1-1-2013

Research practitioner gap: treatments for anorexia nervosa

Michelle M. Block
George Fox University

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Research Practitioner Gap: Treatments for Anorexia Nervosa

by

Michelle M. Block

Presented to the Faculty of the

Graduate Department of Clinical Psychology

George Fox University

in partial fulfillment

of the requirements for the degree of

Doctor of Psychology

in Clinical Psychology

Newberg, Oregon

September 2013
Research Practitioner Gap: Treatments for Anorexia Nervosa

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has been approved

at the

Graduate Department of Clinical Psychology

George Fox University

as a Dissertation for the PsyD degree

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Date: 5.13.13
Acknowledgments

This dissertation would not have been possible without the support of many people. First, thank you to my committee chair and advisor, Mark McMinn, PhD, ABPP, for his continuous encouragement, challenges, and support. Second, to my committee members, Kathleen Gathercoal, PhD, and Elizabeth Hamilton, PhD; my preliminary defense transitioned into a collaborative working meeting to develop a wonderful survey. Thank you for your ideas and support. Thirdly, a thank you to Tammy O’Doherty whose guidance and organization helped to move this dissertation into completion. Finally, I would like to thank my family including my husband, Matt, for his continued love and patience through my doctoral defense preparation and my parents for their multiple means of support during my graduate training.
Anorexia Nervosa can be a detrimental and severe disorder, as it results in death for 5-10% of the patients who are in treatment. Practitioners and researchers have spent much effort researching treatments for Anorexia Nervosa, but the results lack effective outcomes. A common complaint among practitioners is that research does not apply to their clients. Evidence Based Practice states that treatment options for psychologists should not only include the research, but also the intuition of the psychologist and the diversity of the client. This study investigates the difference between practitioners’ and researchers’ values in the three domains of Evidence Based Practice: Research, Clinical intuition and Client diversity. Results show a difference between researchers’ and practitioners’ values towards research and clinical intuition. The perceived gap is greater than the actual gap between the professional groups. Also discussed are the theoretical orientations of both researchers and practitioners and learning tools to address treatment decision making.
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Chapter 1

Introduction

Anorexia Nervosa was first noted as a disorder and named in 1873. Since then, medical records and literature supports that an increased prevalence of anorexia nervosa (AN) has occurred (Hoek & van Hoeken, 2003). Recent research places the prevalence rate among females to be at .3% to 1% (Hoek & van Hoeken, 2003; Wilson, Grilo, & Vitousek, 2008), with the most affected population being females ages 15 to 24. Of those that do receive treatment, 50% recover, 20 to 30% have partial remission, 10 to 20% remain severely ill, and 5 to 10% die of related causes. (Steinhausen, 2002; Wilson et al., 2008).

The Challenge of Empirically Supported Treatments

A variety of treatment approaches for AN have been attempted and advocated. Three articles have surveyed clinical psychologists to find out what theoretical orientation and techniques are being used when treating eating disorders. It is important to note that these results are for eating disorders as a broad category, and not specifically AN. Haas & Clopton, (2003), asked the participant to identify the most recent client they treated for an eating disorder. AN was the diagnosis for 41.9% of practitioners’ most recent client, Bulimia Nervosa for 40.3%, and Eating Disorder NOS for 17.7%.

The most common theoretical techniques used for eating disorder clients are Cognitive Behavioral Therapy (CBT), Psychodynamic Therapy, and Interpersonal Therapy (IPT; Haas & Clopton, 2003; Mussell, Crosby, Scrow, Knopke, Peterson, Wonderlich, & Mitchell, 1999;
Tobin, Banker, Weisberg, & Bowers, 2007). Using techniques from more than one of the above theoretical orientations was more common than using just one theoretical orientation. Tobin et al. (2007) found 13% of clinicians to report using only one theoretical orientation. Mussell et al. (1999) asked for all of the techniques used to treat AN and found 67% of their participants to use CBT techniques, 46.7% to use psychodynamic, 21.7% to use IPT, and 28.3% endorsed using eclectic techniques. Haas and Clopton (2003) found 65.9% of participants endorsed CBT as their primary treatment modality, 11.9% psychodynamic and 9.5% IPT.

A common theme between all three studies was the question: Are empirically supported treatments being used by practitioners? Manual-based treatments have received a degree of empirical support and both Tobin et al. (2007) and Mussell et al. (1999) concluded that practitioners do not use them. Mussell et al. (1999) found that 6% of the participants adhere to closely following manual-based treatments and Tobin et al. (2007) found that most had no formal training in manual treatments. According to Mussell et al. (1999) CBT is the most empirically supported treatment, but only one third of practitioners use CBT as their therapeutic approach. Tobin et al. (2007) concluded that psychodynamic treatment is not empirically supported, yet it was the theoretical approach of many participants, with 98% of the participants indicating that they use psychodynamic interventions at times. Haas and Clopton (2007) also note that practitioners are not using empirically validated treatments.

Manual-based therapies, particularly CBT, receive empirical support as a therapeutic option for eating disorder interventions (Mussell et al., 1999). These findings that suggest a treatment for eating disorders should also be interpreted with caution due to the many disorders that fall under the term eating disorders. Disorders such as binge-eating, bulimia nervosa, over-
eating, and anorexia nervosa each have been found to respond to different treatment interventions (Wilson et al., 2008). CBT manual-based therapies have been named an effective treatment for bulimia nervosa specifically, but manual based-therapies for AN have not received strong empirical support. (Wilson et al., 2008). Generalizing a treatment option as empirically based for eating disorders should be interpreted with caution, due to the broad range of disorders this diagnostic group represents.

While previous studies have considered eating disorders as a general category, treatment for AN is further complicated, both by the wide range of treatments being used and because of a lack of empirical data to support them. Whereas empirically supported treatments can be identified for eating disorders in general, much less clarity exists for the treatment of AN. Family Based Therapy (FBT) is supported by some research, but there is no indication that it provides better results than other treatment options, such as CBT, IPT, and Psychodynamic Therapy (Wilson et al., 2008). The disparity among research on interventions for AN is apparent and concerning. To summarize, it is not clear that practitioners use empirically based treatments when treating eating disorders, and further, it is not entirely clear what empirically supported treatments even exist for treating AN.

Conversely, another potential problem is that research protocols are not always well suited for clinical settings. For example, CBT is the most researched treatment for AN but the results are not an adequate representation to generalize to the private practice setting (Wilson et al., 2008). Most of the research done on treatments for AN provide some results that can be applied, but with caution due to small sample sizes, high attrition rates, and inconclusive results.
The few recommended studies to apply to treatment decisions have not been replicated (Wilson et al., 2008).

