a while*, while 37.8 % selected *sometimes*, 17.6 % selected *often*, and 13.5 % reported *always*. Participants were also asked whether they had trouble managing their child’s behaviors and feeding challenges during the eating process. 21.6 % reported this to be *never* true, 20.3 % reported this to be *once in a while*, 31.1 % reported this to be *sometimes* true, 18.9 % reported *often* true, and 5.4 % reported this to be *always* true. Frequencies were utilized to illustrate the amount of stress that parents are faced with in managing their children’s feeding disorder and related behaviors.

Table 5

Parental Experience of Stress

Stress Survey	<i>n</i>	Percentage
Eating Stressful		
Never	3	4.1
Once in a while	18	24.3
Sometimes	28	37.8
Often	13	17.6
Always	10	13.5
Challenge Severe		
Never	7	9.5
Once in a while	17	23
Sometimes	26	35.1
Often	12	16.2
Always	12	16.2
Difficulty managing		
Never	16	21.6
Once in a while	15	20.3
Sometimes	23	31.1
Often	14	18.9
Always	4	5.4

Additionally, the program evaluation survey assessed parents' perspective regarding the clinic operations, specifically addressing the level of clinic support of parent stress, the length of the feeding appointments, the division of time spent asking questions and providing teaching to parents regarding their child's disorder, and the instructions provided in the appointment. 2.7% of parents reported the clinic has no support for parent stress, 81.1% reported feeling adequately

supported, 4.1% reported too much support, and 12.2% reported too little support. 91.9% of parents reported that the length of the appointment is adequate, 2.7% reported desiring the appointment be shorter in length, and 5.4% reported desiring the appointment to be longer in length. Regarding the instructions provided in the appointment, 95.9% reported the instructions to be adequate, 2.7% reported the instructions being “too few” in ideas, and 1.4% reported “too many” ideas being presented in the appointment. Frequencies were utilized to illustrate the level of support parents perceive in managing stress related to their child’s feeding disorder and their perception of their needs being met in terms of clinic appointment length, use of time, and amount of instructions provided in the feeding clinic appointments (See Table 6).

Parent-Patient Activation

The AYCE-R and P-PAM 13 were utilized to assess specifics related to the experience between parent and child with the feeding disorder at mealtimes (mealtime behaviors) and the parent’s level of activation (knowledge, confidence, and skill) in managing their child’s health and healthcare. Descriptive statistics were run to illustrate how parents responded to the measures (Table 7). Regarding parent activation (P-PAM13), overall activation scores ranged from 36.80 to 100.00 (mean = 73.07, SD = 14.00). Of the four levels of activation, average parent level of activation was 3.29. These results indicated that most parents in this sample endorsed having the knowledge, skills, and confidence to manage the healthcare needs of their child, are actively involved in their child’s healthcare, and are goal-oriented (Insignia, 2017).

Table 6

Satisfaction with Appointment Experience

Clinic Operations	<i>n</i>	Percentage
Support		
None	2	2.7
Adequate	60	81.1
Too Much	3	4.1
Too Little	9	12.2
Appt Length		
Adequate	68	91.9
Shorter	2	2.7
Longer	4	5.4
Use of time		
Adequate	72	97.3
Too Much	2	2.7
Instructions		
Adequate	71	95.9
Too Few	2	2.7
Too Many	1	1.4

Feeding Behaviors

Regarding the AYCE-R, the scores divide into the three factors of Child Resistance to Mealtime, Positive Mealtime Environment, and Parent Aversion to Mealtime. As indicated in Table 7, The first factor, Child Resistance to Mealtime, the 74 parents in the sample scored a minimum of 14, a maximum of 47, a mean of 30.10, and a standard deviation of 8.47. Parents' scores on the Positive Mealtime Environment were a minimum of 9, a maximum of 25, with a

mean of 18.47 and a standard deviation of 3.94. Scores on the Parent Aversion to Mealtime had a minimum of 5 and a maximum of 20, with a mean of 10.51 and standard deviation of 4.33. Most parents endorsed Child Resistance to Eating as area of the most impairment.

Table 7

Parental Activation and Mealtime Environment

	Min.	Max.	Mean	Std. Deviation	<i>n</i>
P-PAM Total	36.80	100.00	73.07	14.00	74
P-PAM Level	1.00	4.00	3.29	0.836	74
Child Resistance	14.00	47.00	30.10	8.47	74
Positive Mealtime	9.00	25.00	18.47	3.94	74
Parent Aversion	5.00	20.00	10.51	4.33	74

Relationship Between Parent Stress and Parent Activation

Correlations were run to assess whether there was a relationship between overall parental activation and the three questionnaire items which addressed parental stress. Results yielded a significant inverse relationship between overall activation and parent endorsement of their child's feeding disorder challenges being stressful ($r = -.269$). The relationship demonstrated that the more stressful the feeding disorder challenges were for parents, the less activated the parents were overall (See Table 8).

Table 8

Correlations Between Parent Stress and Parent Activation

Correlations	P-PAM Total	Challenges Stressful	Challenges Severe	Difficulty Managing
P-PAM Total	1	-.269	-.108	-.226

Relationships Between Parent Activation and Child Feeding Behaviors

Correlations were run to assess whether there was a relationship between the parents’ activation and the three factors of the mealtime environment (parent-child interaction during mealtimes). Results yielded no significant relationship among the variables, meaning that the parents’ activation was not influenced by any of the mealtime environment factors (See Table 9).

Table 9

Correlations Between Parent Activation and Child Feeding Behaviors

Correlations		P-PAM 13 Total	Child Resistance	Positive Mealtime	Parent Aversion
P-PAM Total	Correlation	1	-0.102	0.096	0.003
	Sig. (p-value)		0.387	0.416	0.977
	<i>n</i>	74	74	74	74

A regression was also run to determine the strength of relationship between parent’s overall activation and the severity of mealtime behaviors (mealtime environment). The regression equation was not significant ($F(3, 70) = 0.44, p > 0.445$ with an $R^2 = 0.37$ and adjusted $R^2 = -0.04$).

