

THE PERCEIVED INFLUENCE OF EMOTIONS ON CLINICAL DECISIONS AND
PRACTICES IN CHILD AND ADOLESCENT EATING DISORDERS

by

Stacey Kosmerly

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APPROVED/APPROUVÉ

Thesis Examiners/Examineurs de thèse:

Dr. Adèle Robinson
(Supervisor/Directeur(trice) de thèse)

Dr. Shelley Watson
(Committee member/Membre du comité)

Dr. C. Whissell
(Committee member/Membre du comité)

Dr. Kristin von Ranson
(External Examiner/Examineur externe)

Approved for the Faculty of Graduate Studies
Approuvé pour la Faculté des études supérieures
Dr. David Lesbarrères
M. David Lesbarrères
Acting Dean, Faculty of Graduate Studies
Doyen intérimaire, Faculté des études supérieures

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ABSTRACT

Recently, two theoretical models (the Iatrogenic Maintenance Model for Eating Disorders and the Therapist Drift Model) have identified clinician emotion as a factor that may negatively influence the treatment of eating disorders (ED). However, the role of clinician emotion in the delivery of treatment remains largely unstudied. The present article-based thesis sought to examine clinicians' perceptions of the negative influence of emotions (clinicians' own emotions and those of others) on clinical decisions and practices with respect to child and adolescent eating disorders. Two studies were conducted to examine clinicians' perceptions of whether, and in what ways, emotions play a role in clinical decisions and practices. Overall, clinicians endorsed some degree of negative influence of emotions on clinical decisions. Specific treatment decisions were identified as being perceived to be more vulnerable to the negative influence of emotions (e.g., decisions related to the involvement of a critical or dismissive parent in treatment), and particular client/parent emotional states (anger, flat affect, hopelessness or helplessness) were identified as being perceived to be more likely to lead to a negative influence of emotions on clinical decisions. Clinicians also endorsed specific concerns that they perceive to drive emotion-based decisions, as well as several emotion-driven practices. Finally, clinician characteristics related to the perceived occurrence of this phenomenon were examined. Emotional drain and work setting were factors predictive of the perception of negative emotional influence on decisions and practices. The results are discussed in terms of the implications for clinical practice and future directions.

Keywords: Eating Disorders, Clinician Emotions, Children and Adolescents

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CHAPTER ONE

INTRODUCTION

Stacey Kosmerly, M.A. Candidate.

Department of Psychology, Laurentian University, Canada
Chapter One: Introduction

Eating disorders (ED) are debilitating disorders that are especially prevalent in female adolescents and young women (Fairburn, Cooper, Doll, Norman, & O'Connor, 2000; Goni & Rodriguez, 2007; Lewinsohn, Striegel-Moore, & Seeley, 2000). They are ranked as the third most common chronic illness among adolescent females (Fisher et al., 1995) and have the highest mortality rate of all the psychiatric illnesses (Reijonen, Pratt, Patel, & Greydanus, 2003). Virtually every organ system is affected by ED symptoms (Katzman & Findlay, 2011) and when they occur during adolescence, ED can result in up to a 25-year reduction in lifespan (Norris, Bondy, & Pinha, 2011). The risk of irreversible medical complications (Golden et al., 2003; Katzman & Findlay, 2011) and chronicity (Von Holle et al., 2008) increases with time, making early and effective intervention of ED symptoms critical.

Although they share several core features (Fairburn, Cooper, Shafran, 2003) and are all associated with negative effects to quality of life (Winkler et al., 2014), there are currently three primary categories of ED in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013^a). These include anorexia nervosa, bulimia nervosa, and binge-eating disorder. Anorexia nervosa is primarily identified by restrictions of energy intake resulting in a significantly low weight, as well as a fear of gaining weight (APA, 2013^a). Bulimia nervosa is mainly characterized by recurrent binge eating followed by some method of compensation, which occur on average at least once a week for three months (APA, 2013^a). The third category, binge-eating disorder, is characterized by episodes of binge-eating (without any associated compensatory behaviours) that cause significant distress and occur at least once a week for three months (APA, 2013^a).

The Treatment of Child and Adolescent Eating Disorders

The American Psychiatric Association (APA, 2013^b) recommends the involvement of the family in the treatment of children and adolescents with an eating disorder (ED). Family-based Therapy (Lock & Le Grange, 2013; Lock, Le Grange, Agras, & Dare, 2001) is one such treatment approach. In this manual-based treatment model, clinicians work as part of a multidisciplinary team and support parents to promote weight restoration and symptom reduction in their child (Lock & Le Grange, 2013; Lock et al., 2001). In the first phase of treatment, the focus is on empowering parents to take action against their child's ED in order to restore the child/adolescent's weight and to halt disordered eating behaviours (Lock et al., 2001). Once this phase is complete (weight is restored and symptoms are controlled), Phase 2 of the model requires a shift in the focus of therapy towards returning the child/adolescent to a level of functioning that is developmentally appropriate, which includes the ability to feed herself. Finally, in Phase 3, clinicians address any remaining psychological and emotional issues within the family prior to terminating treatment (Lock et al., 2001).

When delivering Family-based Therapy, clinicians must make a number of difficult decisions that can be met with negative or hostile reactions by children/adolescents, their families, and other members of the multidisciplinary team (i.e., setting goal weights, restricting physical activity, etc.). In addition, children and adolescents with ED are often in denial of the severity of their illness and resist treatment attempts made by their parents (Lock et al., 2001). Denial of illness and resistance to treatment can magnify the difficulty of the clinical work by bringing ethical and moral issues into consideration, as involuntary treatment may be required to prevent serious medical complications in children and adolescents who refuse to engage in

refeeding despite their parents' (and the treatment team's) best efforts (Matusek & O'Dougherty Wright, 2010).

