


An Interpretive Description of Women's Experience in Coordinated, Multidisciplinary Treatment for an Eating Disorder

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Abstract

Coordinated, multidisciplinary treatment for women with eating disorders is consistently recommended as maximally effective, but few studies have considered the patient experience. This qualitative study examined the experiences of women receiving such care in an outpatient setting. Using an interpretive description methodology, we conducted 12 in-depth interviews with participants who were diagnosed with an eating disorder and were receiving team-based treatment. Patients uniformly advocated for the coordinated, multidisciplinary treatment approach. Analysis of participants' experiences yielded four categories: relying on the lifeline of communication, supporting autonomy, drawing on individual strengths, and valuing synergy. These findings build on previous research emphasizing the importance of autonomy support and connectedness in the recovery process from an eating disorder. Findings highlight the importance of nurses to support a multidisciplinary care approach to working with this patient population; these women's voices also support a treatment approach that, despite being widely recommended, is vastly understudied and underutilized.

Keywords

eating disorder, patient experience, qualitative research, coordination, multidisciplinary care

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Introduction

Eating disorders are one of the most challenging psychiatric conditions to treat (Crow & Peterson, 2009). Current international guidelines recommend a multidisciplinary treatment approach for this patient population, which includes several health professions working as a team to address the complexity and multidimensional nature of these disorders. At a minimum, the multidisciplinary team includes a medical provider (such as a physician or nurse practitioner), a therapist or counselor, and a registered dietitian. Nurses are an integral part of the medical management, and the scope and depth of their patient interactions will depend upon the clinical context. Other treatment team members may also include, depending upon the needs of the patient, exercise specialists, dentists, and additional medical specialists (e.g., gastroenterology, endocrinology, gynecology). Though this model is considered best practice, with several international professional organizations (e.g., American Psychiatric Association, the National

Institute of Health and Care Excellence, and the Academy of Eating Disorders) recommending its implementation, limited empirical evidence exists to support the approach.

Despite recommendations supporting the multidisciplinary approach, referral to this type of care occurred for only 35% of the patients in one of the more robust studies on this topic (Mitchell et al., 2015). Garcia-Garcia and colleagues examined 144 patients treated in a 6-month outpatient eating disorder program where patients attended one weekly appointment with either a medical provider, psychotherapist, or dietitian. More than half of the patients

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achieved remission, with other patients experiencing improvements in other clinical outcomes, such as weight gain (anorexia nervosa) and decreased bingeing and purging episodes (bulimia nervosa) (Garcia-Garcia et al., 2013). Mitchell and colleagues (2015) conducted a chart review on 235 college students diagnosed with an eating disorder (according to the *Diagnostic and Statistical Manual of Mental Disorders* [4th ed.; *DSM-IV*; American Psychiatric Association, 1994]) to compare those receiving psychotherapy alone with those referred to treatment in a multidisciplinary context. Patients referred to multidisciplinary care were more likely to stay in treatment longer, utilize group and individual group counseling modalities, and use psychotropic medications.

The patient experience is critical for understanding effective treatment strategies. In the current health care climate, patient satisfaction and patient-reported outcomes are increasingly important for guiding clinical practice as well as determining reimbursement strategies for health care payers. However, the patient experience in the context of coordinated, multidisciplinary outpatient care for eating disorders has received little attention. Hannon and colleagues conducted a qualitative study of the patient experience of illness, treatment, and change in a community treatment setting providing psychological and dietetic management for patients ($n = 5$) with severe anorexia nervosa (Hannon et al., 2017). The treatment experience emerged as one of several themes, and patients indicated overall positive regard for the treatment experience. However, this study included only a small subset of the eating disorder population, lacked a medical provider on the treatment team, and did not specifically examine the effect of the coordinated, multidisciplinary model on the patient experience.

The current study aimed to understand the patient experience of those receiving coordinated, multidisciplinary treatment for an eating disorder employing a qualitative methodological approach. While quantitative research methods are well suited to analyze data that can be counted or compared numerically, qualitative research is uniquely poised to understand human behavior from the perspective of the participant. Specifically, qualitative research sheds light upon the complexity and intricacy of individual experiences, and in the context of health care, this methodology uncovers aspects of humanized care (Todres et al., 2009). Thus, understanding the patient experience allows us to understand an insider perspective and the “evocative impact” of a coordinated, multidisciplinary model that supports the humanization of health care (Todres et al., 2009).