Child resistance to eating. Due to the unequal sample sizes between levels of activation on the PPAM, exploration of descriptive statistics was used to examine the three factors of the AYCE-R (Child Resistance to Eating, Positive Mealtime Environment, and Parent Aversion to Mealtime) and the specific levels of activation of the P-PAM. Within the sample of parents in the clinic, the area of most impairment in their mealtime environment experience was their child's resistance to eating. Most parents who endorsed child resistance to eating scored their level of activation to be in level 4 ($M = 28.75$, $SD = 8.99$). However, the large variance suggested that those responses may be less trustworthy. This was also true for parents whose activation was in Levels 1 and 3. Parents whose activation was in Level 2 had the least variability of scores, likely demonstrating a more reliable view of the severity of resistance experienced at mealtimes ($M = 35.00$, $SD = 5.57$; though only three parents endorsed Level 2 activation). In sum, parents who reported the lowest and highest levels of activation reported more child resistance to eating behaviors, as compared to parents who reported moderate levels of activation. There was no observed trend among the scores within the levels of activation.

Positive mealtime environment. On the next factor, Positive Mealtime Environment, parents with the highest level of activation had the least variance in scores and the highest experience of positive mealtime behaviors ($M = 19.25$, $SD = 3.71$). Higher scores on the questions that load onto this factor indicate more positive mealtime experiences such as enjoyable conversations, looking forward to mealtimes together, and pleasure experienced through watching their child enjoy his/her meal. There was no observed trend, however, among the levels of activation within that factor; parents who endorsed Level 1, the lowest level of activation, reported higher positive mealtime experiences than parents within Level 2 with a

similar spread of scores ($M = 15.00$, $SD = 3.81$ and $M = 14.33$, $SD = 3.79$, respectively). Parents in Level 3 activation reported slightly less positive mealtime experiences than parents in Level 4 with higher variance ($M = 18.52$, $SD = 3.90$).

Parental aversion to mealtime. Parents in activation Level 1 showed the most severity of Parental Aversion to Mealtime, though there was some variance among scores ($M = 13.15$, $SD = 3.33$). Parents within Level 2 reported less aversion to mealtime with a smaller spread of scores ($M = 11.00$, $SD = 2.00$). Those in Level 3 reported the least parental aversion though with the widest spread of scores ($M = 9.78$, $SD = 4.57$), and parents in activation Level 4 reported higher aversion than those in Level 3 though scores were most widespread, which indicated less trustworthiness in the scores. There was no observed trend in the data regarding severity of parental aversion to mealtime overall.

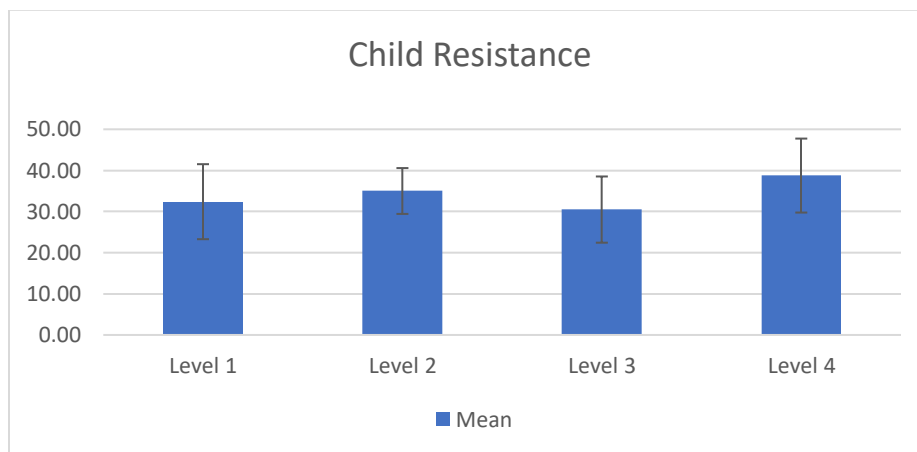
Table 10

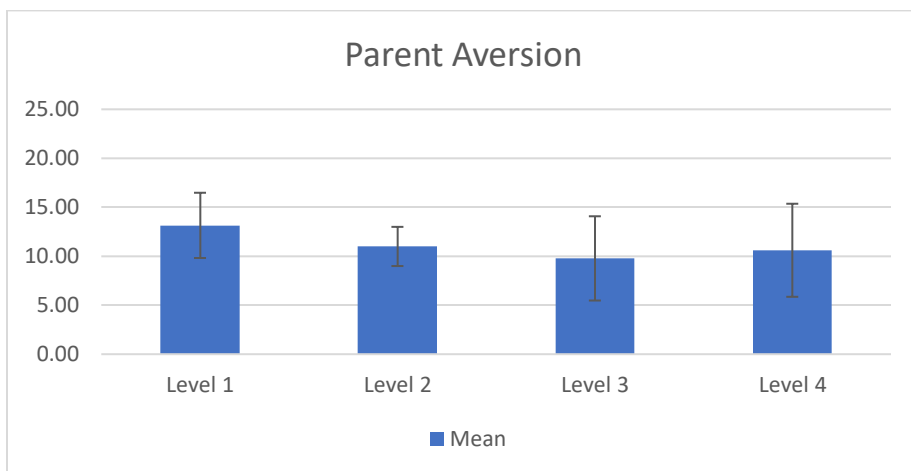
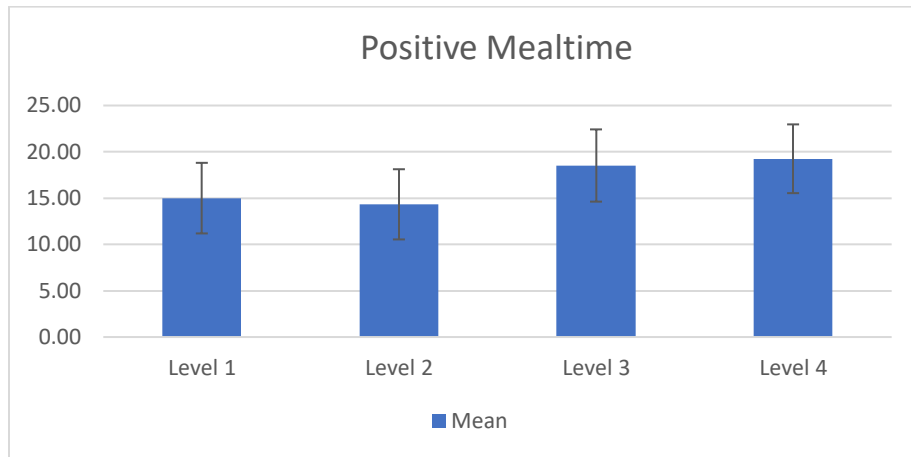
Severity of Mealtime Factors and Level of Activation

AYCE-R	P-PAM	M	SD	n ^a
Child Resistance to Eating	Level 1	32.40	9.12	5
	Level 2	35.00	5.57	3
	Level 3	30.48	8.05	31
	Level 4	28.75	8.99	34
Positive Mealtime Environ.	Level 1	15.00	3.81	5
	Level 2	14.33	3.79	3
	Level 3	18.52	3.90	31
	Level 4	19.25	3.71	34
Parent Aversion to Mealtime	Level 1	13.15	3.33	5
	Level 2	11.00	2.00	3
	Level 3	9.78	4.30	31
	Level 4	10.61	4.57	34

Note. a = 1 missing value.