Recently, theories have emerged, which posit that the emotions of those who care for individuals with an ED (i.e., parents, families) can influence the onset and maintenance of ED (Goddard et al., 2011; Lafrance Robinson, Dolhanty, & Greenberg, 2013; Schmidt & Treasure, 2006; Treasure et al., 2008). The Cognitive-interpersonal Maintenance Model of ED suggests that carers can experience emotional arousal as a result of their loved one's illness, which then can lead them to engage in behaviours that may inadvertently contribute to ED maintenance (Goddard et al., 2011; Treasure et al., 2008; Whitney & Eisler, 2005). For example, carers may feel immobilized in their efforts to help their child recover if they fear that their loved one will stop loving them, stop eating altogether, or self-harm as a result of these efforts (Treasure et al., 2008). Therefore carers can fall into unhelpful patterns in which they accommodate ED symptoms (e.g., buy low-calorie foods, avoid the reintroduction of feared foods in their loved one's diet, etc.) so as to avoid these feared consequences (Treasure et al., 2008). Similarly, the Emotion-focused Family Therapy Model of ED theorizes that carers can experience emotional "blocks" (i.e., fears, anxiety, activation of past emotional traumas) when implementing tasks of recovery, which can interfere with their ability to be effective in their helping roles (Lafrance Robinson et al., 2013). As an example, if ED behaviours activate a parent's sense of shame or self-blame, this can foster hopeless, defensive, or critical behaviours in the parent, which in turn can interfere with their supportive efforts. Interventions that include components aimed at addressing the emotions of carers' have only begun to be examined (e.g., Expert Carers Helping Others; Treasure, Smith, & Crane, 2007), though preliminary evidence suggests that these

approaches are helpful not only in reducing ED symptoms, but also in improving carers' well-being (Goddard et al., 2011).

In light of this body of research, it seems logical to then consider the emotions of the clinician. It is well established that working with individuals with ED can be emotionally challenging (Franko & Rolfe, 1996; Golan, Yaroslavski, & Stein, 2009; Thompson-Brenner, Satir, Franko, & Herzog, 2012; Warren, Schafer, Crowley, & Olivardia, 2013); however, little is known about the ways in which emotional reactions influence treatment delivery. Recently, two theoretical models have considered the possible influence of clinicians' emotions on the delivery of treatment for ED: The Iatrogenic Maintenance Model of Eating Disorders (Treasure, Crane, McKnight, Buchanan, Wolfe, 2011) and the Therapist Drift Model (Waller, 2009). These models suggest that clinicians, like carers, may experience anxiety and other emotions that have the potential to lead to avoidant and unhelpful clinical practices (Treasure et al., 2011; Waller, 2009).

The Iatrogenic Maintenance Model of Eating Disorders

The Iatrogenic Maintenance Model of Eating Disorders was developed on the basis of anecdotal evidence and reports. It proposes four clinician-factors that may negatively affect ED treatment; *interpersonal factors, pro-eating disorder beliefs, thinking style, and emotional style*. Interpersonal factors refer to clinician characteristics, such as overprotectiveness, hostility, and criticism, which may (inadvertently) fuel ED symptoms when acted out in reaction to the ED. An example given by Treasure et al. (2011) is that a clinician acting in an overprotective manner may prematurely or unnecessarily admit a client to inpatient treatment, which “offer a safe ‘hot house’ environment with little opportunity for individuals to undertake behavioural experiments outside the ward” (p. 297). Pro-eating disorder beliefs refer to the ways in which clinicians

engage clients in the refeeding process. According to this model, refeeding achieved through coercive or punitive means can foster food aversion and ED symptomology. Thinking style is defined by Treasure et al. (2011) as clinicians' rigidity in their definition of recovery. Treasure et al. (2011) maintain that when clinicians see recovery as all-or-nothing this can induce a sense of hopelessness and failure in clients. In terms of emotional style, Treasure and colleagues (2011) postulate that during the treatment of individuals with ED, clinicians can experience emotional states such as anxiety, which in turn can foster avoidant practices aimed at reducing these negative states. For example, in fear of evoking a hostile reaction in a client, a clinician may engage in negotiations with the client around treatment recommendations, therefore reducing both the likelihood of a negative response from the client and the clinician's own anxiety. For the purpose of the present thesis, the focus will be the clinician emotional style component of this model.

The Therapist Drift Model

Waller's Therapist Drift Model (2009) introduces three clinician-factors: *clinician cognition, clinician behaviour, and clinician emotion*, which may actively interfere with clinical decisions and practices. Clinician cognition refers to clinician biases, which can result in blaming the client for lack of progress, failing to recognize when treatment is not working, and failing to consider alternative and more appropriate models of treatment when necessary. According to Waller (2009), clinician behaviours that can interfere with therapy include working when over-tired, over-stressed, or ill, as well as failing to push clients for behavioural change when it results in making the client (and in turn, the clinician) uncomfortable. Finally, like Treasure and colleagues (2011), when it comes to clinician emotion, which is the focus of the current thesis, Waller (2009) suggests that clinicians may engage in avoidant practices in order to reduce their

experience of negative emotions like anxiety, fear, shame and guilt. These avoidant practices can take the form of avoiding the discussion of a particular case in supervision, or omitting certain therapeutic tasks, for example. The Therapist Drift Model (2009) also recognizes that positive emotions can equally hamper clinical judgement, as they may mislead and distract from important clinical information and cues. For example, clinicians may become excited about minor changes in a client's course of treatment, which can divert attention away from overarching treatment goals.

Although these theoretical models begin to address the gap in the literature related to the role of clinician emotion in the treatment of ED, there continues to be very little research on this phenomenon. Waller, Stringer and Meyer (2012) explored the relationship between self-reported therapist anxiety and adherence to an empirically-supported treatment protocol for ED (i.e., Cognitive-behavioural Therapy). Results from this study provide some support for the theory of Therapist Drift: clinician anxiety was related to lower levels of adherence to treatment protocol, suggesting that clinicians "drift" away from empirically-supported practices when anxiety is high. A parallel investigation was conducted by Kosmerly, Waller, and Lafrance Robinson (2014) with clinicians who reported to use Family-based Therapy in the treatment of child and adolescent ED. In terms of Therapist Drift, findings revealed that clinicians with greater levels of anxiety were less likely to adhere to treatment protocol, in that they were less likely to weigh the client at the beginning of the session (Kosmerly et al., 2014). There is also some qualitative evidence for the influence of clinicians' emotions on ED treatment. Couturier et al. (2013) conducted interviews with child and adolescent ED clinicians, which revealed that clinicians can feel intimidated and anxious about particular therapeutic tasks (i.e., weighing the client and completing the family meal) related to the delivery of Family-based Therapy (Lock & Le

Grange, 2013; Lock, Le Grange, Agras, & Dare, 2001). This anxiety may in turn interfere with clinicians' use of these techniques (i.e., lead to their omission), and may negatively affect treatment delivery.