Materials and Methods

Design

Interpretive description served as the methodological guide for this qualitative research study. This applied, inductive

methodology begins with the particular—individual experiences of care—and interprets those experiences to construct generalizable knowledge “grounded” in the particulars. Data collection and analysis occur concurrently and iteratively, which allows the participants’ voices to guide the interview process as well as inform the analysis as the findings unfold. This simultaneous collection and analysis draw meaning from the interpretation among and between the patient’s accounts (Hunt, 2009; S. E. Thorne, 2016). Several qualitative studies have previously employed interpretive description as a methodological approach to understand the patient experience in various clinical settings (Bove et al., 2019; Mejdahl et al., 2017; S. Thorne et al., 2014). Interpretive descriptive studies inform clinical reasoning by going beyond description alone and placing subjective experience within the evidence base clinicians consider in care planning and delivery.

The coordinated care context examined in this study includes a “team” approach, whereby providers work together to provide quality care for patients with eating disorders in an outpatient setting. This team serves patients in a metropolitan city in the southwestern United States. Providers representing various health care systems and private practice meet weekly for 90 minutes in a centrally located clinical conference space. There are one physician and one nurse practitioner who manage the medical complications of these patients, and there are approximately six to eight therapists and dietitians each who manage the patients’ therapeutic and nutritional needs. Most providers stay on the team for at least several years, with three members involved since the team’s inception 24 years ago.

The patients may be seen weekly by the different treatment providers or as infrequently as less than once a month, depending upon the patients’ clinical needs and financial resources. For example, some patients have insurance to cover service costs, whereas other patients pay out of pocket. At these “rounds,” patients themselves are not present, but rather the providers share details of their treatment plans for shared patients, collaborate to ensure the delivery of consistent messages to patients, and update fellow providers on the patients’ physical, emotional, and psychological health. The providers may have slightly different treatment approaches to managing their patients’ needs, but rounds allow them to get on the same page with each other regarding how to manage their patients’ care. Due to the ongoing, collaborative working relationship of this team, disagreements can be addressed on a provider-to-provider level before the patient encounters different priorities or care directions. These provider communications also prevent triangulation and undue burden on patients to manage the team. The rounds environment also allows providers to stay abreast of best practices in eating disorder treatment through the sharing of current research and evidence-based recommendations.

This research involved human subjects as thus was conducted according to the World Medical Association

Table 1. Interview guide for semistructured interviews.

Questions and Prompts
When you were first diagnosed with an eating disorder, tell me about the care you received.
What was your relationship like with your [physician, nutritionist, psychologist, whoever was mentioned in the first part of the question]?
What did you learn from that first experience?
How is your care different now from how it was at the beginning?
What results did you most want when you first realized you had an eating disorder? What about now? What results are most important to you?
What has been involved in your treatment over the past 3 years or so?
What has the process included, the steps along the way?
Who has been involved in your care or treatment? And what have they done with or for you?
What have you personally done as part of your treatment over that time?
Tell me about the relationship you have with the care team. What's it like to be a patient in that team?
What has been most helpful about your providers coordinating your care?
Has this experience of coordinated care been similar to, or different from, other types of care you may have received for your eating disorder?
What have you found most helpful or most positive in your treatment over the past 3 years?
What do you think has most positively impacted your health and your quality of life over that time?
What specifically have those involved in your care done individually or collectively that you think has helped with your health and quality of life over that time?
What specifically in what you have personally done do you think has helped with your health and quality of life over that time?
What have you found as lacking or perhaps not so helpful or positive in your treatment over the past 3 years?
What do you think may have detracted or gotten in the way of improvements to your health or your quality of life?
What specifically about the care you've received from the individual care providers or the care providers as a whole have you found to be lacking or not so helpful or even hurtful to your health or your quality of life?
What specifically about your own efforts have you found lacking or not so helpful to your health or your quality of life?
Is there anything else about receiving coordinated, multidisciplinary care that we did not capture already that you would like to share?