Figure 1. Mealtime factors and levels of activation.





Chapter Four

Discussion

Most parents who participated in the clinic evaluation reported that the eating challenges of their child who had been diagnosed with a feeding disorder was “sometimes” stressful, “sometimes” severe, and they “sometimes” had trouble managing their child’s eating challenges and behaviors. The majority reported feeling supported in managing stress via the clinic and believed themselves to be adequate in their confidence, skills, and knowledge (activation) related to taking care of their child. Most parents’ scores placed their activation in level three, which means that the parents likely have experienced some success in making behavioral changes and some confidence in managing certain aspects of their child’s health (Insignia Health, 2013). This was like other studies that evaluated levels of activation, which found that four out every five patients report themselves to be in the higher two levels of activation (Greene, Hibbard, Sacks, Overton, & Parrotta, 2015). This higher rating of parent activation was consistent also with research which assessed parental activation in samples with chronically ill patients, which found most parents managing the chronic illness of their child expressed enhanced capability in managing their child’s health, therefore rating themselves to be at level three or four activation, with most falling within level three (Pennarola et al., 2015).

Most parents believed the length of their feeding clinic visit was an appropriate duration of time with an adequate balance of time spent gathering information from families and time spend on intervention strategies to help their child with their specific feeding challenges.

Instructions provided during their feeding clinic visits were reported to be adequate in the number of ideas presented to inform their child's individualized treatment plans. Research identified that parent experience of the feeding team and clinic operations is key to supporting parent stress, and the parent-professional collaboration is necessary for the well-being of the parents and children (Cowpe et al.; Wu et al., 2012).

There were a few parents who reported that they did not feel as supported regarding parent stress and who were not satisfied with the clinic operations and experienced their child's feeding disorder challenges as often or always stressful, severe, and difficult to manage, though this did not necessarily match up to level of activation. In the literature, low patient activation has been found to be related to increased stress, a passive approach to their healthcare, and an increase in doctor visits or hospitalizations due to poorly managed health regarding chronic health conditions (Hibbard & Greene, 2013). Comparisons of overall parental activation with the questions targeted at parental stress yielded a significant inverse relationship between parent's perception of the stressfulness of their child's feeding disorder challenges and activation; the more stressful, the less activated parents reported to be, though few reported to be in the lower two levels of activation. There was no significant relationship between overall activation and the severity of the mealtime environmental factors, however. This is consistent with previous research which indicated no significance between the level of activation and the behaviors of children with chronic health conditions (Hibbard & Greene, 2013).

Also, previous research shows no significant associations have been found between parent level of activation and quality of family interactions, such as problematic behaviors observed in patient and parent dyad (Pennarola et al., 2015). The unobserved trend among the

spread of scores of severities of behaviors and parent-child interactions and various levels of parent patient activation was interesting, as initial assumption likely would lead to the belief that lower activation would show higher severity among the factors on the AYCE-R. Instead, scores were variable and unbalanced, as there were only a few parents who endorsed low levels of activation and a very small sample size overall.

Implications and Recommendations

Based on the preliminary findings of the evaluation, the feeding and swallowing disorder clinic appears to be sufficiently meeting the needs of many of the parents and children who engage in the clinic regarding appointment length and instruction, as well as addressing parent stress. However, it is important to consider a couple likely possibilities: it may likely be that parents completed the measure in ways that were not completely forthright, or that those who completed the questionnaires may already be higher functioning regarding management of stress and their child's feeding disorder challenges and due to the small sample size, they are likely not a representative of the feeding clinic. Another possibility is the fact that it takes a certain level of activation to even make it to the feeding clinic, and parents under constant stress related to their child's feeding challenges may experience major stress differently than parents of children without feeding disorders, as their baseline perception of what is a normal level of stress may likely be higher, so identification that stress is present and bothersome may be lower. Based on this likelihood, it is important that the clinic discuss parent stress in every appointment and check in with parents regarding their struggles in implementing the feeding plan for their child and make sure parents understand the specifics of the feeding plan. The following recommendations may be helpful for the clinic:

Stress management. Parents may benefit from psycho-education regarding stress management techniques. This may include teaching about ways that stress affects the body and emotional functioning as well as the ability to engage in their child's feeding disorder treatment plan. It is important to assess the parents' support network and discuss ways that parents can schedule time for self-care, engage in mindfulness techniques such as guided imagery or progressive muscle relaxation, and continually work on adequate sleep, nutrition, and exercise. This also may likely present opportunity for healthy modeling of stress management to the child struggling with a feeding disorder. Research has demonstrated the impact of such mindfulness practices on reducing maladaptive stress experiences. A meta-analysis of studies focused on parents and caregivers of children with ASD and stress reduction found that training in mindfulness effectively reduced parenting stress and increased parental satisfaction (Cachia, Anderson, & Moore, 2015). Additionally, mindful approach to stress reduction in parents and caregivers of individuals with chronic illness and other conditions has been found to enhance caregivers' psychological functioning in terms of stress, anxiety, and depression and assisted in enable self-care (Li, Yuan, & Zhang, 2016). Measurable differences in participant stress hormone levels have also been documented as a result in participating in mindfulness-based stress reduction interventions, specifically progressive muscle relaxation, and participants expressed lowered stress on self-report measures (Chellew, Evans, Fornes-Vives, Perez, & Garcia-Banda, 2015).