The Present Research Study

The present article-based thesis aimed to understand clinicians' perceptions of the negative influence of emotions (their own and those of others) on clinical decisions and practices in the context of child and adolescent ED treatment. This goal was accomplished via two studies. The first study (Chapter 2) examined whether clinicians perceive emotions to negatively influence clinical decisions when working with children and adolescents with ED. In light of evidence that suggests that clinicians can sometimes lack objectivity when reporting on the influence of emotions on clinical decisions (Brown, 2004; 2005), the sample was randomly assigned to one of two groups: the *Self* group completed a survey assessing their perception of the influence of their own emotions on their clinical decisions, while the *Other* group completed a parallel version of the survey which assessed their perceptions of the influence of emotion on their colleagues' clinical decisions. Both groups also reported the degree to which specific treatment decisions related to the treatment of child and adolescent ED were perceived to be vulnerable to negative emotional influence. Comparisons between groups and overall results related to the perception of the negative influence of emotions are discussed. Specific treatment decisions perceived to be more vulnerable to this phenomenon are also outlined. Study 2 (Chapter 3) sought to deepen our understanding of the ways in which clinicians perceive this phenomenon to occur. This study examined specific client emotional states that were perceived to be particularly emotionally challenging for clinicians, specific practices reported to be utilized in response to emotions, and specific clinician concerns (or anxieties) perceived to negatively

impact clinical decisions. Furthermore, Study 2 examined the relationship among various clinician characteristics (i.e., experience, level of emotional drain, supervision, working as part of a multidisciplinary team) and the negative influence of emotion on clinical decisions and practices. Implications for clinical practice, future research directions, and limitations to the present study are discussed.

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CHAPTER TWO

The Perceived Influence of Clinician Emotion on Decisions in Child and Adolescent Eating
Disorder Treatment

Stacey Kosmerly, M.A. Candidate.

Department of Psychology, Laurentian University, Canada

ABSTRACT

The aim of the present study was to examine clinicians' perceptions of the negative influence of emotions on clinical decisions when working with child and adolescent eating disorders. Three hundred and five eating disorder clinicians from various disciplines participated in one of two online surveys: the *Self* group ($n = 143$) completed a survey assessing the perception of the negative influence of emotions on their own clinical decisions, while the *Other* group ($n = 145$) completed a parallel version of the survey that assessed their perceptions of the negative influence of emotion in their colleagues. Both groups endorsed this phenomenon to some degree (30.5%), although differences in reporting were noted between groups. In terms of specific treatment decisions, decisions regarding the involvement of a critical or dismissive parent in treatment were perceived by both groups to be the most emotionally charged. The results are discussed in terms of their implications for practice and future research.

Keywords: Treatment, Eating disorders, Emotions.

The Perceived Influence of Clinician Emotion on Decisions in Child and Adolescent Eating Disorder Treatment

It is widely accepted that emotions play a role in the development and maintenance of eating disorders (ED; Dolhanty & Greenberg, 2007; Fox & Powers, 2009; Treasure, 2012). For example, ED symptoms have been found to be related to difficulties with emotion recognition (Becker-Stoll & Gerlinghoff, 2004; Bydlowski et al., 2005), emotion regulation (Harrison, Sullivan, Tchanturia, & Treasure, 2009; Tasca et al., 2009), and socio-emotional processing (Treasure, Corfield, & Cardi, 2012). Interventions targeting emotional processes have been steadily increasing (i.e., Emotion-focused Therapy, Dialectical Behaviour Therapy for ED, Enhanced Cognitive Behaviour Therapy for ED) and are showing promise as effective interventions for ED (Dolhanty & Greenberg, 2007; Fursland et al., 2012; Lenz, Taylor, Fleming, & Serman, 2014).

In the treatment of child and adolescent ED, carers (i.e., parents, family members) are often highly implicated in the delivery of treatment (e.g., Family-based Therapy [FBT]; Lock & Le Grange, 2013). Interestingly, there is a growing body of literature that supports the theory that the emotions of those who care for individuals with an ED can also influence ED etiology and maintenance (Goddard et al., 2011; Lafrance Robinson, Dolhanty, & Greenberg, 2013; Schmidt & Treasure, 2006; Treasure et al., 2008). For example, the Cognitive-interpersonal Maintenance Model of ED suggests that carers can experience emotional arousal as a result of their loved one's illness, which then can lead them to engage in behaviours that may inadvertently contribute to its maintenance (Goddard et al., 2011; Treasure et al., 2008). Similarly, the Emotion-focused Family Therapy model of ED posits that carers can experience emotional "blocks" when implementing the tasks of recovery (i.e., fears, anxiety, past emotional trauma)

which can interfere with their ability to be effective in their helping role (Lafrance Robinson et al., 2013).

Building on this literature, recent theoretical models have also emerged highlighting the importance of clinician emotion in the treatment of ED. Two theoretical models, the Iatrogenic Maintenance Model for ED (Treasure, Crane, McKnight, Buchanan, Wolfe, 2011) and the Therapist Drift Model (Waller, 2009), identify factors related to emotion that can negatively influence ED treatment practices. Just as carers' emotions are hypothesized to lead to unhelpful behaviours that have the potential to maintain ED symptoms, these models suggest that some emotionally-driven practices in clinicians may also unintentionally contribute to ED maintenance and hinder treatment progress.

Developed on the basis of anecdotal evidence and reports, the Iatrogenic Maintenance Model (Treasure et al., 2011) proposes that four clinician-factors; *emotional style*, *interpersonal factors*, *pro-eating disorder beliefs*, and *thinking styles*, can negatively affect ED treatment. In terms of emotional style specifically, it is proposed that clinician emotions, like anxiety, can foster unhelpful practices. For example, when faced with a client whose condition is declining, a clinician may feel anxious and be more inclined to avoid the discussion of difficult topics (i.e., food and weight) in an effort to neutralize their own anxiety as well as a possible negative reaction from the client.

Like Treasure and colleagues (2011), Waller (2009) suggests that clinicians can be led to engage in potentially unfavourable practices as a result of the emotions they experience in delivering treatment for ED. The Therapist Drift Model (Waller, 2009) introduces three clinician-factors that can actively interfere with clinical decisions and practices: *clinician emotion*, *clinician cognition*, and *clinician behaviour*. With respect to *clinician emotion*,

clinicians may engage in avoidant practices to reduce their experience of negative emotions like anxiety, fear, shame and guilt. Similarly, both positive and negative emotions can shape a clinician's judgement, as they can mislead and distract from important clinical information and cues.