**A Research-Practice Gap**

Anorexia Nervosa has been the subject of hundreds of studies and most hoped to find evidence for effective treatment. But the results have been discouraging as few comparative trials have been produced, results have been inconclusive and generally modest benefits identified (Wilson et al., 2008). But clinical work goes on, as clients continue suffering from AN, and the prevalence rate of AN has been rising (Hoek & van Hoeken, 2003). Clients need help even though the research is inconclusive on best treatment options. Therefore, practitioners are left to determine their treatment plan using tools beyond evidence-based treatments.

In a study evaluating if there is a gap between research and practice in the treatment of eating disorders Hass and Clopton (2003) concluded that practitioners are not using empirically validated treatments. This finding was based on a review of the literature by the authors and a survey sent out to practitioners. Two main reasons for not using empirically validated treatments were identified by practitioners. The first reason was not having been formally trained in an empirically-valid treatment, which is also supported by Mussell et al. (1999). In both findings, practitioners expressed a willingness to learn more about empirically validated treatments. The second reason practitioners were found to not use empirically validated treatments was because the participants represented in the research labs are perceived to be quite different than clients seen by the practitioners. Practitioners in Hass and Clopton (2003) study reported that 70% of clients have comorbid diagnosis, but research rarely mentions comorbid issues, except perhaps to note that participants were removed from the study if they indicated a comorbid issue. Overall,
practitioners are either not trained in empirically validated treatments or they think that empirically validated treatments are not flexible enough to fit their clients comorbid problems or severe situations (Hass & Clopton, 2003).

**Toward an Integrated Understanding of Evidence-Based Practice**

In 2005, the President of the American Psychological Association (APA), Ronald F. Levant, suggested a degree of rapprochement in how psychologists determine interventions in psychotherapy. Some psychologists believe that the only interventions that should be used are those that have been studied in randomized clinical trials, while others - including Levant - believe there are more ways to determine if an intervention is valuable (Levant & Hasan, 2008). Levant argued that there are multiple ways to determine what interventions and clinical decisions should be used in therapy. The APA Presidential Task Force was charged with the following:

The mission of the APA Presidential Task Force on Evidence-Based Practice in Psychology was threefold, corresponding to the three components of the Institute of Medicine’s … definition of EBP (“Evidence-based practice is the integration of best research evidence with clinical expertise and patient values, . . . ”):

1. To consider how a broader view of research evidence, one that inclusively considers multiple research designs, research in public health, health services research, and health care economics, should be integrated into a definition of EBPP.

2. To explicate the application and appropriate role of clinical expertise in treatment decision making, including a consideration of the multiple streams of evidence that must be integrated by clinicians and a consideration of relevant
research regarding the expertise of clinicians and clinical decision making.

3. To articulate the role of patient values in treatment decision making, including a consideration of the role of ethnicity, race, culture, language, gender, sexual orientation, religion, age, and disability status, and the issue of treatment acceptability and consumer choice. (Levant & Hasan, 2008, p. 659).

Research evidence, clinical expertise, and the values of the patient are all integrated into treatment decisions, according to the more recent guidelines, called Evidence-Based Practice (EBP). EBP provides a voice to practitioners and clients, along with value to their clinical judgment and client diversity in intervention decision-making.

EBP seems particularly fitting for a disorder such as AN, where clients and clinicians are continually seeking treatment options, but the research evidence does not point strongly to one treatment of choice. EBP provides two other important values to consider beyond research evidence in deciding a treatment intervention. When practitioners are struggling with whether an empirically validated treatment is appropriate to use with their diverse clients, including those presenting comorbid diagnosis or severe circumstances, EBT affirms the value of their clinical judgment. EBT is valuable in the pursuit for using psychotherapy to its maximum potential and it is also helpful for third party payers (Levant & Hasan, 2008).

In the treatment for AN, giving value to the clinician’s expertise in treatment options may protect practitioners and encourage third party payers to support their clinical judgment for treatment interventions. Newnham & Page (2010, p. 128) provides an excellent question to guide the clinician in choosing a treatment intervention: What treatment, by whom, is most effective for this individual, with that specific problem, and under which set of circumstances? This question
weighs the research evidence, the clinician, the patient, the disorder, and the setting when deciding what treatment interventions to choose.

Still, EBP standards do not elevate clinical judgment above research evidence. Herbert, Neeren, & Lowe (2007) discuss the risks of using only clinical intuition and past clinical experience. Research shows human cognition to be imperfect, and just as Newnham and Page (2010) suggests multiple resources should be used in treatment decision making. Herbert et al. (2007), suggest that clinical intuition put together with research is beneficial. “A scientific approach is an important advance over raw clinical experience because it addresses the limitations imposed by human cognition,” yet “Clinical research can yield practice guidelines, but the clinician must always adapt these general principles to the specific features and unique circumstances of each case. This adaptation is the ‘artistic’ heart of psychotherapy” (Herbet et al., 2007, p. 17).

Thus, ignoring the research on AN would be a misuse of research findings. Research provides necessary information, for example that adolescents and clients with a short duration of symptoms are going to respond to CBT better than their counterparts (Fairburn, 2005; Wilson et al., 2008,). At the same time, overgeneralizing from research findings, such as insisting that all clinicians use treatment manuals in every situation, does injustice to the broader definition of evidence based practice that is currently emerging. Research findings and clinical expertise are both recognized tools by the APA for treatment decision making.

Evidence-based Practice—the inclusion of research evidence, clinical expertise, and the values of the patient—are all domains to consider when treating an AN client. Eating disorder research suggests practitioners may not be using the research evidence in their treatments, but
with AN the research is inconclusive on what treatments are effective. Little is known about practitioners’ value of clinical expertise and their patients’ values. Researchers’ values on all three domains is also unknown. The purpose of this study is to find to what extent researchers and practitioners understand and value the three dimensions of evidence-based practice for the treatment of AN. It is hypothesized that practitioners’ and researchers’ values differ for two of the three dimensions of evidence-based practice. Agreement on the value of research for treatment of AN is expected to be similar between researchers and practitioners, but a gap is assumed to be found for the value of clinical expertise and client values during treatment.
Chapter 2
Methods

Participants

Practitioners and researchers who specialize in eating disorders participated in this study. One hundred and ninety-four practitioners who identified as specializing in eating disorders were identified through the APA directory. Practitioners who had not treated an Anorexia Nervosa client in the past five years were excluded from the study. Researchers were identified through a PsychArticles search. Fifty-four doctoral level clinical psychologist authors of empirical research on eating disorders involving AN were invited to participate. Authors of articles published over ten years ago were excluded from the search.