For the clinic evaluated in this study, addressing parental stress via psycho-education and experiential interventions may impact the level of stress parents experience and ultimately enhance treatment outcomes for their child's feeding disorder plan (Mitchell, Farrow, Haycraft,

& Meyer, 2013) Since research supports a multidisciplinary approach to pediatric feeding disorder treatment, utilization of psychologists to support parental stress may be beneficial (Sharp, Volkert, Scahil, McCracken, & McElhanon, 2017). Teaching mindfulness approaches to address and reduce stress and providing appropriate interventions in accompaniment to the regular feeding therapy may have a positive impact for families and the clinic.

Clinic operations. The feeding clinic may benefit from focusing on stress management and goal completion in every clinic appointment. This may include opportunities for practicum students, interns, or residents, to address parent stress and clinic satisfaction. Additionally, incorporation of ongoing evaluation questions for parents to respond to regarding their clinic experience may be helpful for the feeding and swallowing disorders clinic providers. This will likely help providers to see what is helpful or less helpful to parents and their child. Research has noted that self-report measures has increased in healthcare, as providers have developed growing interest in patient satisfaction with services provided. These measures have become valuable as they are significant markers of the quality, efficacy, as well as feasibility of healthcare services (Boquiren, Hack, Beaver, & Williamson, 2015). Evaluations assessing treatment outcomes for the children may also be helpful to incorporate in every appointment, so providers can implement changes to the treatment plans as needed.

Limitations

Several limitations are evident in this evaluation. In the original plan, participant ethnicity was to be incorporated into the demographic portion of the questionnaire and unfortunately this information unintentionally was missing from the final document which was distributed to participants in the feeding and swallowing disorders clinic. This is a limitation to the study.

Overall clinic demographic information collected from the hospital database provided patient ethnicity, this information is strictly the patient versus the parents or caregivers, which was the focus of this evaluation. Not having this information limits interpretation of results, as factors such as access to care and the parent or caregiver's health literacy ability may impact data collected. Therefore, fully understanding factors impacting parents' stress, ability to engage in their child's treatment plan, and confidence in caring for their child is insufficient. Additionally, parent employment information was also to be collected and was missed on the final draft of the questionnaires administered, as was parent age. These are important pieces of information and would have been helpful in better assessing the demographics of the population served and how to best accommodate and support the parents and child with the feeding disorder.

Another limitation evident in this evaluation is the number of responses obtained. Data was collected for three months, and although data was collected every day the clinic operated, a total of 81 participants were obtained, with seven responses being discarded due to lots of missing data, so 74 usable participants were indicated. This low number of participants means that understanding overall stress of parents, confidence in caring for their child, and satisfaction with the feeding clinic operations is a definite shortcoming.

Finally, most participants scored in the higher levels of activation. This is positive information for the clinic, knowing that they have engaged caregivers, however, it may also mean that those parents in the lower levels of activation are not accessing the clinic's care. With a larger, more representative sample of parents/caregivers of children with feeding disorders, we may be able to better understand the relationship between activation and the stress of feeding disorders.

Areas for Further Evaluation

Considering this study's limitations, an area for further evaluation might consider a measure of the parent and caregiver level of health literacy regarding their child's feeding and swallowing disorder and their role as caregivers in implementing their child's treatment plan. Many factors can interplay and affect an individual's level of health literacy such as education level, language barriers, cognitive ability, learning style, and mental health or substance abuse challenges, as well as communication between the professionals in the field and the parent (Hibbard, 2017 and DeCamp, Leifheit, Shah, Valenzuela-Araujo, Sloand, Polk, & Cheng, 2016). Health literacy is an important component that may likely impact satisfaction with the feeding and swallowing disorders clinic, parent stress, and the ability to fully participate appropriately in the treatment of their child with the feeding disorder, as this construct has been shown to be a predictor of understanding and utilization of healthcare information provided (Hibbard, 2017). Additionally, including the parent's demographic information and their child's demographic information in greater detail may likely provide valuable information to the clinic. Assessing treatment follow-through and outcomes may also be an area of focus for further evaluation.

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Appendix A

Clinic Questionnaire

OHSU Feeding Clinic - Outcome Evaluation Survey

Thank You for participating! Your feedback helps our clinic make improvements to ensure continued high-quality care for you and your child. We appreciate you taking the time to complete this survey and we value your thoughts.

1) Who is completing this survey?

- Parent
- Foster Parent
- Caregiver
- Other

2) Are you the child's primary caregiver?

- Yes
- No

3) What is your relationship status?

- Single
- Married
- Separated/Divorced
- Domestic Partnership

Other

4) Highest level of education you completed:

High School diploma

GED

Some college

Associate Degree

Bachelor Degree

Graduate Degree

Other

5) How old is your child with feeding/swallowing challenges?

6) Gender of your child with feeding/swallowing challenges:

Male

Female

Prefer not to disclose

Other

7) Other than feeding/swallowing challenges, does your child have a formal diagnosis of any of the following diagnoses?

Autism Spectrum Disorder

- Attention Deficit/Hyperactivity Disorder
- Intellectual Disability
- Physical or Mental Disability
- Other Mental Health Diagnosis
- Not Applicable

8) My child's eating challenges are stressful for me: (please circle one choice)

Never Once in a while Sometimes Often Always

9) My child's eating challenges are severe: (please circle one choice)

Never Once in a while Sometimes Often Always

10) I find it difficult to manage my child's feeding challenges and behaviors surrounding the feeding process: (please circle one choice)

Never Once in a while Sometimes Often Always

11) Does the clinic provide positive support regarding parental stress related to your child's feeding challenges?

Too Little	Adequate	Too Much
Support	Support	Support

12) Please answer the following questions about your clinic experience: (please circle one choice for each)

A) *Length of appointment:*

Shorter Than	Adequate	Longer Than
Needed	Length	Needed

B) *Regarding information provided to you during the appointment, was this information:*

Too Little	Adequate	Too Much
Information	Information	Information

C) *Regarding the division between time spent asking you questions to get to know your child and providing information or interventions to help, was the amount of time:*

Too Much Time	Adequate	Too Much Time
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Appendix B

About Your Child's Eating – Revised

Appendix content begins on the following page.