To date, two studies have been conducted to empirically examine the role of clinicians' emotions during the treatment of ED. Waller, Stringer and Meyer (2012) explored the relationship between self-reported therapist anxiety and adherence to an empirically-supported treatment protocol for ED (i.e., Cognitive-behavioural Therapy). Results indicated that clinician anxiety was related to lower levels of adherence to treatment protocol, suggesting that clinicians "drift" away from empirically-supported practices when anxiety is high (Waller et al., 2012). A parallel investigation was conducted with clinicians who reported to use FBT in the treatment of child and adolescent eating disorders (Kosmerly, Waller, & Robinson, 2014). Of note, clinicians with greater levels of anxiety were less likely to weigh the client at the beginning of the session (Kosmerly et al., 2014).

Evidence for the influence of clinicians' emotions on ED treatment has also been reported qualitatively. Couturier et al.'s (2013) interviews with child and adolescent ED clinicians revealed that they can feel intimidated and anxious about certain therapeutic tasks (e.g., weighing the client and completing the family meal) related to the delivery of FBT (Lock, Le Grange, Agras, & Dare, 2001; Lock & Le Grange, 2013). It is possible that this anxiety in turn may interfere with their use of these therapeutic techniques.

The Present Research Study

As part of a larger investigation, the present study examined clinicians' perceptions of the negative influence of emotions on clinical decisions when working with child and adolescent

ED. More specifically, this study aimed to examine: 1) whether, and to what degree clinicians perceive emotions to negatively influence clinical decisions; and 2) which specific treatment decisions encountered when working with child and adolescent ED are perceived to be the most negatively influenced by clinician emotion. Furthermore, this study examined 3) whether differences emerged when clinicians reported on the perception of the negative influence of emotions on their own clinical decisions versus the occurrence of this phenomenon in their colleagues.

METHOD

Participants

Three hundred and five clinicians (280 women) who reported working with children and adolescents with ED participated in the study. Participants' years of experience working with child and adolescent ED ranged from less than one 1 year to 32 years, with an average of about 8 years of experience ($M = 8.44$, $SD = 6.90$). Seventy percent of participants ($n = 212$) reported using FBT as a model of treatment for children and adolescents with ED. Participants came from diverse professions, including social work ($n = 63$, 21.0%), psychology ($n = 62$, 20.7%), psychiatry ($n = 14$, 4.7%), medicine ($n = 25$, 8.3%), nursing ($n = 49$, 16.3%), dietetics ($n = 38$, 12.7%), occupational therapy ($n = 2$, 0.7%), and other therapy professions¹ ($n = 47$, 15.7%). Seventy-six percent ($n = 228$) of those surveyed reported working within an ED program for children/adolescents, and almost all participants ($n = 265$, 90.4%) reported working as part of a multidisciplinary team. The majority of clinicians ($n = 212$, 80.6%) reported engaging in informal and/or formal clinical supervision. Frequency ranged from daily to a few times per year, with weekly supervision being the most commonly endorsed item ($n = 108$, 41.1%).

¹ For example, participants who identified as being counsellors, family therapists, 'eating disorder clinicians', etc., were grouped together and labelled "other therapy professions".

ED clinicians were recruited through a database compiled by the authors, the Academy of Eating Disorders listserv, and through in-person recruitment at federal and provincial ED conferences in Canada. Participants were invited to complete an anonymous online survey.² Participants were excluded from the analyses if they were not directly involved in the treatment of child and adolescent ED (i.e., administration staff), or if they completed less than 20% of the survey.

Measurements

A survey was designed with the goal of examining whether and to what degree clinicians perceive emotions to have a negative influence on clinical decisions in working with child and adolescent ED. Questions were based on the theoretical models developed by Treasure and colleagues (2011) and Waller (2009), and were informed by practice guidelines for the treatment of child and adolescent ED. Anders' (2012) guidelines for the development of surveys was also consulted and the survey was reviewed by the resident expert in survey design at the researcher's institution. Two versions of the survey were created in order to explore differences in responding. In the first survey, clinicians reported on their perceptions of the negative influence of emotions on their *own* decisions when working with child and adolescent ED (the *Self* group). For the second version of the survey, clinicians reported on their perceptions of the negative influence of emotion on their *colleagues'* clinical decisions in the same context (the *Other* group). Participants were randomly assigned to either the *Self* ($n = 143$) or the *Other* ($n = 145$) condition according to their year of birth (odd vs even numbers).

² Given that all clinicians were also asked to forward the survey on to eligible colleagues, it was not possible to determine the completion rate; however the number of responses is comparable or exceeds those of similar studies (e.g., Kosmerly et al., 2014; Wallace & von Ranson, 2011; Waller et al., 2012).

After completing demographic information, a brief introduction to the study was presented. Clinicians were then asked, “Do you feel (your/your colleagues’) emotions negatively influence (your/their) clinical decision-making?” Only those participants who responded “Yes” ($n = 86$, 30.5%) to this question completed the remainder of the questions presented in the subsequent analyses. Of this subset of participants, those in the *Self* group ($n = 30$) indicated the percentage of the time their clinical decisions were negatively influenced by their emotions on an 11-point scale ranging from 1-10% to 100%. Participants in the *Other* group ($n = 56$) indicated the percentage of their colleagues who may be negatively influenced by emotions in making clinical decisions. Next, all remaining participants were asked to rate on a scale from 1 (not at all) to 10 (very much) the degree to which they (*Self*) or their colleagues (*Other*) were negatively influenced by emotion in regards to 16 treatment decisions commonly encountered in the treatment of child and adolescent ED (Table 1).

Statistical Analysis

Statistical analyses were performed using the SPSS 17.0 package. A statistical significance level of $p < 0.05$ was employed for all tests. Statistical tests met all assumptions. The demographic information was outlined using descriptive statistics. A Pearson chi-square test (χ^2) was used to compare conditions (*Self/Other*) regarding the perception of the negative influence of emotion on clinical decisions. Treatment decisions were ranked based on mean values and independent samples *t*-tests were used to compare group (*Self/Other*) ratings for the perception of negative emotional influence for each of the 16 treatment decisions.

RESULTS

Clinicians' perceptions of the negative influence of emotions on clinical decisions

Overall, 30.5% ($n = 86$) of participants endorsed a negative influence of emotions on clinical decisions, whether their own or those of colleagues. A Pearson chi square test revealed that clinicians in the *Other* group endorsed this item more frequently (40.0%) than those in the *Self* group (21.1%), $\chi^2(1) = 11.85, p = 0.001$. Only those participants who endorsed a negative influence of emotions were included in the subsequent analyses.

In order to assess for the perceived intensity of this phenomenon, clinicians in the *Self* group ($n = 30$) reported on the frequency with which they were negatively influenced by their own emotions in making clinical decisions. Nearly all participants (96.4%) reported being negatively influenced by their emotions between 1% and 30% of the time. The most frequently reported response was 11-20% (range 1-7, $M = 2.18, SD = 1.19$).