A total of 194 surveys were sent to practitioners and 54 to researchers. Of these, 16 practitioner surveys and 4 researcher surveys were returned unopened. Seventy-three practitioners and 27 researchers returned completed surveys, resulting in a 44% overall return rate. Ninety percent of respondents identified as European American, 2% identified as multiracial, and 1% identified as Hispanic. Ages ranged from 26 to 82 years, with a mean of 53. Practitioners had been licensed from 1 to 46 years with a mean of 25 years. Researchers had been licensed from 4 to 50 years, with a mean of 17 years. Practitioners had seen a median of five clients in the past five years that met the criteria for AN. Researchers had published a median of three projects on AN.
Instruments

The instrument developed for this study was a brief self-report questionnaire, shown in Appendices A and B. The survey gathered information about the participants’ opinions on the effectiveness of treatments for AN and how often they should be used. Treatment options included Cognitive Behavioral Therapy, Family-Based Therapy, Psychodynamic Therapy, Interpersonal Therapy, medical monitoring, inpatient referral, and nutritional counseling. Participants were also asked about their choice of treatment education tools along with how helpful the tools are. Finally, the participants were given statements aligning with the three dimensions of Evidence-Based Practice and weighted the amount of value they give to each. These percentages were used to determine the participants’ value of the conclusions of empirical research, the amount of clinical expertise that is used by practitioners, and how the diversity of clients influences a treatment plan.

Procedure

Participants were contacted through US postal mail. The mailing included informed consent, survey, and an incentive of two dollars. The participants volunteered to take part in the study and could have opted out of the study at any time. Likert-type scale questions and statements regarding their value of the three domains of Evidence-Based Practice were collected along with demographics of the participants. The conclusion of the survey thanked participants and provided instructions for those who wish to receive results at the end of the study. Surveys were returned to the researcher through US postal mail and collected for up to six weeks after the initial mailing.
Chapter 3

Results

Hypothesis 1

Hypothesis 1 states that the value placed on research will be similar for researchers and practitioners. Contrary to the hypothesis, results show that researchers place a higher value on research than clinicians, $t(97) = 3.46, p = .001$. See Table 1.

Table 1

Means, Standard Deviations, and n for both Practitioners and Researchers are Reported Below. All Three Values of Evidence-Based Practice are Included

<table>
<thead>
<tr>
<th></th>
<th>Practitioners</th>
<th></th>
<th></th>
<th>Researchers</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>N</td>
<td>Mean</td>
<td>SD</td>
<td>N</td>
</tr>
<tr>
<td>Research</td>
<td>35.75</td>
<td>17.49</td>
<td>72</td>
<td>49.13</td>
<td>17.49</td>
<td>27</td>
</tr>
<tr>
<td>Clinical Experience</td>
<td>37.55</td>
<td>16.04</td>
<td>72</td>
<td>27.84</td>
<td>11.3</td>
<td>27</td>
</tr>
<tr>
<td>Contextual Factors</td>
<td>29.63</td>
<td>29.49</td>
<td>72</td>
<td>22.65</td>
<td>9.28</td>
<td>27</td>
</tr>
</tbody>
</table>

Note. Participants were asked to distribute 100 points among the three categories of Evidence Based Practice (Research, Clinical Experience, and Contextual Factors).
Hypothesis 2

Hypothesis 2 states that the value placed on clinical expertise will be higher for practitioners than researchers. As expected, the value placed on clinical expertise was higher for practitioners than researchers, $t(97) = 2.88$, $p = .005$. See Table 1.

Hypothesis 3

Hypothesis 3 states that the value placed on contextual considerations of the client will be higher for practitioners than researchers. Contrary to the hypothesis, a significant difference was not observed between researchers and practitioners on contextual considerations, $t(95) = 1.20$, $p = .232$. See Table 1.

Additional Findings

In response to researchers and practitioner’s perceptions of one another, four additional questions were considered. First, how do researchers perceive clinicians with regard to how much they emphasize research in their treatment of AN? In this sample, researchers perceived practitioners to value research less than practitioners actually reported, $t(94) = 2.22$, $p = .029$. See Table 2. Second, how do clinicians perceive researchers with regard to how much they value research in treating AN? This sample of practitioners perceived researchers to value research more than researchers actually reported, $t(95) = 2.65$, $p = .009$. Third, how much do researchers perceive practitioners to value clinical expertise in treating AN? Researchers in the sample perceived practitioners to value clinical expertise more than practitioners actually reported, $t(95) = 2.76$, $p = .007$. Finally, to what extent do practitioners perceive researchers to value contextual considerations in the treatment of AN? This sample of practitioners perceived researchers to
value contextual factors of the client less than researchers actually reported, \( t(94) = 2.14, p = .035 \).

Table 2

*Means, Standard Deviations and n for Each Group Perception*

<table>
<thead>
<tr>
<th></th>
<th>Practitioners’ perception of researchers’ values on…</th>
<th>Researchers’ perception of practitioners’ values on…</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Research</td>
<td>60.06</td>
<td>18.89</td>
</tr>
<tr>
<td>Clinical Experience</td>
<td>22.28</td>
<td>13.32</td>
</tr>
<tr>
<td>Contextual Factors</td>
<td>17.91</td>
<td>9.95</td>
</tr>
</tbody>
</table>

*Note.* Participants were asked to distribute 100 points among the three categories of Evidence Based Practice (Research, Clinical Experience, and Contextual Factors).

Researchers’ and practitioners’ preferences towards theoretical approaches to treat AN were also analyzed. Using a multivariate analysis of variance (MANOVA), an overall group difference between practitioners and researchers was found, Wilks’ \( \lambda(7,83) = 363.73, p < .001 \). This justified individual \( t \)-test to consider group differences on specific treatment approaches, using a conservative alpha of .01 to reduce the risk of Type I error. See Table 3.

Differences in relative preferences for theoretical orientation among practitioners and researchers were also tested. In both cases, some theoretical orientations were rated higher than
Anorexia Nervosa Treatments

others, Wilks’ $\lambda(6,60) = 21.541, p < .001$; Wilks’ $\lambda(6,19) = 63.596, p < .001$, respectively. The overall differences justified paired-sample t-tests to conduct profile analyses. See Tables 4 and 5.