Appendix A. About Your Child's Eating

Child's Name: _____ Date: _____ Age: _____
 Filled Out By: _____

A variety of situations take place in families around children's eating. Please indicate how often each of the following occur between you and your child or in your family

1 Never	2 Once in a while	3 Sometimes	4 Often	5 Nearly every time
1	2	3	4	5
1. My child hates eating.				
1	2	3	4	5
2. I feel like a short-order cook because I have to make special meals for my child.				
1	2	3	4	5
3. Meal times are among the most pleasant in the day.				
1	2	3	4	5
4. I feel that it is a struggle or fight to get my child to eat.				
1	2	3	4	5
5. My child refuses to eat.				
1	2	3	4	5
6. I worry that my child will not eat right unless closely supervised.				
1	2	3	4	5
7. My child is a picky eater.				
1	2	3	4	5
8. The family looks forward to meals together.				
1	2	3	4	5
9. My child enjoys eating.				
1	2	3	4	5
10. Mealtime is a pleasant, family time.				
1	2	3	4	5
11. I get pleasure from watching my child eating well and enjoying his/her food.				
1	2	3	4	5
12. I dread meal times.				
1	2	3	4	5
13. We have nice conversations during meals.				
1	2	3	4	5
14. Meal times are the pits.				
1	2	3	4	5
15. It is hard for me to eat dinner with my child because of how he/she behaves.				
1	2	3	4	5
16. There are arguments between me and my child over eating.				
1	2	3	4	5
17. My child seems to have no appetite.				
1	2	3	4	5
18. My child has mealtime tantrums.				
1	2	3	4	5
19. My child refuses to eat a planned meal.				
1	2	3	4	5
20. I have to force my child to eat.				
1	2	3	4	5
21. I use preferred foods (such as dessert) as rewards or bribes to get my child to eat "good" foods.				
1	2	3	4	5
22. We watch television during meals.				
1	2	3	4	5
23. There are house rules about how much kids have to eat (for example, the "Clean Plate Club"; No dessert until you eat what's on your plate).				
1	2	3	4	5
24. I have thought about putting my child on a diet.				
1	2	3	4	5
25. We end up grabbing meals whenever we can with no time for planning.				
1	2	3	4	5

Appendix C

Parent-Patient Activation Measure



Parent Patient Activation Measure

Below are some statements that people sometimes make when they talk about their child's health. Please indicate how much you agree or disagree with each statement as it applies to you and your child by circling your answer. Your answers should be what are true for you and not just what you think your doctor would want you to say. (If you have more than one child, answer these questions with only one child in mind.)

If the statement does not apply to you, circle N/A.

When all is said and done, I am the person who is responsible for taking care of my child's health.	Disagree Strongly	Disagree	Agree	Agree Strongly
2. Taking an active role in my child's health care is the most important thing that affects his/her health.	Disagree Strongly	Disagree	Agree	Agree Strongly
3. I am confident I can help prevent or reduce problems associated with my child's health.	Disagree Strongly	Disagree	Agree	Agree Strongly
4. I know what each of my child's immunizations are for.	Disagree Strongly	Disagree	Agree	Agree Strongly

<p>5. I am confident that I can tell when I need to go get medical care and when I can handle my child's health problem myself.</p>	<p>Disagree Strongly</p>	<p>Disagree Strongly</p>	<p>Agree Strongly</p>	<p>Agree Strongly</p>
<p>6. I am confident I can tell a doctor concerns I have about my child's health, even when he or she does not ask.</p>	<p>Disagree Strongly</p>	<p>Disagree Strongly</p>	<p>Agree Strongly</p>	<p>Agree Strongly</p>
<p>I am confident that I can follow through on medical treatments I need to do for my child at home.</p>	<p>Disagree Strongly</p>	<p>Disagree Strongly</p>	<p>Agree Strongly</p>	<p>Agree Strongly</p>
<p>8. I understand my child's health problems and what causes them.</p>	<p>Disagree Strongly</p>	<p>Disagree Strongly</p>	<p>Agree Strongly</p>	<p>Agree Strongly</p>
<p>I know what treatments are available for my child's health.</p>	<p>Disagree Strongly</p>	<p>Disagree Strongly</p>	<p>Agree Strongly</p>	<p>Agree Strongly</p>
<p>10. I have been able to help my child maintain (keep up with) recommended changes like eating right or exercising.</p>	<p>Disagree Strongly</p>	<p>Disagree Strongly</p>	<p>Agree Strongly</p>	<p>Agree Strongly</p>
<p>I know how to prevent problems with my child's health.</p>	<p>Disagree Strongly</p>	<p>Disagree Strongly</p>	<p>Agree Strongly</p>	<p>Agree Strongly</p>

<p>12. I am confident I can figure out solutions when new situations arise with my child's health.</p>	<p>Disagree Strongly</p>	<p>Disagree</p>	<p>Agree</p>	<p>Agree Strongly</p>
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<p>13. I am confident I can help my child maintain changes, like eating right and exercise, even during times of stress.</p>	<p>Disagree Strongly</p>	<p>Disagree</p>	<p>Agree</p>	<p>Agree Strongly</p>
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Appendix D**Curriculum Vitae****Erin L. Besser**

21540 NW Franson Way Apt 2305
 Hillsboro, Oregon 97006
 971.724.6464
 Erin.besser1@gmail.com

EDUCATION

Doctorate of Clinical Psychology **Aug. 2018**

George Fox University
 American Psychological Association Accredited Program
 Emphasis in integration and research

Doctorate of Clinical Psychology (transferred; 2 years completed) **2010**

John F. Kennedy University, Pleasant Hill, California
 American Psychological Association Accredited program
 Emphasis in multicultural competency

Master of Science in Applied Psychology: Mental Health Counseling **2008**

Southern Oregon University, Ashland, Oregon
 CACREP Accredited Program for LPC licensure
 Graduated with honors

Bachelor of Science in Psychology **2006**

Southern Oregon University, Ashland, Oregon
 Graduated Cum Laude
 Graduated with honors

CLINICAL EXPERIENCE

Kaiser Permanente **Aug. 2017- Present**

Fresno, California

Title: Clinical Psychology Doctoral Intern

Treatment Setting: Hospital

- Adolescent intensive outpatient (AIOP) therapy
 - Provide intensive group therapy 3 days per week for suicidal teens
- Co-located behavioral medicine with adults
 - Provide 30 min sessions to address treatment adherence and mood challenges that