To assess clinicians' perceptions of the prevalence with which emotions negatively influence their colleagues' clinical decisions, the *Other* group ($n = 56$) reported on the proportion of their colleagues they perceived to be negatively influenced by emotions when making decisions. Results indicated a wide range of variability in responding (range 1-11, $M = 5.10, SD = 2.79$). The most frequently reported selection was 21-30% of colleagues.

The perceived negative influence of emotion on specific treatment decisions

Clinicians ($n = 86$) rated the degree of perceived negative influence of emotions associated with specific treatment decisions commonly encountered throughout the course of ED treatment when working with children, adolescents and families (e.g., the degree to which emotions are perceived to negatively influence decisions about whether or not to make individual therapy with the child the primary mode of treatment). The mean ratings are presented in Table 1

in rank order based on the mean ratings of the overall sample. *T*-tests were conducted to compare group (*Self/Other*) ratings. Although some differences were observed, the ratings between groups were similar for many of the decisions listed. The groups were in agreement when it came to the treatment decision they perceived to be the most negatively influenced by emotions: determining the degree of involvement of a critical or dismissive parent in treatment. Differences were noted between groups with regard to decisions perceived to be the second and third most likely to be negatively influenced by emotion. For the *Self* group, supporting the child/adolescent's travel plans and allowing for passes rounded the top three treatment decisions perceived to be the most likely to be negatively influenced by emotions. For the *Other* group, the treatment decisions perceived to be the most likely to be negatively influenced by emotions included determining the intensity of treatment required and discharging the client from treatment.

Table 1: Means, standard deviations, and *t*-tests for *Self* and *Other* ratings of the perception of negative emotional influence on decisions encountered in the treatment of child and adolescent ED

| Decisions | Total <i>n</i> = 86 <i>M</i> (<i>SD</i>) | Group | | <i>t</i> -test |
|---|--|---|--|---|
| | | Self <i>n</i> = 30 <i>M</i> (<i>SD</i>) | Other <i>n</i> = 56 <i>M</i> (<i>SD</i>) | |
| Determining the degree of involvement of critical/dismissive parents in treatment | 6.40 (2.57) | 6.08 (2.78) | 6.56 (2.47) | |
| Determining the intensity of treatment required (outpatient, inpatient, etc.) | 5.65 (2.53) | 4.40 (2.42) | 6.29 (2.36) | |
| Discharging the client from tertiary care | 5.59 (2.69) | 4.44 (2.48) | 6.10 (2.65) | * <i>t</i> (56) = 2.25, <i>p</i> = 0.029 |
| Allowing for passes | 5.40 (2.59) | 4.50 (3.09) | 5.71 (2.37) | |
| Deciding to make individual therapy with the child the primary mode of treatment | 5.32 (2.86) | 4.20 (2.66) | 5.90 (2.82) | * <i>t</i> (72) = 2.50, <i>p</i> = 0.015 |
| Supporting the child's travel plans (e.g., overseas) | 5.28 (2.63) | 4.59 (2.72) | 5.67 (2.53) | |
| Determining the degree of involvement of non-custodial/alienated parents in treatment | 5.22 (2.84) | 4.48 (2.92) | 5.62 (2.74) | |
| Determining the degree of involvement of separated parents in treatment | 4.96 (2.85) | 3.88 (2.70) | 5.55 (2.78) | * <i>t</i> (71) = 2.48, <i>p</i> = 0.016 |
| Determining an acceptable level of physical activity/sports activities | 4.67 (2.60) | 3.95 (2.59) | 5.00 (2.51) | |

| | | | | |
|---|-------------|-------------|-------------|-----------------------------------|
| Ordering tube feeding | 4.44 (3.12) | 3.00 (2.06) | 4.84 (3.26) | |
| Determining whether the ongoing weight will be shared/ not shared with the family | 4.37 (2.58) | 3.87 (2.38) | 4.60 (2.66) | |
| Reintroducing meat in a child's vegetarian diet | 4.36 (2.46) | 3.27 (2.45) | 4.85 (2.32) | * $t(68) = 2.60$, $p = 0.011$ |
| Introducing feared foods | 4.18 (2.39) | 3.08 (2.19) | 4.82 (2.28) | * $t(69) = 3.15$, $p = 0.002$ |
| Increasing calorie recommendations | 4.00 (2.20) | 3.39 (2.00) | 4.26 (2.26) | |
| Determining goal or target weights | 3.99 (2.59) | 2.95 (2.54) | 4.43 (2.51) | * $t(68) = 2.25$, $p = 0.028$ |
| Recommending a structured meal plan (as opposed to parental instructions) | 3.91 (2.43) | 3.41 (2.09) | 4.15 (2.56) | |

Note: Means and standard deviations were calculated based on Likert scale ratings from 1 (not at all) to 10 (very much). Figures presented in bold font represent the 3 highest ranked decisions for each group, respectively. Only significant t -tests ($p < 0.05$) are presented.

DISCUSSION

This study examined clinicians' perceptions of the negative influence of emotion on clinical decisions when working with child and adolescent ED. Overall, this phenomenon is perceived to affect some clinicians some of the time. The frequency with which the *Self* group reported to be negatively influenced by emotions (21%) is consistent with other research examining the influence of emotions (positive or negative) on treatment decisions related to chronic pain (19%; Brown, 2004). Brown's (2005) follow-up study revealed that clinicians were hesitant to endorse the importance of emotion when making treatment recommendations for reasons that included fear of being viewed as unprofessional. Contrasting Brown's (2005) findings with the discrepancy between *Self* and *Other* observed in the present study, it is possible that clinicians may be reluctant to endorse the occurrence of this phenomenon in themselves for similar reasons.

Results also provide preliminary support for the anecdotal evidence of the occurrence of this phenomenon on which Treasure and colleagues' (2011) Iatrogenic Maintenance Model was based. In light of the complexity of these illnesses and the high stakes of ED treatment, the fact that some clinicians perceive themselves/their colleagues to be vulnerable to negative emotional influence in their delivery of treatment is not surprising (Bellon & Fenandez-Asensio, 2002). In fact, the literature suggests that clinicians experience more negative emotional reactions when working with clients with ED than when working with other client groups (Brotman, Stern, & Herzog, 1984; Franko & Rolfe 1996; Thompson-Brenner et al., 2012). The present study suggests that some clinicians perceive these emotional reactions to negatively influence the treatment of children and adolescents with ED and therefore this topic is worthy of further investigation.