Declaration of Helsinki. The study protocol was submitted to the Institutional Review Board (IRB) and was determined to be exempt status (IRB #00113954).

Participants

Purposive sampling identified participants who were women diagnosed with eating disorders seen in a coordinated care context for 6 months or longer. Study fliers, approved by the IRB (approval #00113954) that stated the study purpose, were distributed to health care professionals in the coordinated, multidisciplinary eating disorder treatment team. These professionals distributed the study flier to their respective patients who would likely meet the inclusion criteria for the study. Potential participants then contacted Kary Woodruff, and upon determination of meeting inclusion criteria, we provided study participants the study consent cover letter as approved by the IRB. This letter informed participants of their rights as human subjects, provided a summary of the study's aim and protocol, and identified resources available to the participants in case they have further questions or concerns. Participants then provided informed consent verbally to the interviewers by agreeing to participate in the study.

Data Collection

Two female researchers, Kary Woodruff and Nica Clark, both with qualitative interviewing experience, and professional backgrounds in clinical nutrition, conducted one-on-one interviews in person or via telephone using a guided interview approach (Table 1). Interviews were audio-recorded. The participants were free to elaborate, and the interviewer asked follow-up questions that helped deepen and expand the discussion of the treatment approach and her experience of it. Interview questions were asked in a flexible order in response to the direction of the interview, as led by the participant.

Nica Clark interviewed any prospective participants who had clinical interactions with Kary Woodruff. Kary Woodruff transcribed the audio-recorded interviews verbatim. We removed all identifying information and assigned a pseudonym to each participant. Field notes were recorded by interviewers upon conclusion of each interview.

We considered the sample size of 12 to 15 participants to be adequate based on the concept of information power within qualitative research studies (Malterud et al., 2016). Specifically, the more information the sample holds relevant to the research question, the fewer the number of

participants that are needed. This sample size is consistent with other interpretive description studies of clinical populations (Balneaves et al., 2018; Grattan et al., 2018; Kolltveit et al., 2017).

Data Analysis

We used the constant comparative method, derived from grounded theory and recommended within interpretive description (S. E. Thorne, 2016), to analyze transcripts in the Dedoose qualitative software program (Dedoose, 8.2.14, 2018). Inductively developed descriptive codes summarized the data with a short word or phrase. We applied process codes to reflect observable and abstract action (Saldaña, 2016). Examples of these codes were “feeling supported” and “meeting emotional needs.” We then modified, added, and removed codes throughout the analysis of subsequent interviews. We recoded previous interviews as we refined the codebook. Kary Woodruff synchronously logged analytic memos that summarized the main points of each woman’s treatment experience. We recoded the 12 interviews upon completion using the finalized codelist, emphasizing the iterative nature of analysis by constantly returning to the data. Our analysis of code frequency as well as code re-occurrence elucidated the relevance of the different codes.

Kary Woodruff next looked at the intersection between the coded data and the original research questions using an iterative framework proposed by Srivastava and colleagues (Srivastava & Hopwood, 2009). Specifically, we asked: what is the data telling us? What is it that we want to know (based on our research question of the patient experience)? Then by asking the question, what is the dialectical relationship between what the data are telling us, and what we want to know, we could refine our focus and link our data back to our research question. Using our findings from these questions, along with the coding results, we constructed the major categories that were grounded in the data. Finally, the entire corpus of the interview data was analyzed to identify patterns across the participants’ experiences that transected the categories. The final result was an interpretive description of the patient experience of coordinated, multidisciplinary care for the outpatient treatment of patients with eating disorders.

We employed several strategies to safeguard rigor. First, Kary Woodruff and Nica Clark met regularly to discuss the completed interviews to ensure that we captured the essential treatment experience. The two interviewers then met upon the conclusion of the interviews to discuss the main points that had surfaced. The interviewers reviewed each interview question and discussed how each completed interview contributed to an understanding of each research question. Kary Woodruff communicated her summary of the interviews, and Nica Clark assessed if this was an accurate representation of what she heard from the women. The two interviewers then explored the rich interpretive possibilities of the transcripts and how the women’s voices came together to provide a deep

understanding of the patient experience of this treatment model.