- are barriers to effective medical treatment
 - Engage in warm-handoffs to assist medical providers with patients as needed
- Psychodiagnostic Assessments
 - Interview and evaluate patients for diagnostic clarity to address concerns regarding attention, memory, or mood challenges
- Coping skills group for adolescents
 - Weekly therapy for teens who have graduated IOP and who need ongoing help for severe depression
- Dialectical Behavioral Therapy (DBT) class
 - Co-facilitate DBT skills training class for adults
- School of Unlimited Learning (SOUL)
 - Provided ongoing therapy to adolescents who struggle with traditional education
- Supervisors: Dr. Diane Kawagoe, PhD, and Dr. Maria Rubino-Gaab, PhD

Childhood Associates of Salem (CHAOS)

Jul. 2016 – Jul. 2017

Salem, Oregon

- **Title:** Behavioral Health Consultant
- **Treatment Setting:** Pediatric Primary Care
- Integrated behavioral health consultant ages 0-21 years and families
- About 50 % Spanish-speaking; extensive work with translators
- Serves largely low SES families
- Treated patients for mental health and behavioral needs
- Coordination of wrap-around care
- Warm-handoffs with pediatricians to provide comprehensive treatment and increase work flow productivity
- Taught psychoeducational classes for the clinic and for the community
- Multi-disciplinary team environment
- Supervisor: Joy Mauldin Psy.D.

Oregon Health Science University

Jul. 2014-Jul. 2016

Child Development & Rehabilitation Center

Doernbecher Children's Hospital

Neurodevelopment Clinic

Portland, Oregon

- **Title:** Neurodevelopmental Psychometrician/ Student
- **Treatment Setting:** Neurodevelopmental Assessments for children 0-23 years old regarding learning challenges, intellectual disability, and ADHD
- Wide range of ethnic backgrounds, abilities, religious, and economic diversity
- Provided clinical interview, assessment, diagnosis, and comprehensive feedback to families as well as completing full psychological evaluation reports with recommendations for the family, teachers, and other providers involved
- Completed weekly disability evaluations for the state of Oregon for children and families

seeking financial support for their child's challenges

- Multidisciplinary team including neuropsychology and developmental pediatricians
- Live supervision model with two-way mirrored treatment rooms
- Supervisor: Darren Janzen, Psy.D.

Subspecialty: Feeding and Swallowing Disorders Clinic

- **Title:** Psychology Practicum Student
- **Treatment Setting:** Specialty clinic for children ages 0-21 with feeding or swallowing challenges; wide diversity of ethnic background, religion, and socioeconomic status
- Assisted in behavioral support to children and families within an interdisciplinary team to address feeding/swallowing challenges, including OT, PT, and Pediatricians.
- Dissertation study provided a program evaluation that assessed parent satisfaction with feeding clinic operations and with how parent stress is handled in the clinic.

Portland State University

Sep. 2013-2014

Portland, Oregon

- **Title:** Psychometrician
- **Treatment Setting:** University health and counseling center
- Administered and scored initial assessments for students aged 18-65+ coming in for learning and attention challenges. Tests administered included: WAIS-IV, MMPI-2 or MMPI-RF, Nelson-Denny, IVACPT, Stroop, and Woodcock-Johnson Achievement and Cognitive batteries
- Supervisor, Susannah Castle, PsyD

Depression Recovery Program by Dr. Nedley

Oct.-Nov. 2013

Newberg, Oregon

- **Title:** Therapist/Facilitator
- **Treatment Setting:** Community psychoeducational and process group for adults 18-70+ focusing on depression recovery with healthy lifestyle changes for 8 weeks
- Co-facilitated the group and provided motivational interviewing and solution-focused interventions for members working on their depression
- Supervisor: Dr. Tami Rogers, MD

George Fox University Pre-Practicum

2013

Newberg, Oregon

- **Title:** Pre-Practicum Therapist
- **Treatment Setting:** University
- George Fox University undergraduate students
- 20 total sessions with 2 undergraduate students

- Supervisors: Heather Bruschwein, M.A.; Carlos Taloyo, PhD

Youth Villages – OR Intercept**2012- 2013**

Portland Metro Area, Oregon

- **Title:** Family Intervention Specialist
- **Treatment Setting:** Intensive outpatient within the community for children in foster care and adoptive families with extreme behavioral and mental health challenges
- Multidisciplinary team including social workers, state caseworkers, parents, teachers, and medical professionals
- Provided intensive in-home therapy and case management to children ages 5-18 years with severe behavioral and mental health challenges. Met with the child and family at least 3 times per week until discharge.
- Utilized evidenced-based CBT and Solution-Focused approaches and Motivational Interviewing as well as parent training and skill development for families
- 24/7 crisis support, and coping skills training provided to increase safety and stabilization in the child's home and community
- Care coordination within the team for each client
- Supervisors: Jordain Kopeski and Mallory Smith, LPC

A Hope for Autism Foundation**2012**

Portland, Oregon

- **Title:** Applied Behavioral Analyst Assistant
- **Treatment Setting:** In-home behavioral treatment for children with severe Autism Spectrum Disorder
- Provided Applied Behavior Analysis (ABA) techniques and skill building to promote independence and skills in self-care, speaking, reading, writing, and social engagement.
- Followed a strict behavioral model and recorded daily data to monitor the child's progress
- Supervisor: Robbin Sobotka-Soles, BCBA

Under Construction-body.mind.nutrition**2012**

Beaverton, Oregon

- **Title:** Therapist
- **Treatment Setting:** Fitness Company incorporating mental health, nutrition, and personal training for adult clients aged 18 – 65+
- Provided mental health counseling utilizing Solution-Focused, CBT, MI, and Interpersonal approaches along with psychoeducation regarding emotional eating, trauma, depression, and anxiety to help clients achieve fitness and lifestyle goals
- Supervisor: Crem Frazier, Owner

Understanding Behavior, Inc.**2011**

Scappoose, Oregon

- **Title:** Behaviorist
- **Treatment Setting:** In-home ABA services for a child with Autism Spectrum Disorder
- Provided behavioral and social skills training along with parent coaching to teach the child behavioral skills in a variety of situations.
- Created and implemented a scheduled environment with a token economy/reward system and assisted parents/caregivers in parenting skills.
- Worked with supervisor to develop plan in working with the family
- Supervisor: Ellen Hodell, BCBA

STE Consultants, LLC**2011**

Berkeley, California

- **Title:** Behavioral Aide
- **Treatment Setting:** Special Education classroom in a local elementary school for an 8-year old child
- Provided behavioral and social skills training to assigned child within a variety of classes and situations throughout the school day
- Utilized a token economy, social stories, and CBT techniques to teach appropriate behaviors and skill development and some problematic behaviors began to improve
- Supervisor: Amanda Johnson, M.A.