Table 3

*Means, Standard Deviations, n, and Group Differences are Reported*

<table>
<thead>
<tr>
<th></th>
<th>Practitioners</th>
<th></th>
<th></th>
<th>Researchers</th>
<th></th>
<th></th>
<th>Group Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>N</td>
<td>Mean</td>
<td>SD</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>CBT</td>
<td>4.24</td>
<td>1.083</td>
<td>70</td>
<td>3.92</td>
<td>.891</td>
<td>26</td>
<td>No</td>
</tr>
<tr>
<td>Family therapy</td>
<td>3.37</td>
<td>1.050</td>
<td>68</td>
<td>3.78</td>
<td>.751</td>
<td>27</td>
<td>No</td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>2.97</td>
<td>1.484</td>
<td>70</td>
<td>1.89</td>
<td>.934</td>
<td>27</td>
<td>$t = 3.5, p = .001$ Cohens $d = .871$</td>
</tr>
<tr>
<td>Interpersonal Therapy</td>
<td>3.32</td>
<td>1.239</td>
<td>68</td>
<td>3.04</td>
<td>.980</td>
<td>27</td>
<td>No</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>4.26</td>
<td>1.208</td>
<td>69</td>
<td>4.12</td>
<td>1.177</td>
<td>26</td>
<td>No</td>
</tr>
<tr>
<td>Medical Monitoring</td>
<td>4.17</td>
<td>1.394</td>
<td>71</td>
<td>4.89</td>
<td>.320</td>
<td>27</td>
<td>$t = -2.7, p = .009$ Cohens $d = -.712$</td>
</tr>
<tr>
<td>Inpatient Referral</td>
<td>2.85</td>
<td>.797</td>
<td>68</td>
<td>3.04</td>
<td>.587</td>
<td>27</td>
<td>No</td>
</tr>
</tbody>
</table>

*Note.* CBT = cognitive behavioral therapy. Practitioners were asked how often they use each of these approaches and researchers were asked how often practitioners should use each of these approaches on a 5-point Likert-type scale, ranging from 1 (Never) to 5 (Always).
Table 4

*Rank Ordered Preferences for Theoretical Orientation Among Practitioners*

<table>
<thead>
<tr>
<th>Theoretical Approach</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutritional Counseling</td>
<td>4.23</td>
</tr>
<tr>
<td>CBT</td>
<td>4.23</td>
</tr>
<tr>
<td>Medical Monitoring</td>
<td>4.12</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>3.38*</td>
</tr>
<tr>
<td>Interpersonal Therapy</td>
<td>3.30</td>
</tr>
<tr>
<td>Psychodynamic Therapy</td>
<td>2.97</td>
</tr>
<tr>
<td>Inpatient Referral</td>
<td>2.85</td>
</tr>
</tbody>
</table>

*Note. CBT = cognitive behavioral therapy. Practitioners were asked how often they use each of these approaches on a 5-point Likert-type scale, ranging from 1 (Never) to 5 (Always).*

*Significant differences from the theory one rank above*

An overall difference was also found in researchers’ and practitioners’ preferences for how practitioners do or should learn about treating AN, Wilks’ $\lambda(7,90) = .021, p < .001$. This overall difference justified individual t-tests for each of the learning sources. See Table 6.

The rank ordered lists for how practitioners do or should learn about treating AN also showed differences for practitioners, Wilks’ $\lambda(6,66) = 52.739, p < .001$, and researchers, Wilks’ $\lambda(6,20) = 3.331, p = .019$. The overall difference justified paired-sample t-tests to conduct a profile analysis. See Tables 7 and 8.
Table 5

*Rank Ordered Preferences for Theoretical Orientation Among Researchers*

<table>
<thead>
<tr>
<th>Theoretical Approach</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Monitoring</td>
<td>4.88</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>4.08*</td>
</tr>
<tr>
<td>CBT</td>
<td>3.88</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>3.76</td>
</tr>
<tr>
<td>Inpatient Referral</td>
<td>3.08*</td>
</tr>
<tr>
<td>Interpersonal Therapy</td>
<td>2.96</td>
</tr>
<tr>
<td>Psychodynamic Therapy</td>
<td>1.84*</td>
</tr>
</tbody>
</table>

*Note. CBT = cognitive behavioral therapy. Researchers were asked how often practitioners should use each of these approaches on a 5-point Likert-type scale, ranging from 1 (Never) to 5 (Always). *Significant differences from the theory one rank above*
Table 6

*Means, Standard Deviations, n, and Group Differences are Reported*

<table>
<thead>
<tr>
<th></th>
<th>Practitioners</th>
<th></th>
<th>Researchers</th>
<th></th>
<th>Group Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>N</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Reading books and journals</td>
<td>4.19</td>
<td>.877</td>
<td>73</td>
<td>4.48</td>
<td>.802</td>
</tr>
<tr>
<td>Talking with clinicians</td>
<td>3.95</td>
<td>.896</td>
<td>73</td>
<td>3.96</td>
<td>.720</td>
</tr>
<tr>
<td>Talking with researchers</td>
<td>2.19</td>
<td>1.182</td>
<td>72</td>
<td>3.88</td>
<td>.864</td>
</tr>
<tr>
<td>Patient Feedback</td>
<td>4.31</td>
<td>.816</td>
<td>72</td>
<td>4.00</td>
<td>1.000</td>
</tr>
<tr>
<td>Continuing education</td>
<td>4.11</td>
<td>.966</td>
<td>73</td>
<td>4.44</td>
<td>.751</td>
</tr>
<tr>
<td>Previous experience</td>
<td>4.56</td>
<td>.781</td>
<td>73</td>
<td>3.74</td>
<td>.859</td>
</tr>
<tr>
<td>Supervision</td>
<td>2.71</td>
<td>1.184</td>
<td>73</td>
<td>4.11</td>
<td>.934</td>
</tr>
</tbody>
</table>

*Note.* Practitioners were asked how they get treatment information and researchers were asked how practitioners should get treatment information on a 5-point Likert-type scale, ranging from 1 (*Never*) to 5 (*Always*).
### Table 7

**Rank Ordered Preferences for Clinician Learning Tools Among Practitioners**

<table>
<thead>
<tr>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous experience</td>
</tr>
<tr>
<td>Patient feedback</td>
</tr>
<tr>
<td>Reading books and journals</td>
</tr>
<tr>
<td>Continuing education</td>
</tr>
<tr>
<td>Talking with clinicians</td>
</tr>
<tr>
<td>Supervision</td>
</tr>
<tr>
<td>Talking with researchers</td>
</tr>
</tbody>
</table>