Second, Lauren Clark verified the coding application of several transcripts and debriefed with Kary Woodruff throughout the analysis. This coding verification ensured the consistent and appropriate application of codes across the transcripts. The debriefing conversations between Kary Woodruff and Lauren Clark provided probing questions about the coded content and prompted Kary Woodruff to incorporate clinical insights reflexively within the analysis process. Finally, as Kary Woodruff was concluding the analysis of the women’s experiences, she discussed her findings with Lauren Clark, who had read several of the transcripts, to discuss how the findings were best compiled into the study categories.

Kary Woodruff was familiar with this patient population from a clinical perspective, as a registered dietitian with 10 years of experience as an outpatient clinical dietitian in the field of eating disorders. Given that individuals affected with an eating disorder often share sensitive and private information with their providers, and that Kary Woodruff has clinical relationships with patients that can extend for many years, Kary Woodruff also likely has personal biases stemming from this intimate work. One of the questions that often arose in the clinical role is that as providers, we believed that this model of care improved the delivery of care to our patients. What we did *not* know is how the patients felt about receiving this team-based care. It was this curiosity and concern that motivated this research question using a qualitative research design.

It was also clear that Kary Woodruff’s clinical experiences added both insight and biases to the interpretation of the patients’ experiences of team-based care. Importantly, it was evident that interviewing women would necessitate taking on the role of nontherapeutic *listening* to their recovery experiences of receiving treatment, instead of connecting with patients as in a clinical partnership. Women with whom Kary Woodruff had professional interactions were interviewed by Nica Clark who was not known to the women but was a trained, qualitative interviewer. For all women, we prioritized creating a chance for them to explore their experiences in whatever way they wished during the interview, and the interview provided some guided questions and prompts, as needed, to maintain a general focus on the experience of receiving coordinated, multidisciplinary care. In the analysis, we relied on Lauren Clark and Nica Clark in interpreting data to balance Kary Woodruff’s prior experience, question our assumptions, and to extend the data in new ways based on alternative interpretation.

Results

Sample Description

We interviewed 12 women (aged 18–42 years) with diagnosed anorexia nervosa (7 women), bulimia nervosa (3

women), or unspecified eating disorders (2 women). Interviews, on average, lasted approximately 39 minutes (range = 23–58 minutes). Transcripts were not reviewed by the participants, though interviewers followed up with two interviewees to clarify questions from their interviews. Three interviews took place in a community setting; nine interviews took place on the phone. Participant time in treatment for eating disorders ranged from 3 years to 30 years (average of 14 years, median 12.5 years), though patients may not have been receiving treatment in a coordinated context for this entire duration. While it is unknown how many individuals chose not to participate, no participants dropped out throughout the study.

Categories of Patient Experiences of Coordinated, Multidisciplinary Care

Though women reported diverse experiences, analysis of the data revealed important commonalities that were essential to the recovery process. Thoughtful and careful examination of the women's experiences identified four categories that further our understanding of the uniqueness of this treatment approach: (a) relying on the lifeline of communication; (b) supporting autonomy; (c) drawing on individual strengths; and (d) valuing synergy.

Relying on the lifeline of communication. The importance of communication between members of the care team and between the care team and the women frequently surfaced in the accounts. Individuals with eating disorders may hold deeply entrenched beliefs that perpetuate their eating disorder thoughts and behaviors. These beliefs surround unhealthy eating patterns or supplement use and ideas about body weight and shape, for example. In the multidisciplinary team, these beliefs are challenged. Consider Claire's experience:

I think a lot of times when I'm told something, especially if it goes against something that I have built a very strong belief about, I immediately get defensive. I don't fully believe what they tell me. So to have it kind of re-emphasized from another, it's like having that third-party validation. So like having like them communicate, and the validation is more reassuring [especially] when you have a hard time trusting.