Alameda County Medical Center**2010****Highland Hospital**

Oakland, California

- **Title:** Psychology Intern
- **Treatment Setting:** Public hospital in Alameda County with the primary trauma unit in the county
- Provided brief interventions to patients who were victims of violent crimes admitted through the Emergency Department (ED), focused on coping skills and support
- Consulted with medical doctors and social workers regarding patient's functioning and wrap-around care coordination for outpatient services
- Engaged in psychoeducational grand rounds in a variety of topics in health psychology including diabetes, chronic pain, and gang violence
- Supervisors: Amanda Withrow, PhD and Maurice Fried, PhD

Cronin House**2009–2010****Horizon Services, Inc.**

Hayward, California

- **Title:** Therapist
- **Treatment Setting:** Residential inpatient drug and alcohol treatment center based on the 12-step program of recovery
- Provided individual and group therapy to women aged 18-60+ in recovery from drugs and alcohol utilizing the 12-step model as well as motivational interviewing, interpersonal, solution-focused, and cognitive behavioral approaches
- Attended weekly didactics on topics such as tobacco cessation, stress management, gang activity, drugs, abandonment and trauma, and psychotropic medications.
- Administered assessment screeners to clients
- Supervision included training and case conceptualization in group and individual weekly meetings
- Supervisor: Ann Rawley, PhD

The Pacific Center for Human Growth
Berkeley, California

2008- 2009

- **Title:** Psychology Intern
- **Treatment Setting:** LBGTQ center which provides mental health services to members of the LBGTQ population and their families
- Worked as an ethnographer immersed in a new cultural environment to learn about the LBGTQ community and how to best be effective therapeutically with this population
- Weekly supervision included individual and group didactics regarding how to be an effective clinician with this population and included confronting personal biases, videos, and discussions.
- Created a resource binder of LBGTQ safe services for therapists to utilize when coordinating care for clients
- Observed and engaged in milieu therapy
- Supervisor: Aaron Testard, MFT and Jill M., PsyD

Youth and Family Services
Community Works
Medford, Oregon

2007-2008

- **Title:** Mental Health Therapist Intern
- **Treatment Setting:** Community Mental Health center
- Provided individual therapy to children and teenagers aged 6-18 who struggled with homelessness, abuse, substance use, gang involvement, depression, Bipolar Disorder, self-esteem, Anxiety, grief and loss, and behavioral challenges.
- Individual therapy centered on cognitive behavioral, systems, and existential approaches, as well as solution-focused interventions
- Weekly individual and group supervision focused on trainings on case conceptualization, family systems, and professional development

- Supervisors: Tricia Hibner, Ed.D. and Sharon Bolles, LPC

Crossroads Alternative School

2007- 2008

Community Works

Medford, Oregon

- **Title:** Mental Health Therapist Intern
- **Treatment Setting:** Alternative school setting for children kicked out of regular schools
- Provided individual therapy to children aged 13-17 who were dealing with behavioral issues including violence, anger problems, and poor relationships as well as learning challenges
- Focused therapy on coping skills, anger management, and behavioral change utilizing cognitive behavioral and solution-focused approaches
- Multidisciplinary team incorporating teachers, parents, and social workers
- Weekly individual and group supervision focused on working effectively with youth
- Supervisor: Tricia Hibner, Ed. D., Sharon Bolles, LPC

Central Point High School

2007-2008

Community Works

Central Point, Oregon

- **Title:** Mental Health Therapist Intern
- **Treatment Setting:** Local high school
- Provided individual therapy to female teenagers aged 14-18 utilizing solution-focused and cognitive behavioral therapy
- Weekly individual and group supervision focused on effective therapy with youth and their families
- Supervisor: Tricia Hibner, Ed. D., Sharon Bolles, LPC

Rogue Community College Counseling Center

2007 – 2008

Medford, Oregon

- **Title:** Mental Health Therapist Intern
- **Treatment Setting:** Community College Health and Counseling Center
- Provided individual therapy and academic counseling to students at the local community college
- Weekly supervision focused on therapeutic interventions and professional development
- Supervisor: Sharon Bolles, LPC

SUPERVISION EXPERIENCE

Clinical Team

2016-2017

George Fox University, Newberg, Oregon

- **Title:** Fourth Year Oversight
- **Treatment Setting:** Doctoral Program
- Oversight of first and second year PsyD students
- Assist in their professional development regarding clinical and assessment competencies
- Assist in teaching clinical team and provide evaluative feedback
- Supervision provided oversight and direction weekly
- Supervisor: Elizabeth (Libby) Hamilton, PhD

Advanced Counseling**2014**

George Fox University, Newberg, Oregon

- **Title:** Graduate Assistant
- **Treatment Setting:** Undergraduate Program
- Taught clinical skills in a small group format for 16 weeks
- Provided feedback on observed clinical work via role-plays and videos
- Weekly supervision and oversight from class professor
- Supervisor: Kris Kays, PsyD

 OTHER RELEVANT EXPERIENCE

Helpline**2007- 2008**

Medford, Oregon

- **Title:** Hotline Volunteer
- **Treatment Setting:** Suicide and other help phone hotline
- Provided assistance for crisis calls and information referrals as needed
- Logged every call and kept record of frequent callers who were disruptive
- Supervisor: Tricia Hibner, EdD

Rogue Community College**2007 – 2008**

Medford, Oregon

- **Title:** Facilitator
- **Treatment Setting:** Community College – special programs
- Co-facilitated an adult psychoeducational group focused on job skills such as effective job searches and resume tips. Discussed challenges related to maintaining sobriety and maintaining a job.