*Note.* Practitioners were asked how they get treatment information and researchers were asked how practitioners should get treatment information on a 5-point Likert-type scale, ranging from 1 (Never) to 5 (Always). *Significant differences from the clinician learning tool one rank above.*

### Table 8

**Rank Ordered Preferences for Clinician Learning Tools Among Researchers**

<table>
<thead>
<tr>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading books and journals</td>
</tr>
<tr>
<td>Continuing education</td>
</tr>
<tr>
<td>Supervision</td>
</tr>
<tr>
<td>Patient feedback</td>
</tr>
<tr>
<td>Talking with clinicians</td>
</tr>
<tr>
<td>Talking with researchers</td>
</tr>
<tr>
<td>Previous experience</td>
</tr>
</tbody>
</table>

*Note.* Practitioners were asked how they get treatment information and researchers were asked how practitioners should get treatment information on a 5-point Likert-type scale, ranging from 1 (Never) to 5 (Always).
Chapter 4
Discussion

Researchers have yet to agree on effective treatments for AN (Wilson et al., 2008), and the prevalence rate is increasing (Hoek & van Hoeken, 2003). This study is an attempt to evaluate the weight given when considering three dimensions, (a) Research, (b) Clinical Expertise, and (c) Contextual Considerations. Findings suggest that researchers and practitioners value treatment decision-making differently, reflecting a familiar gap within the field of psychology. Researchers value research more than practitioners do and practitioners value clinical expertise more than researchers. The value of the third domain, contextual considerations, was similar for both professional groups.

Though psychologists have noted the gap between researchers and practitioners (Hass & Clopton, 2003), results of the current study suggest that we need to go a step further and consider both the gap itself and the perceptions of the gap. In this study the actual differences are smaller than researchers and clinicians believe them to be. That is, researchers believe practitioners to value research less than practitioners actually value research, and researchers believe practitioners value clinical expertise more highly than they actually do. Conversely, practitioners perceive researchers to value research more highly than they actually do.

In light of previous studies that found practitioners often do not implement research recommendations (Tobin et al., 2007), and in light of inconsistent research results about effective treatments (Wilson et al., 2008), participants in the current study were asked where practitioners
best learn about effective treatments. Researchers suggest that practitioners talk to researchers involved in AN studies. When practitioners were asked to rank how often they have conversations with researchers, this was the least likely form of education chosen. Clearly, researchers and practitioners need to develop more effective ways of communicating and learning from one another.

Findings from the current study support much of the existing literature regarding theoretical orientations and techniques used by practitioners. CBT is the most commonly used orientation, and family therapy, interpersonal therapy, and psychodynamic therapy continue to be used as well. The literature is inconclusive, but most commonly identifies family therapy as an empirically supported treatment option for AN. Researchers surveyed in this study indicated that their recommended treatment of choice would be CBT or family therapy, with nutritional counseling and medical monitoring being equal to, or even more important than, the theory used.

The current findings support Levant’s understanding of Evidence-Based Practice, with all three areas being valued by both researchers and clinicians. The span between the lowest (29.6%) and highest (37.6%) rated values was 8% for practitioners. For researchers, the span between the lowest (22.7%) and highest (49.1%) was 26.4%. In both cases, respondents are substantially valuing all three areas.

**Recommendations**

Two areas of recommendation can be offered from this research. First, ways of enhancing communication between researchers and practitioners need to be considered. Second, it is important to consider how to maintain a degree of balance in the three domains of EBP.
Regarding communication between practitioners and researchers there are three ways to better engage in bridging the gap between the two professionals. One is for practitioners and researchers to extend an invitation to the other professional, two is for professionals to be seen in the other’s professional setting, and three is to attend open events to which both professionals are invited.

The first way is to provide an invitation. Practitioners can invite researchers to their consultation meetings and researchers can invite practitioners to join their research. Clinical group practices are common, along with group meetings and consultation. Inviting a researcher to do a briefing with a clinical group will provide a two way dialogue, the researcher can share his or her findings, and the practitioners can dialogue about the findings. This will help inform the practitioners and provide the researcher with likely application of their findings. Inviting a practitioner to join a research team also provides great dialogue. The practitioner is a resource for consultation and implementation of treatment. Well informed research questions considers clinical expertise and the current questions clinicians are asking. The practitioner will also learn about research through their experience of consultation and conducting treatment among researchers.

Second, seeking out the other professional in their environment for consultation is important. This recommendation is a highlight in the findings of this study. Researchers requested that practitioners seek researchers out for consultation. Researchers can seek out practitioners as well. For example, researchers could consider including practitioners in grants as a clinical consultant. Also, consulting to better understand the nature of clinical expertise in treatment decision-making will help inform future research.
Third, events are already established where researchers and practitioners can participate together. The challenge is to communicate with one another within these settings, rather than spending most time with similar professionals. Professional conferences are filled with both researchers and practitioners. Practitioners can seek out individuals who have research in a common clinical area, and researchers can seek out practitioners who are interested in their findings or who are presenting in an area of interest. Other established events include continuing education and university settings. Researchers can join continuing education, even if it is not required to maintain a license. It will provide an avenue to be included in the work of the practitioners and to learn questions remaining. Practitioners can involve themselves in universities. Enrolling in a class, mentoring graduate students or consulting with faculty are all appropriate ways to be involved in universities. If both researchers and practitioners invite, seek out, and participate with one another the effect will be a decrease in the research practice gap.

Related to finding a degree of balance among the domains of EBP, it is encouraging that all three areas are reportedly being considered and valued by both researchers and practitioners. Still, it is important for clinicians to find ways to maintain awareness of research findings. This is often recommended through subscribing to journals and online databases. Both can be subscribed to through the American Psychological Associations website. PsycARTICLES database and journals such as Journal of Psychotherapy Integration and Health Psychology would be helpful options for AN treatment decision making. This is the main avenue researchers currently have to communicate their findings to practitioners. There are other ways practitioners can use to remain engaged in research findings. Intentional decisions about continuing education provide opportunity to know the current research and dialogue about treatment decision making.
informed by research. Continuing education that appropriately involves research findings is a criterion that should be asked when practitioners choose trainings. Remaining engaged in research can be done through the use of testing in a practitioner’s own therapy office as well. Many evaluative tests help gauge the effectiveness of treatment and express a respect towards research. The testing results can help influence a practitioner’s treatment decision making, and can be provided to interested researchers. Graduate education is the beginning of practitioner’s treatment decision-making foundation; transformation of training should follow the current professional move towards EBP. Intentional training in all three domains of EBP should be developed and implemented. To encourage more engagement in research findings, research findings should be an expectation in clinical training. Examples and supervision about how to implement research findings into practice will help the future of clinicians to value research and implement research into their clinical work.