In instances when women had received uncoordinated care, they struggled with the burden of having to tell and retell their stories, challenges, and eating disorder behaviors. For some, the cognitive impairment associated with their illness limited the quality of their communication with their providers. The women might forget what information they had, or had not, provided to each care team member. Other women intentionally withheld information from some providers due to feelings of shame or guilt. For example, women may have withheld information from one or more providers about specific eating disorder behaviors in which the woman

engaged (e.g., the number of times the patient purged each day, how few calories the patient consumed, etc.), while being more open and honest with other providers about these same behaviors. Consequently, not all providers received the same information. From the clinician perspective, access to information across visits and from different providers can maximize the provider's ability to provide effective treatment. Isabel described one such instance:

. . . especially when I was really down and out, obviously my brain wasn't functioning 100%, and so I would forget sometimes to tell someone this. The coordinated care probably helped them [providers] as well . . . They can tell each other when I wasn't able to tell them. I think that's a really important part. And even now, I forget sometimes, "oh yeah I probably should have told you that, but I thought I already said it to someone else," so the fact that I don't have to repeat myself is a huge benefit.

A treatment team that regularly communicated and coordinated care relieved the women's burden of having to communicate all details to all providers and shifts some of this responsibility onto her providers. The women acknowledged the importance of their providers having all of the information to provide effective care, and if her providers were on a team, they were able to share relevant information.

Team communication allowed women to be heard more effectively and enhanced women's understanding of their providers' messages. There was value in having team members that served as "translators" for other team members. For example, one woman described how her therapist re-phrased information the woman had given to her therapist and made it understandable to her medical provider. At her next appointment, the woman felt that her medical provider better understood what she was trying to convey. Care team members also improved communication in the opposite direction, when therapists could translate important medical information to the women. Women consistently agreed that the coordinated treatment model facilitated communication with their providers such that the women felt understood. This sense of feeling heard engaged the women in their treatment and more deeply connected them to their providers.

There were a couple of women who were occasionally frustrated when communication seemed to be insufficient. While women understood they were receiving coordinated, multidisciplinary care, they did not always understand what this meant. One woman was uncertain about how often her providers met as a team, and to what extent her providers coordinated her care. She speculated that this "communication" was transpiring via electronic medical record system messaging; she was not aware that her providers met weekly in person to discuss their patients' care. This feedback provided by some women illustrates how the perception of poor provider communication could detract from the coordinated care experience.

Supporting autonomy. Women stressed the importance of maintaining autonomy over their treatment and for providers to support this independence. Several women needed to experiment with different strategies to decrease eating disorder behaviors independently. These women disliked overly protective providers and deemed it was harmful to their recovery process. For example, one woman's provider encouraged her to wean off laxatives gradually, but the woman disagreed; she felt strongly that complete cessation was best, and she was successful in this approach. Other women discussed experimenting with their own iterations of the meal plans that had been provided by their dietitians to establish an effective eating routine. Others admitted the need to "learn the hard way" and that unsuccessful attempts provided as many opportunities for learning and growth as successful ones. The women appreciated providers that valued their input and provided sufficient leeway for experimentation.

The women emphasized that the treatment team helped them develop this sense of autonomy and provided guidelines regarding safe experimentation. If the women were to fail, they knew they had their entire treatment team to fall back on for support. Importantly, this experimentation generated self-confidence, which extended to other areas of treatment and empowered the women to take ownership of their recovery. The experimentation process also supported women in acquiring their personal recovery strategies. Danielle's comments illustrate this concept well:

And my team that I have right now has given me the space to do that where it's not this immediate reaction to things, everybody's letting me test the waters and like figure out for myself, and I think that's been helpful for me to just . . . develop some sort of competence that other people aren't the ones to keep me afloat, that I'm actually doing it, which I think is hard early on in eating disorder treatment, because you do have so many people telling you how to do things, that one of the things that happened to me is that I sort of lost a sense of my own competence.

The women pointed out that when they took ownership of their recovery, they experienced a more authentic and successful healing process than without this sense of autonomy. Providers that supported this independence and ability to experiment were able to cultivate trust, which enhanced the women's self-confidence and strengthened their relationship with their providers. This value of trust between the women and their providers surfaced in many of these stories.

Most women conceded that it was appropriate for providers, on occasion, to discourage experimentation. The women acknowledged that such leeway was unwarranted when they were stuck in their eating disorder behaviors or were unstable medically or cognitively. The women's ability to experiment throughout their treatment shifted and changed according to their level of functioning and stability in their recovery process.