Supervisor: Sharon Bolles, LPC

“Expression through Adversity”**2006**

Dunn House

Talent, Oregon

- **Title:** Co-facilitator
- **Treatment Setting:** “Dunn House” shelter for abused women and children
- Co-facilitated an art process group for women who had experienced domestic violence and were moving toward safety and independence through support of the shelter.
- Met weekly for 6 weeks with 8-12 women
- Projects centered on healing and discussion of emotions
- Provided personal journals to each woman to utilize

Supervisor: Paul Murray, PhD

 TEACHING EXPERIENCE

Guest Lectures**2015****George Fox University**

Newberg, Oregon

- **Undergraduate course: Introduction to Psychology**
- Lectured on assessment of ADHD, Autism, Intellectual Disability, and Learning Disorders in a hospital setting
- **Graduate course in Psy D program: Substance Abuse**
- Lecture: Neurobiology of addiction and treatment challenges

Psychopharmacology**2017****George Fox University Graduate Department of Psychology**

Newberg, Oregon

- **Title: Graduate Assistant**
- Graded tests and other assignments
- Provided study sessions for test material
- Analyzed test content for validity
- Assisted students with help regarding lecture material
- Supervisor: Glenna Andrews, PhD

Neuropsychological Assessment**2017****George Fox University Graduate Department of Psychology**

Newberg, Oregon

- **Title: Graduate Assistant**
- Assessed students' competencies in neuropsychological administration, scoring, and

interpretation for a variety of measures

- Supervisor: Glenna Andrews, PhD

Substance Abuse

2015

George Fox University Graduate Department of Psychology

Newberg, Oregon

- **Title: Graduate Assistant**
- Assisted in grading, lectures, class discussion and group exercises centered on understanding addiction
- Addressed role of shame and guilt in an individual's development of addiction(s)
- Supervisor: Jory Smith, PsyD

Advanced Counseling Skills

2014-2015

George Fox University

Undergraduate Psychology class

Newberg, Oregon

- **Title: Graduate Assistant**
- Graded assignments
- Observed videos and role-plays of clinical skills
- Led small group of students in advanced counseling skills and theoretical models
- Provided psychoeducation and support on theories, body language, and building rapport in treatment
- Provided feedback regarding skill development
- Supervisor: Kris Kays, PsyD

Rogue Community College

2008

Medford, Oregon

- **Title: Mental Health Counseling Intern**
- Assisted in teaching career and job skills to people who were in recovery from addiction to drugs and alcohol
- Discussed goals and created plans to achieve those goals.
- Presented information about how to become a drug and alcohol counselor

CLINICAL TRAININGS

Behavior Analysis- Autism

2010-2011

Berkeley California and Portland, Oregon

- Learned and practiced basic behavioral analysis under the supervision of licensed BCBAs.

Domestic Violence and Trauma 2006, 2007
Dunn House, Medford/Talent, Oregon

- 60-hour training to work with abuse survivors at a domestic violence shelter.

Certified Mediator (State of Oregon) 2006
Mediation Works, Medford, Oregon

- 40- hour training on how to work as a mediator in the state of Oregon. Included role-plays and problem-solving skill development.

Multicultural Competency 2006- 2010
John F. Kennedy University, Pleasant Hill, California
Southern Oregon University, Ashland, Oregon

- Educational classes and discussions geared toward recognizing bias, prejudice, and multicultural issues and how to become an advocate as a therapist.

LEADERSHIP AND INVOLVEMENT

American Psychological Association 2015- 2017
• Division 54: Pediatric Psychology Campus Representative

Pediatric Student Interest Group (SIG) 2015-2017
George Fox University
• Founder and Leader

Student Editor 2015-2017
George Fox University GDCP
• Edit documents for students in the PsyD program

Student Council 2015- 2017
George Fox University
• Treasurer 2016-2017
• Cohort Representative 2015-2016

Worship Team 2014- 2016
George Fox University
• Co-leader/Member

Multicultural Committee 2014-2017
George Fox University
• Committee Member

- George Fox University Community Serve Day** **2013- 2016**
- Volunteer

PROFESSIONAL MEMBERSHIP

- American Psychological Association** **2013- Present**
- Affiliate Member
 - Division 54: Pediatric Psychology
- Oregon Psychological Association** **2014-Present**
- Student Member
- American Mental Health Counseling Association** **2007-2009**
- Student Member

AWARDS AND ACKNOWLEDGEMENTS

- Phi Kappa Phi** **2008**
National Honor Society
- Psi Chi** **2005**
National Honor Society of Psychology
- President's and Dean's Honors** **2004-2006**
Southern Oregon University
- Southern Oregon University Scholarship** **2003-2006**
Southern Oregon University

RESEARCH EXPERIENCE

Dissertation Title: *Evaluation of parental stress and appointment satisfaction in a feeding disorders clinic*

Summary: The program evaluation was designed to assess parent satisfaction with their appointments in a pediatric feeding disorders clinic and parent stress and provide recommendations to the clinic on how to improve operations and support parents in the feeding treatment for their child's feeding challenges.

Committee Chair: Marie-Christine Goodworth, PhD

Committee Members: Darren Janzen, PsyD and Celeste Flachsbart, PsyD

Expected Completion:

- Final Defense: February 2018

Research Vertical Team Member**2013-2017**

- Bi-monthly group for developing research competencies
- Creation of dissertation
- Supplemental research projects
- Assisted fellow colleagues with research interest development

 PRESENTATIONS

Polits, M., **Besser, E.**, Goodworth, M. (2016, August 04). *Components that influence repeat visits for psychiatric patients in emergency departments*. Poster session presented at the American Psychological Association Annual Conference, Denver, CO.

Blankenship, G.L., **Besser, E.**, Shumway, K., Goodworth, M., & Marston, A. (2016, May 07). *Music, mind, and heart: Novel approaches to improving emotion regulation*. Poster session presented at the meeting of the Oregon Psychological Association, Portland, OR.

Gelien, E.L., Zarb, D.S.H., Hancock, S.L., Foster, L., Janzen, D. (May 2015). *Proposed intervention for primary caregivers of children with feeding disorders*. Poster presented at the Oregon Psychological Association Annual Conference, Eugene, Oregon.

McKittrick, K.J., **Gelien, E.**, Eng, S., Landry, A., Kriz, D. (May 2015). *Parent satisfaction with their child's psychological evaluation*. Poster presented at the Oregon Psychological Association Annual Conference, Eugene, Oregon.

 REFERENCES

Diane Kawagoe, PhD Supervisor, Kaiser Permanente Pre-doctoral Internship	559-448-4766
Joy Mauldin, PsyD and Joel Lampert, PsyD Supervisors, Childhood Associates of Salem (CHAoS)	503-364-2181
Darren Janzen, PsyD Supervisor, Oregon Health Science University Doernbecher Children's Hospital CDRC Neuro Development Clinic	503-459-3010