Clinicians were significantly more likely to endorse this phenomenon in their colleagues than they were to report being negatively influenced themselves. There are a number of possible explanations for this discrepancy. For example, one possibility is that the differences in reporting observed between groups may be reflective of the different ways in which each group is influenced by social desirability and other biases. For example, self-evaluations are said to be more vulnerable to the influence of social desirability (Vazire & Carlson, 2011), and tend to represent a more favourable image of the self (i.e., we view ourselves as being more competent and less vulnerable to biases) (Brosan, Reynolds, & Moore, 2008; Pronin, 2008; Pronin et al., 2002; Walfish, McAlister, O'Donnell, & Lambert, 2012). Therefore the *Self* group reports may represent an underestimation of what actually occurs in clinical practice. Conversely, the evaluations of others are less likely to be influenced by social desirability and are based on limited information (i.e., that which is observable), including biased perceptions of others such as stereotypes and heuristics (Paunonen & O'Neill, 2010) and therefore may represent an overestimation of the occurrence of negative emotional influence (e.g., Yeager & Krosnick, 2011). Although the nature of the data prevents us from drawing firm conclusions regarding the discrepancies between groups, researchers have suggested that considering both sources of information together (*Self* and *Other* evaluations) can be valuable in helping understand study findings, in this case in improving our understanding of the negative influence of emotions on clinical decisions (e.g., Atwater, Ostroff, Yammarino, & Fleenor, 1998; Vazire & Carlson, 2011). The results from both groups (*Self* and *Other*) allow us to assume with some degree of confidence that some clinicians in the field of child and adolescent ED perceive there to be at least some degree of negative influence of emotions on clinical decisions.

Despite some differences between groups with regards to the extent to which emotions were perceived to negatively influence specific treatment decisions, both groups (*Self* and *Other*) agreed on the decision perceived to be the most likely to be negatively affected by clinician emotion: determining the degree of involvement of a critical or dismissive parent in treatment. At this time, very little is known about the factors that can affect a clinician's decision to involve a parent in ED treatment. It is possible that well-intentioned clinicians are sometimes cautious regarding the intensity or type of involvement of a critical or dismissive parent for fear that the parent's style may exacerbate the child's symptoms and hinder treatment. It is also possible that clinicians are hesitant about engaging that parent in treatment in order to shield themselves from witnessing the parental criticism. In either case, when parents present as critical or dismissive, this style is highly suggestive of a clinical marker of underlying fears, shame or helplessness, indicating a need for the clinician to attend to the parent's emotional experience in order to support its resolution (Lafrance Robinson et al., 2013). Given the importance of parental involvement in the treatment of children and adolescents with ED (APA, 2013; Le Grange, Lock, Loeb, & Nicholls, 2009; National Collaborating Centre for Mental Health, 2004) and the fact that therapy-interfering behaviours can be conceptualized as "emotional blocks" in the parent needing to be processed (Lafrance Robinson et al., 2013), it may be useful for the field of child and adolescent ED treatment to start to discuss the issue of working with critical and dismissive parents, which may then serve to better prepare clinicians for these emotionally charged parent processes. It will also be important to continue to research this phenomenon in order to better support clinicians to make family-based treatment decisions that are not influenced by their own emotional reaction to family members or situations.

Other specific treatment decisions were identified as more vulnerable to negative emotional influence. Decisions related to the child's autonomy (i.e., supporting the child's travel plans and allowing for passes) were among the treatment decisions perceived by the *Self* group to be the most likely to be negatively influenced by emotion, whereas decisions about the intensity of treatment required and discharge from tertiary care were among the treatment decisions the *Other* group perceived to be the most likely to be negatively influenced by emotion. Following Treasure et al. (2011) and Pemberton and Fox (2011), it is conceivable that decisions of this nature may be impacted by clinician feelings of frustration, helplessness, and anxiety; emotions often reported to be experienced by clinicians when working with ED clients (Franko & Rolfe, 1996; Thompson-Brenner et al., 2012). In fact, Brotman et al. (1984) discuss cases in which clinician anger, helplessness, and anxiety contribute to the decisions about treatment intensity and client discharge. Although practice guidelines exist for some of these decisions (e.g., those for hospitalization in Lock & Le Grange, 2013), results from the current study suggest that decision-making guidelines and other clinician supports may be helpful to explore in order to reduce the possible negative influence of clinician emotion in these situations.

The present study is not without limitations. Patterns of participation associated with the recruitment methods employed have the potential to bias the results. For example, it is possible that clinicians who participated in the survey had more of an interest in this topic than those who chose not to participate. Although the findings are interesting and worthy of follow-up, the conclusions that can be drawn from this study are limited by the nature of the instrument (self-report) as well as the differences that emerged between groups (*Self* vs *Other*). Additionally, it is possible that variables not examined in the present study may affect clinician emotion and its possible influence on treatment delivery. For example, follow-up studies could examine the

impact of clinician-factors that may contribute to the frequency of this phenomenon, such as a history of personal psychotherapy, specialized training, supervision type, level of burnout and team factors that could play a role, such as the culture around emotional expression and self-care. Furthermore, experimental investigations, including the testing of clinician responses to case vignettes using facial affect coding and physiological responses are recommended in order to better understand these processes. Finally, it will be important to determine the impact of emotion-based decisions on treatment outcomes with child and adolescent ED populations.

Overall, our findings suggest that some clinicians believe that emotions can negatively affect the treatment of ED, and in particular when making decisions regarding the involvement of a critical or dismissive parent in treatment. Although our understanding of the ways in which emotions negatively influence clinical decisions in a day-to-day clinical setting is limited by the discrepancy between groups (*Self vs Other*), the results suggest that ongoing research in this area is warranted. It will be important to examine the factors which influence this phenomenon, including clinician variables (i.e., level of experience, emotional drain, etc.) and team variables (i.e., specialized program, culture of acceptance around emotions, etc.). In addition, given that most clinicians surveyed were already working within specialized programs and engaging in regular supervision, it will be necessary to examine the ways in which team dynamics and supervision can better protect clinicians from the negative influence of emotions on clinical decisions. For example, the potential benefit of supervision and team consultation may be curtailed when supervisors and teams are non-acceptant of clinicians' disclosures of emotions (Figuroa & Dalack, 2013; Jacobs & Nye, 2010). As such, it will be important to ensure that teams foster an emotion-focused milieu where clinicians can process their emotions without fear of judgement. It may also be worthwhile to augment clinicians' training with specific skills and

strategies to identify and address this phenomenon when it arises in themselves, in their colleagues and perhaps even in the parents with whom they work. Given that ED are treatment-resistant (Berkman, Lohr, & Bulik, 2007; Fassino & Abbate-Daga, 2013) and can lead to irreversible medical complications (Golden, et al., 2003), any and all possible factors that have the potential to affect treatment outcomes, including clinician emotions, must be explored.