Drawing on individual strengths. Many women emphasized that each provider contributed unique expertise that was valuable for their recovery. These women recognized functions specific to the nurse practitioner/physician, dietitian, and therapist that could only be filled by these respective individuals. The medical provider ensured that the women's physical health was being monitored and managed women's medications; the dietitian supported the development of normalized eating habits and addressed the women's relationship with food; the therapist helped identify etiological factors contributing to their eating disorders and addressed the management of cognitive and emotional challenges to recovery.

These women also acknowledged the occasional overlap between the different provider roles, noting that such overlap was also important for consistent messaging. For example, women described the medical provider and dietitian as providing therapeutic support; these individuals were not simply serving as a medical provider or nutrition expert. We hear this in Isabel's experience with her nurse practitioner:

So, I remember, I mean, even at times with [nurse practitioner], [nurse practitioner] would do a lot of kind of the mind work which was really . . . I had never had a [medical provider] like that, one a [medical provider] that would spend time with me in the room . . . so she sat down, and talked to me. Kind of wanted to get me out of my own head and she really, really worked hard at that, in a good way, very intimidating, and I needed that. I needed like, kind of that gentle coach figure, who wasn't a parent or an older sibling, or um, even like a therapist. And it was very helpful for me—terrifying at the time, but I look back on it and I was very very grateful for that. So they all kind of took on each other's roles, too?

Women highlighted the importance of the "fit" in the client-provider relationship. Different providers have diverse treatment approaches and personalities; finding a strong rapport and alignment of goals was essential to establishing a therapeutically beneficial relationship. Danielle discussed the significance of this alliance:

And so, I think that the most valuable thing was that all of my providers rallied around that goal for me, and there were definitely rules in place . . . I think the learning experience from that and why I ended up, I stopped treatment for a while and then I went back to it, was just that I realized that providers would align with my goals, and what I wanted for myself, and would, I felt like people would take that into account when they would work with me.

The women emphasized the importance of working with a diverse team of experts, noting that they needed to trust that each provider was experienced in treating individuals with eating disorders. Many women recalled adverse experiences with providers who lacked sufficient expertise. Some women admitted to being able to "get away with" eating disorder behaviors when working with inexperienced providers and

described their frustration when working with providers who did not understand their concerns and challenges. Working with eating disorder experts with insightful and actionable recommendations enhanced women's recovery.

While the role of each provider was clear for most women, two women were confused about the role of the medical provider. These women both had previous experiences with medical providers that included in-depth physical exams at every appointment. These women were confused about why their medical visits did not always include this exam when meeting in their current interdisciplinary care team. While these women still reported having an overall positive experience, this was one area of uncertainty. Each provider played an important role in women's treatment, and the concept of communication resurfaced in delivering expectations for *how* each specific provider would participate. Improved communication about providers' roles would likely enhance these women's experiences.

Feeling "cared for" by different members of the treatment team was essential, with some women stating unequivocally that this was the most beneficial aspect of their treatment. While the expertise of each provider was important, this desire for compassion and empathy was deemed essential and independent of the provider's specialty. The women desired an interpersonal relationship with each provider. Consider Laura's example:

Since my diagnosis, I think like what's most important for me is when I know that someone on my treatment team cares about me. I think that's very important to me. I'm very much a relationship person versus go in and get it done, I guess?

Valuing synergy. An overarching category was that the coordinated, multidisciplinary care provided value that went beyond the sum of the parts (i.e., the individual attributes of each of the providers). Women who had experienced both coordinated and uncoordinated multidisciplinary care consistently reported that the former resulted in a significantly superior experience and a more effective treatment. Other women did not have this contrasting experience, yet they often spoke of this team effect as transcending the influence of the individual providers.

Women trying to convey the essence of this synergism often spoke to the experience of connectivity. Women emphasized the significance of feeling tethered to others during recovery, which provided a sense of stability and constancy. The women knew they were not alone in their recovery but instead had the steadfastness of their treatment team. This connection had a grounding effect on women. Having a coordinated team of providers enhanced this sensation compared with having only one treatment provider. The coordinated team provided a more "holistic" approach that considered the entirety of the person. Women valued "having all of my bases covered." Kala describes this well:

I feel like they have literally saved my life. I think I think there's so much more you can capture by coordinating care because you're not just seeing one provider, you're getting that input from a whole team of people. The fact that they can meet together and discuss your care, it just, makes such a difference. I feel like it's absolutely one of the most important things you can do in eating disorder recovery.