Similarly, it is helpful for researchers to remain current in issues of clinical expertise because it helps inform the research questions they ask and the designs they implement. Researchers can maintain a degree of competency in clinical expertise by practicing in the clinical field with a small private practice. This is a logical way to remain informed about the clinical expertise in practice. Many researchers do not have or maintain a license, which makes learning through practice an unavailable option. Training in graduate school can help reduce this research-practice gap by training students in EBP framework (Levant & Hasan, 2008). Evidence-Based Treatments are non-negotiable in the training of psychology professionals, as they keep psychology rooted in science and provide effective treatments to clinicians, but the EBP framework enhances previous models of evident based treatments (e.g. Chambless & Hollon,
1998) by emphasizing the importance of clinical expertise and client diversity. As we train our professionals to value the EBP framework, we will build a professional foundation for the importance of clinical expertise as well as empirical support. For current non-clinical researchers, it will be important to attend of conferences and seek out clinicians with expertise in the researchers’ area of interest. Clinically based lectures also provide the researcher opportunity to hear what questions are being asked by clinicians to better inform future research questions.

**Limitations and Future Research**

The limitations of this study include the potential risk of response bias, due to the self-report nature of the survey. Though the response rate is respectable, it is possible that those who responded differ in some systematic way from those who did not respond. Also, the sample of respondents lacks diversity in ethnicity and work setting, with 90% of the respondents being form a European American decent and 70% of practitioners working in a private practice setting. In addition, the participants may represent a more experienced sample of practitioners in regards to treatment for AN. Patients with AN do not only seek eating disorder experts for treatment, but are in search of any practitioner willing to treat eating disorders. This study specifically identified practitioners who identify eating disorders as a specific expertise.

Perhaps the most striking need for ongoing research in this area has to do with identifying treatment approaches that are most effective. Currently, it is not clear which approach has the most empirical support (Wilson et al., 2008). As a result, the practitioners may find research outcomes on treating AN to be inconsistent and difficult to apply to AN patients. In addition, findings from this study suggest it may be useful to consider the actual gap between researchers and practitioners as somewhat different than the perceived gap. Continued study about both the
actual and perceived gap will be important, as well studies on how to promote effective communication between researchers and practitioners. Finally, it will be important to study practices of practitioners who do not identify as specialists in eating disorders yet treat AN as generalist practitioners. Acknowledging these generalist practitioners’ contributions and limitations to the treatment of AN will lead to a better understanding of current practices in professional psychology.

Conclusion

Anorexia Nervosa is a difficult and severe disorder, and the prevalence rate is increasing (Hoek & van Hoeken, 2003). Practitioners are most often using Cognitive Behavioral Therapy as a form of treatment along with both nutritional counseling and medical monitoring. Practitioners report they gain treatment information through many avenues, including clinical experience, patient feedback, reading books and journals, continuing education, and consultation. Researchers request that practitioners speak openly with them about treatment options as an additional tool for education. Researchers and practitioners value treatment decision-making differently, but the differences in their perceptions of one another are greater than the gap in their actual values. Greater collaboration between researchers and practitioners could ultimately enhance both the relevance of research in the area and the effectiveness of treatment provided to patients with an Anorexia Nervosa diagnoses.
References


Appendix A

Practitioner Survey
Treating Anorexia Nervosa

1. In the past five years, about how many of your clients met criteria for:

<table>
<thead>
<tr>
<th></th>
<th>Anorexia Nervosa</th>
<th>Eating Disorder NOS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>#</td>
</tr>
</tbody>
</table>

2. In your practice how often do you use each of the following treatment approaches when treating clients with Anorexia Nervosa or Eating Disorder NOS:

<table>
<thead>
<tr>
<th>Treatment Approach</th>
<th>Anorexia Nervosa</th>
<th>Eating Disorder NOS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never 1 2 3 4 5</td>
<td>Never 1 2 3 4 5</td>
</tr>
<tr>
<td>Cognitive-behavioral therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychodynamic therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient referral</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. How do you get information about treating individuals who meet criteria for Anorexia Nervosa and Eating Disorder NOS? How useful is each source of information?

<table>
<thead>
<tr>
<th>How you get information</th>
<th>How useful it is</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never 1 2 3 4 5</td>
</tr>
<tr>
<td>Reading books and journals</td>
<td></td>
</tr>
<tr>
<td>Talking with clinicians</td>
<td></td>
</tr>
<tr>
<td>Talking with researchers</td>
<td></td>
</tr>
<tr>
<td>Patient feedback</td>
<td></td>
</tr>
<tr>
<td>Continuing education</td>
<td></td>
</tr>
<tr>
<td>Previous Experience</td>
<td></td>
</tr>
<tr>
<td>Supervision</td>
<td></td>
</tr>
</tbody>
</table>
4. Evidence-Based Practice* starts with the patient and asks what research evidence will assist in achieving the best outcomes. It integrates the best available research with your clinical expertise in the context of the client’s characteristics, culture, and preferences.

Assume you have 100 “points” to distribute among these three facets of EBP for each of these questions:

<table>
<thead>
<tr>
<th>Contextual Considerations (e.g., Culture and Values of Client)</th>
<th>Your Clinical Expertise</th>
<th>Best Available Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>you give to each of these in your current treatment of patients with Anorexia Nervosa? (The total should equal 100)</td>
<td>researchers prefer you to give to each of these in your current treatment of patients with Anorexia Nervosa? (The total should equal 100)</td>
<td></td>
</tr>
<tr>
<td>Your Clinical Expertise</td>
<td>Your Clinical Expertise</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Best Available Research</td>
<td>Best Available Research</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>TOTAL</td>
<td></td>
</tr>
</tbody>
</table>

5. What complexities do you face when trying to use evidence based practice with patients whom have symptoms of Anorexia Nervosa?