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CHAPTER THREE

Clinicians' Emotions and their Perceived Influence on Clinical Decisions and Practices in the Treatment of Child and Adolescent Eating Disorders

Stacey Kosmerly

Department of Psychology, Laurentian University, Canada

ABSTRACT

The current study sought to further our understanding of clinicians' emotions and the ways in which they are perceived to negatively influence clinical decisions and practices in the context of child and adolescent eating disorder treatment. One hundred and forty clinicians participated in an online survey that assessed client/parent emotional states and clinician concerns perceived to negatively influence clinical decisions, as well as practices utilized in response to emotions. Clinician characteristics (e.g., level of experience, level of emotional drain, frequency of supervision received, whether one works as part of a multidisciplinary team) were also explored as predictors of negative emotional influence on clinical practices. With respect to client emotional states, clinicians perceived client and parent anger, flat affect and hopelessness/helplessness to be the most likely to negatively influence decisions. In response to emotions (their own or those of others), clinicians most frequently reported focusing on another, less emotionally arousing topic, overemphasizing minor improvements in the client, and rationalizing, negotiating, and/or bartering with the client. In terms of concerns perceived to negatively influence clinical decisions, clinicians most frequently reported concerns related to alienating the client in some way (i.e., arousing a hostile or negative emotional reaction, causing the family to disengage from treatment) and feelings of incompetence. Of the clinician characteristics examined, emotional drain and work setting were predictive of the perception of the negative influence of emotions on clinical decisions and practices. Findings shed light on the ways in which clinicians perceive emotions to negatively affect clinical decisions and practices. Implications for clinical practice and future research are discussed.

Keywords: Eating Disorders; Clinician Emotion; Clinician Factors

Clinicians' Emotions and their Perceived Influence on Clinical Decisions and Practices in the Treatment of Child and Adolescent Eating Disorders

Eating disorders (ED) are serious and life-threatening illnesses that frequently occur in childhood and adolescence (Rosen & The Committee on Adolescence, 2010). In fact, they are ranked as the third most common chronic illness among adolescent females (Fisher et al., 1995) and have the highest mortality rate of all the psychiatric disorders (Reijonen, Pratt, Patel, & Greydanus, 2003). The risk of ED becoming chronic (Von Holle et al., 2008) and leading to irreversible medical complications increases with time (Golden et al., 2003; Katzman & Findlay, 2011), making it essential to intervene early and effectively. Family-based Therapy (FBT) is an intervention that is used to treat child and adolescent ED, which has been shown to be effective in reducing ED symptoms (Chen et al., 2010; Le Grange, Binford, & Loeb, 2005; Le Grange, Crosby, Rathouz, & Leventhal, 2007; Lock et al., 2010; Lock, Le Grange, Forsberg, & Hewell, 2006). However, although many families recover with FBT, a significant proportion continues to struggle with ED symptoms (Herzog et al., 1999). It is therefore important to explore factors that may increase the rate of positive outcomes.

There have been reports dating back as far as three decades suggesting that clinicians' emotions can influence the treatment of ED (Brotman, Stern, & Herzog, 1984; Garner, 1985). There is also a substantial body of research that suggests that working with clients with ED can be an emotionally-charged experience (Brotman et al., 1984; Franko & Rolfe, 1996; Golan, Yaroslavski, & Stein, 2009; Thompson-Brenner, Satir, Franko, & Herzog, 2012). Specifically, clinicians have been found to experience more negative affect, frustration, hopelessness, and helplessness when working with clients with an ED than when working with other client groups (Brotman et al., 1984; Franko & Rolfe, 1996). ED clinicians have also been found to be

particularly vulnerable to burnout (Warren, Schafer, Crowley, & Olivardia, 2013), suggesting that working with this population can be emotionally draining and can negatively affect clinicians' well-being.

Two theoretical models have emerged that point to clinician factors related to emotion that may interfere with the treatment of ED. More specifically, the Iatrogenic Maintenance Model for ED (Treasure, Crane, McKnight, Buchanan, & Wolfe, 2011) and the Therapist Drift Model (Waller, 2009) suggest that clinicians may experience anxiety and other emotions during the treatment of ED, which can lead to unhelpful practices. For example, clinicians may experience anxiety about their client's physical or emotional well-being or shame about their own clinical performance, which can then negatively affect treatment delivery (Waller, 2009). Clinicians may also experience anxiety about creating a negative emotional reaction in their client (i.e., distress, anger, etc.), which can also lead to avoidant clinical procedures (Treasure et al., 2011; Waller, 2009).

Despite the emotional nature of the clinical work, to our knowledge only two studies have examined clinician emotion and its relation to treatment delivery, both of which have focused on clinician anxiety. For example, clinician anxiety has been found to be related to lower levels of adherence to evidence-based practices in the treatment of ED (Kosmerly, Waller, & Lafrance Robinson, 2014; Waller, Stringer, & Meyer, 2012). Specifically, clinicians who report greater levels of anxiety have been found to be less likely to adhere to manual-recommended practices in the delivery of Cognitive-behavioural Therapy for ED (Waller et al., 2012) and to be less likely to weigh the client at the beginning of every session in the delivery of FBT (Kosmerly et al., 2014).

Predictors of Negative Emotional Influence

Identifying clinician characteristics that may be related to the perception of the negative influence of emotion on treatment decisions and practices will be important in order to better understand this phenomenon. Evidence from studies related to similar concepts (i.e., burnout and clinicians' emotional reactions) suggests clinician characteristics worthy of exploration. These attributes include level of clinical experience, level of emotional drain, and frequency of supervision received. For example, more novice ED clinicians have been found to be more vulnerable to burnout/emotional drain (Warren, Schafer, Crowley, & Olivardia, 2012) and to experiencing negative reactions towards their clients (Franko & Rolfe, 1996; Thompson-Brenner et al., 2012). In terms of emotional drain, McCarthy and colleagues (1999) found that clinicians who were perceived to experience a higher degree of burnout were also perceived to have delivered less adequate care, suggesting that level of emotional drain may influence treatment delivery. Conversely, a factor that may protect against suboptimal care is the frequency with which clinicians engage in clinical supervision. It has been noted that engaging in clinical supervision can reduce clinicians' experiences of burnout/emotional drain (Warren et al., 2012; Warren, Crowley, Olivardia, & Schoen, 2009) as well as the frequency with which clinicians experience negative emotions towards their ED clients (Franko & Rolfe, 1996). Additionally, given the complexity of ED in children and adolescents, best practice involves a multidisciplinary approach (Lock & Le Grange, 2013; Rome et al, 2003). Working within a multidisciplinary team is suggested as another clinician characteristic to consider given the increased availability of peer support and ED expertise in these settings (Mental Health Commission, 2006).