The coordinated team removed roadblocks that would have existed with individual providers. When the women became more ill or were in crisis, coordinated providers helped the women to access higher levels of treatment more quickly than if the care were uncoordinated. The channels of communication and coordination were already in place to facilitate greater support for these women.

Discussion

Despite multiple, international guidelines recommending coordinated, multidisciplinary care for the treatment of eating disorders, limited evidence exists to support its efficacy. We understand even less about patient perceptions of this treatment approach (Ozier et al., 2011; Yager et al., 2014). To our knowledge, this is the first study to examine the patient experience of those receiving coordinated, multidisciplinary care for the treatment of an *anorexia nervosa* and *bulimia nervosa* in an outpatient setting. Each woman interviewed advocated for the implementation of this treatment model. In instances where women had previously received uncoordinated care, the women universally recognized the advantage of the coordinated model.

The findings derived from this examination of women's experiences of team-based care provide valuable clinical insight for nurses and other eating disorder professionals. Several conclusions can be drawn. First, communication among treatment team members and the patient is essential to establish trust, relieve the patient burden, and support provider recommendations. This team communication is more than just exchanging words and ideas; rather, a treatment team strives to come to a shared vision or belief about the patient's needs. Second, eating disorder practitioners can support the autonomy of their patients to encourage their ownership over treatment. Autonomy can enhance the individual's confidence to care for themselves. When providers working in a coordinated team support experimentation, patients can discover meaningful and effective recovery strategies. Third, patients value that each provider in a multidisciplinary team contributes unique expertise to a different aspect of patient care. This expertise increases the patient's trust in their providers and enhances the effectiveness of the therapeutic relationship. Fourth, patients emphasize that providers are more effective when viewed as experts in this field. Finally, while each provider plays an important role individually, there is a synergistic benefit to coordinated,

multidisciplinary care that provides a more holistic approach that is valued by the patient.

Intertwined in each of these categories is the idea of connectedness. Communication supported greater connectivity simply through the ability of the women to come and talk with someone every week; having a coordinated, multidisciplinary team approach increased such opportunities. Women identified the trust and connectedness with their team members as that which provided them the safety net to experiment and develop autonomy. Women repeatedly emphasized how their relationships with each provider, as well as with the whole team, fostered a sense of connectivity. Previous research supports these findings that social connectedness may decrease disordered eating behaviors as mediated by positive body image (Pinto et al., 2017). When nurses value the importance of simply connecting with their patients, these providers help to diminish the shame and secrecy that so often perpetuate eating disorder thoughts and behaviors.

An interesting point made by several women was that no matter how effective their multidisciplinary team was, the success of their recovery was also dependent upon themselves. As patients, they acknowledged their role in the recovery process. The women admitted that they needed to be ready to accept help, and they needed to be ready to change regardless of their treatment context; a lack of readiness was a significant barrier. These findings align with the Transtheoretical Model of Change (Prochaska & DiClemente, 1992), whereby preparedness for change predicts a behavior change. Indeed, studies have shown that patients' level of preparedness predicted improvements in eating disorder treatment outcomes, such as weight restoration (Rodríguez-Cano & Beato-Fernández, 2005), dietary restraint (Bewell & Carter, 2008), and binge eating behaviors (Castro-Fornieles et al., 2011). Recognition of an individual's stage of change in eating disorder care allows nursing staff to support recovery in an appropriate way. For example, if an individual is in the contemplation stage of change regarding their eating disorder treatment, a nurse may help the individual to understand the benefits of working with a coordinated, multidisciplinary care team; nurses may provide individuals in the preparation stage with resources for local multidisciplinary care teams.

The women's value of having some autonomy over their treatment, and for providers to support such autonomy, is also consistent with previous research. Within the framework of the Self-Determination Theory (Ryan & Deci, 2008), autonomous motivation supports improved clinical outcomes regarding eating disorder pathology. Steiger and colleagues (2017) examined 97 women diagnosed with an eating disorder and found that experiencing autonomous support from both therapist and nontherapists was associated with increased motivation among these individuals. This heightened autonomous motivation correlated with improved clinical outcomes of dietary restraint, weight concerns, global eating symptoms, and change in body mass index

(Steiger et al., 2017). The women in this study repeatedly emphasized the significance of the team, not just the individual provider, in encouraging their autonomy, reflecting its relevance to coordinated care.