6. What suggestions do you have for bridging the gap between research and practice in the treatment of Anorexia Nervosa?

7. Finally, just a few questions about you…

Your age: Ethnicity: 
Years of licensed clinical experience: Primary work setting:

Appendix B

Researcher Survey
Treat Anorexia Nervosa

1. In your published research projects, about how many studies have been on:

<table>
<thead>
<tr>
<th></th>
<th>Anorexia Nervosa</th>
<th>Eating Disorder NOS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>#</td>
</tr>
</tbody>
</table>

2. How often do you think clinicians should use each of the following treatment approaches when treating clients with Anorexia Nervosa or Eating Disorder NOS:

<table>
<thead>
<tr>
<th>Treatment Approach</th>
<th>Anorexia Nervosa</th>
<th>Eating Disorder NOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive-behavioral therapy</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
</tr>
<tr>
<td>Family therapy</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
</tr>
<tr>
<td>Psychodynamic therapy</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
</tr>
<tr>
<td>Interpersonal therapy</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
</tr>
<tr>
<td>Nutritional counseling</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
</tr>
<tr>
<td>Medical monitoring</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
</tr>
<tr>
<td>Inpatient referral</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
</tr>
</tbody>
</table>

3. Where should clinicians be getting information for treating individuals who meet criteria for Anorexia Nervosa and Eating Disorder NOS? How influential should each area be?

<table>
<thead>
<tr>
<th>How they get information</th>
<th>Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading books and journals</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
</tr>
<tr>
<td>Talking with clinicians</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
</tr>
<tr>
<td>Talking with researchers</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
</tr>
<tr>
<td>Patient feedback</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
</tr>
<tr>
<td>Continuing education</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
</tr>
<tr>
<td>Previous Experience</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
</tr>
<tr>
<td>Supervision</td>
<td>Never 1, Sometimes 2, Always 3, 4, 5</td>
</tr>
</tbody>
</table>
4. Evidence-Based Practice* starts with the patient and asks what research evidence will assist in achieving the best outcomes. It integrates the best available research with clinical expertise in the context of the client’s characteristics, culture, and preferences.

Assume you have 100 “points” to distribute among these three facets of EBP for each of these questions:

<table>
<thead>
<tr>
<th>Contextual Considerations (e.g., Culture and Values of Client)</th>
<th>Clinical Expertise</th>
<th>Best Available Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>In your opinion, how much weight do clinicians give to each of these in their current treatment of patients with Anorexia Nervosa?</td>
<td>In your opinion, how much weight should clinicians give to each of these in your current treatment of patients with Anorexia Nervosa?</td>
<td></td>
</tr>
</tbody>
</table>

(The total should equal 100)

5. What complexities may arise when clinicians use evidence based practice with patients whom have symptoms of Anorexia Nervosa?

6. What suggestions do you have for bridging the gap between research and practice in the treatment of Anorexia Nervosa?

7. Finally, just a few questions about you…

Your age: 
Ethnicity: 
Years of professional research experience: 
Primary research area: 

Appendix C

Curriculum Vitae
Michelle M. Block

Education

2009 – present
**Doctor of Psychology, Clinical Psychology**
Graduate Department of Clinical Psychology: (APA Accredited)
George Fox University, Newberg, Oregon
Anticipated Graduation Date: May 2014

2009 - 2011
**Masters of Arts, Clinical Psychology**
George Fox University, Newberg, Oregon
Received: May 2011

2005 – 2009
**Bachelor of Arts, Psychology**
George Fox University, Newberg, Oregon
Graduation Date: May 2009

Supervised Clinical Experience

August 2013- August 2014
**Pre-Doctoral Internship**
Portland State University - Student Health and Counseling
Portland, Oregon

*Clinical Duties*
- Individual Therapy
- Intake Assessment
- ADHD and Learning Disability Assessment
- Crisis Intervention
- Group Therapy
- University Outreach

*Supervision*
- Weekly Clinical Supervision
- Weekly Assessment Supervision

*Training*
- Case Conference
- Professional Development
- Didactics

June 2012- May 2013
**Fourth Year Practicum**
OHSU Family Medicine at Richmond, Oregon Health & Science
University, Portland, Oregon
Behavioral Health Intern at a family medicine federally qualified health center (FQHC).

*Clinical Duties*
Anorexia Nervosa Treatments

Multidisciplinary treatment: consultation and therapy
Psychological Evaluations
Electronic medical records for treatment planning and note taking
Warm hand-off’s

Supervision
Weekly individual supervision
Weekly group supervision

Training
Weekly behavioral health consultation team
Monthly psychiatric consultation
Monthly didactics on resources in the area (E.G. addiction treatment centers, assessment clinics, social security)

Supervisor
Tami Hoogestraat, PsyD, MBA

August 2011- May 2012
Third Year Practicum
Health and Counseling Center, George Fox University, Newberg, Oregon

Clinical Duties
Individual Therapy
ADHD and Learning Disability Evaluations
Personality Assessments
Managed personal case load
Multidisciplinary Center: consultation with nurse and nurse practitioner
Maintaining charts- intake, treatment plan, progress notes, termination
Intake Assessment and dictation

Supervision
Weekly individual supervision, with video recording review
Weekly group supervision

Training
Weekly didactics on a variety of student mental health topics

Supervisors
William Burrhow, PsyD and Kristina Kays, PsyD

September 2010 - June 2011
Second Year Practicum
North Clackamas School District, Milwaukie, Oregon

Clinical Duties
Cognitive and Achievement Testing
Comprehensive Evaluations for Special Education
Individual Therapy
Group Therapy

Supervision
Weekly individual and group therapy focusing on case conceptualization, intervention, and assessment interpretation.

Supervisor
Fiorella Kassab, Ph.D, and Leslie Franklin, Ph.D

January 2010 – April 2010
**Pre-Practicum Therapist (First year)**
**George Fox University**, Newberg, Oregon

*Clinical Duties*
- Conducted intake assessments.
- Provided weekly individual psychotherapy.
- Engaged in treatment planning.
- Report writing

*Supervision*
- Group and individual supervision with videotape review, case presentations, and consultation

*Supervisors*
- Mary Peterson, Ph.D. and Rikki Mock, Psy.D.

January 2008 – May 2008
**Field Experience**
**West Linn High School**, West Linn, Oregon

*Clinical Duties*
- Observation and debriefing of high school counseling sessions.
- Individual counseling with students.
- Parent and teacher consultations.

*Supervision*
- Individual supervision
- High School Counseling Team weekly meeting

*Supervisors*
- Kristina Kays, Psy.D, Michelle Olson, M.A., and Tom Swearingen, M.A.