The importance of understanding the patient experience in the context of receiving team-based care among a patient population as vulnerable as individuals with eating disorders cannot be undervalued. Eating disorders are vastly underdiagnosed, with stigma and shame identified as one of the most significant barriers to receiving treatment (Ali et al., 2017). These findings allow nurses to humanize their treatment process. We see this in the agency women want to have over their treatment, the uniqueness of each woman's experience, their desire to be connected to others, and their sense of recovery as a personal journey on which these women are traveling (Todres et al., 2009). In humanizing their experiences, nurses give voice to individuals who may otherwise feel shame for having an eating disorder. This humanization also fights against existing stigmas about eating disorders that may serve as a barrier to accessing treatment.

This study provides prompts for nurses and other health care providers to consider based on some patients' adverse experiences. A few women were unsure of the specific role each provider would play, and they were uncertain about what the coordination between providers entailed. As frequent coordinators of patient care, nurses can clearly define the coordinated approach in their patient interactions and can convey the frequency of communication that transpires among providers. This nursing role can establish realistic expectations and improve the patient experience.

Nurses are well-established team members in the care of eating disorders (Chitty, 1991; Foa et al., 2019; Oakley et al., 2017). Nurses are often the point of entry for patients into the medical system and can identify patients that are at risk of an eating disorder. Nurses who are familiar with the medical, psychological, and nutritional needs of these individuals can support effective medical and mental health assessments and interventions. Nurses can also facilitate the referral of a patient to a multidisciplinary, coordinated team. Given that the medical community at large often neglects to recommend or implement a multidisciplinary approach, nurses can educate their fellow health care team members on the importance of improving the patient experience with this team-based approach.

It is also important to note that most patients who seek treatment for an eating disorder are women; nationally, most nurses are also women. Some nurses have personal or family experiences with eating disorders. This potential crossover of a gender-based experience may provide a position of commonality between nurses and their patients that is rooted in shared cultural values in a society that has particular beliefs about women's bodies. Nurses are often in a unique position to form therapeutic alliances with other treatment team members and with patients to advance this more holistic treatment approach. Ultimately, the findings from these

interviews support nurses in building upon their meaningful interactions with this patient population and providing patient-centered care.

We acknowledge several limitations in the study design. First, none of the participants were men. Roughly one out of 10 individuals diagnosed with an eating disorder is male; however, men are more likely to go undiagnosed than women due to a variety of factors that are outside of the scope of this article (Murray et al., 2017). Unfortunately, there were no men receiving care from this treatment team that expressed an interest in serving as a study participant. Furthermore, the treatment team that provided care to the women in this study only included one male provider. While the women did not communicate any gender-related influences in their provider relationships in response to the questions, this is a topic that might be explored in greater depth in future studies. The study findings warrant additional consideration of how the well-known distribution of the condition by gender may also play a role in the gendered talk and therapeutic alliances in the clinic. The gender-role differences in eating disorder treatment that may be part of the multidisciplinary team approach cannot be understood in this study of women and warrant additional consideration of the male patient experience.

All women were patients of one particular treatment team, and the patient experience in diverse multidisciplinary care models may differ. Gail states it succinctly: “I don’t know if it’s the model, or if it’s the [specific] people.” Further research can extend these study questions to patients receiving care in different outpatient settings using different multidisciplinary care teams. While this study included anorexia nervosa and bulimia nervosa, the voices of patients with binge eating disorder were not represented. Other factors that could influence the interpretation of the findings include the women’s stage of recovery at the time of the interview, the duration and severity of illness, psychiatric comorbidities, social support, educational status, and socioeconomic status. These participant characteristics also limit the generalizability of the findings.

Despite these limitations, we believe our findings support the practice of coordinated, multidisciplinary care for the treatment of individuals with eating disorders, an overlooked model in the outpatient treatment setting. These patient insights may guide nurses and other health care providers working with this patient population. Given that this effective model is universally underutilized, future research can examine the barriers perceived by eating disorder professionals for the implementation of coordinated, multidisciplinary care in an outpatient setting.

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