---

**Provision of Supervision**

August 2012 – May 2013
**Clinical Foundations Supervisor**
**Department of Clinical Psychology**, George Fox University, Newberg, Oregon

*Clinical Duties*
- Supervisor of first year doctoral students
  - Intake Assessments
  - Individual therapy from a Person Centered theoretical orientation
  - Mentoring over the transition to doctoral school
- Weekly group supervision
- Video review of every client session

*Supervision*
- Weekly group supervision from the director of clinical training

*Supervisor*
- Carlos Taloyo, PhD
August 2012–May 2013  
**Oversight Supervisor**  
Department of Clinical Psychology, George Fox University, Newberg, Oregon  
*Clinical Duties*  
- Once a week oversight supervision (in conjunction with practicum supervisor)  
- Application of supervision skills being taught in supervision and management course are  
*Supervisor*  
- Joel Gregor, PsyD

August 2011 – December 2011  
**Advanced Counseling Group Leader- Teaching Assistant**  
George Fox University, Newberg, Oregon  
- Led weekly small groups to assist and guide undergraduate student’s basic counseling skills.  
- Focused on personal reflection, vocational exploration, here and now processing, and self-development.  
*Supervisor*  
- Kristina Kays, PsyD

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**Relevant Consultation and Mentoring Experience**

**Family Development and Mentoring Consultation**  
Rolling Hills Community Church, Tualatin, Oregon  
- Provided consultation on the development of church support and education to families on how to raise spiritually healthy children. Consultation involved survey editing, statistical analysis, providing results, coaching on effective feedback to pastors and church members, and developing tools to meet the needs of the church, based on the survey results.  

**Peer Mentor**, George Fox University, Newberg, Oregon  
- Mentored a first-year doctoral student in the Graduate Department of Clinical Psychology.  
- Provided guidance to help facilitate transition to graduate school.

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**Research Experience and Professional Presentations**
**Doctoral Dissertation**

**Researcher Practitioner Gap: Treatments for Anorexia Nervosa**

Block, M. M., & McMinn, M. R (August 2012). Research practitioner gap: Treatments for Anorexia Nervosa. Poster’s presented at the annual meetings of the American Psychological Association in Orlando, FL and Honolulu, HI.

**APA Annual Conference 2013, Honolulu, HI. Division 29**

**APA Annual Conference 2012, Orlando, FL. Division 12**

Prelim Proposal Accepted: December 2011

Data Collected: March 2012

Final Defense May 2013

George Fox University, Newberg, Oregon

*Supervisor*

Mark McMinn, Ph.D.

*Abbreviated Abstract*

This study is interested in the difference between practitioners and researchers values in the three domains of Evidence Based Practice: Research, Clinical intuition and Client diversity. Practitioners and researchers have spent much effort researching treatments for Anorexia Nervosa, but the results lack effective outcomes. A survey has been sent out to both practitioners and researchers whom are active with Anorexia Nervosa treatment to evaluate the differences in values on the three domains of Evidence Based Practice.

**Training in Religious and Spiritual Diversity: Faculty and Student Perspectives**


**APA Annual Conference Division 29**

George Fox University, Newberg, Oregon

*Supervisor*

Mark McMinn, Ph.D.

*Abbreviated Abstract*

This symposium offers multiple perspectives on the challenges and opportunities inherent in training doctoral students to be competent in religious and spiritual diversity. Each part of the symposium is co-authored by a student and faculty member, demonstrating the collaborative approach to training that is required in topics as complex and value-laden as religious and spiritual values. After a brief introduction to the topic, each team will provide a brief overview on perspectives related to research.
perspective, competencies, course work, clinical training, ethical issues, and assessing outcomes will be discussed.

October 2011 – August 2012

**Religiosity and Spirituality Among Present and Future Clinicians**

**APA Annual Conference Division 36**
George Fox University, Newberg, Oregon

*Supervisor*
Mark McMinn, Ph.D.

*Abbreviated Abstract*
The aim of the current study was to understand religious and spiritual commitments among trainers and trainees at APA-accredited doctoral programs and pre-doctoral internships. Participants were asked to self-report religiosity and spirituality on a 5-point Likert-type scale. Data analyses revealed that participants self-identified as significantly more spiritual than religious. Furthermore, most indicated that their religious commitments were not very important in their lives.

September 2010 – February 2012

**Positive Psychology and Food**
George Fox University, Newberg, Oregon

Meta-Analysis of the literature published in the past decade relating to the topic of positive psychology and food.

*Supervisor*
Mark McMinn, Ph.D.

November 2006-December 2006

**Research Assistant**
Dissertation of Meg Alvey, Psy.D.
George Fox University, Newberg, Oregon

Assisted Dr. Alveys’ dissertation by finding participants, editing survey questions, entering data, and analyzing the data.

August 2005 – December 2006

**Reaction Time and Speech**
George Fox University, Newberg Oregon

Researched effects between a person’s use of vocabulary and their reaction time.

*Supervisor*
Chris Koch, Ph.D.
### Professional Development Training and Workshops

<table>
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<tr>
<th>Date</th>
<th>Title</th>
<th>Location</th>
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<tr>
<td>October, 2012</td>
<td><strong>Transgender Issues</strong></td>
<td>George Fox University, Newberg, Oregon</td>
<td>Erica Tan, PhD</td>
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<tr>
<td>March, 2012</td>
<td><strong>Strengthening Your Internship Applications</strong></td>
<td>George Fox University, Newberg, Oregon</td>
<td>David Indest, PhD and Betsy Goy, PhD</td>
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<td>March, 2012</td>
<td><strong>Mindfulness</strong></td>
<td>George Fox University, Newberg, Oregon</td>
<td>Erica Tan, PhD</td>
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<td>October, 2011</td>
<td><strong>Motivational Interviewing</strong></td>
<td>George Fox University, Newberg, Oregon</td>
<td>Michael Fulop, PsyD</td>
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<td>October, 2010</td>
<td><strong>Best Practices in Multi-cultural Assessment</strong></td>
<td>George Fox University, Newberg, Oregon</td>
<td>Eleanor Gil-Kashiwabara, PhD</td>
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<td>October, 2010</td>
<td><strong>Primary Care Behavioral Health: Where Body, Mind &amp; Spirit Meet</strong></td>
<td>George Fox University, Newberg, Oregon</td>
<td>Neftali Serrano, Psy.D.</td>
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<td>March, 2010</td>
<td><strong>Current Guidelines for Working With GLBT Clients: The new APA practice guidelines</strong></td>
<td>George Fox University, Newberg, Oregon</td>
<td>Carol Carver, PhD</td>
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<td>February, 2010</td>
<td><strong>Integrative and Clinical Dimensions of Gratitude</strong></td>
<td>George Fox University, Newberg, Oregon</td>
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### Awards

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<tr>
<td>2008</td>
<td><strong>Richter Grant</strong></td>
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<td>Funding for reaction time and speech research.</td>
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