The Present Research Study

Understanding clinicians' perceptions of the influence of emotion on the treatment of ED may lead to improvements in treatment delivery, which in turn can positively influence treatment outcomes. In light of this possibility, and in the context of child and adolescent treatment for ED, the present study was designed to:

1. determine which emotions displayed by clients are perceived to be the most likely to influence clinician decisions;
2. investigate practices reported to be used in response to emotions (clinicians' own or those of others);
3. identify clinician concerns that may negatively impact clinical decisions and,
4. identify clinician characteristics (e.g., experience, level of emotional drain, supervision, working as part of a multidisciplinary team) that may predict the negative influence of emotion on clinical decisions and practice.

METHOD

Participants

One hundred and forty clinicians (131 women) who reported working with children and adolescents with ED participated in the present study³. Participants' years of experience working with child and adolescent ED ranged from less than 1 year to 32 years, with an average of about 9 years of experience ($M = 9.28$, $SD = 7.52$). Sixty-five percent of participants ($n = 95$) reported that FBT was one of their primary models of treatment for children and adolescents with ED. Participants came from diverse professions, including social work ($n = 36$, 25.2%), psychology ($n = 28$, 19.6%), psychiatry ($n = 5$, 3.6%), medicine ($n = 15$, 10.5%), nursing ($n = 20$, 14.0%),

³ Only participants for the *Self* group ($n = 140$; see Chapter 2) were included in the analyses for this chapter.

dietetics ($n = 16$, 11.2%), occupational therapy ($n = 2$, 1.4%), and other therapy professions⁴ ($n = 18$, 12.6%). Seventy-two percent ($n = 103$) of those surveyed reported working within an ED program for children and adolescents, and the vast majority of participants ($n = 127$, 88.8%) reported working as part of a multidisciplinary team. Participants were excluded from the analyses if they were not directly involved in the treatment of child and adolescent ED (i.e., administration staff), or if they completed less than 20% of the survey.

Measurements

A survey was created to examine clinicians' perceptions of the negative influence of emotions on their clinical decisions and practices when working with child and adolescent ED. Additional details regarding the survey and recruitment are described in Chapter 2. Demographic information was collected, including questions about clinical experience, level of perceived emotional drain, frequency of clinical supervision, and work setting (multidisciplinary team). Clinicians then indicated whether and to what degree the expression of emotion by others (e.g., children/adolescents, parent, colleagues, etc.) has a negative influence on their own clinical decisions. Those who endorsed some degree of negative influence subsequently ranked the top three client and parent emotional states perceived to be the most likely to negatively influence their decisions. With respect to practices, clinicians selected from a list the practices they may utilize in response to emotion (their own or to those of others). Finally, clinicians were invited to select from a list of concerns those that they felt have a negative influence on their clinical decisions when working with child and adolescent ED.

Statistical Analyses

⁴ For example, participants who identified as being counsellors, family therapists, 'eating disorder clinicians', etc.

Statistical tests met all relevant assumptions. The demographic information was examined using descriptive statistics. Clinicians ranked the client and parent emotional states they perceived to be the most likely to negatively influence clinical decisions, response choices were summed, and the three most frequently reported emotional states were presented. Frequency statistics were used to describe practices driven by emotion as well as clinician concerns. The total number of concerns perceived to have a negative influence on clinical decisions and the total number of emotion-driven practices were summed to create a measure of negative emotional influence. A standard multiple regression analysis was conducted to determine whether clinician characteristics (e.g., years of experience, level of emotional drain, frequency of supervision, and whether one worked as part of a multidisciplinary team) could predict this measure of negative emotional influence.

RESULTS

Expressions of emotions by others which may negatively influence clinical decisions

Twenty-eight percent of participants ($n = 39$) felt that in general, expressions of emotion by others (children, adolescents, parents, other colleagues, etc.) negatively influence their clinical decisions. This subset of participants ($n = 39$) subsequently rated the extent to which they perceive the emotions of others to negatively influence their clinical decisions on a scale from 1 (not at all) to 10 (very much). The most frequently reported rating was 6 ($M = 4.67$, $SD = 1.77$). These participants also ranked the emotions in child/adolescent clients and in parents that, when expressed, would most likely negatively affect their clinical decisions. Anger was the emotion ranked the most likely to negatively influence clinical decisions, followed by flat affect and hopelessness/helplessness.

Practices performed in response to emotion

Table 1 presents the frequency with which each emotion-driven practice was endorsed by all clinicians surveyed ($n = 140$). Results suggest that in response to emotions (their own or those of others), clinicians are most likely to focus on another, less emotionally arousing topic with the client (35.9%, $n = 46$); overemphasize minor improvements in the client (31.5%, $n = 52$); and rationalize (29.5%, $n = 43$), negotiate and/or barter with the client (29.5%, $n = 43$).

Table 1: Frequency of emotion-driven practices ($n = 140$)

| In response to your own emotions or to those of others, do you believe you engage in any of the following behaviours? | % | n |
|---|-------|-----|
| Focusing on another, less emotionally arousing topic with the client/parents | 35.9% | 52 |
| Overemphasizing minor improvements in the client/parents | 31.5% | 46 |
| Rationalizing with client/parents to another clinician | 29.5% | 43 |
| Bartering/negotiating with client/parents | 29.5% | 43 |
| Adhering rigidly to a treatment protocol | 15.8% | 23 |
| Discounting options that may cause strong emotional reactions in client/parents | 13.0% | 19 |
| Referring child/parent to another clinician | 6.2% | 9 |
| Avoiding case discussion in supervision | 4.8% | 7 |
| Discharging the client/parents from care | 4.1% | 6 |

Clinician Concerns

Table 2 presents the frequency with which clinicians ($n = 140$) endorsed concerns that they perceived to negatively influence clinical decisions. The most frequently endorsed items included: arousing a hostile or negative reaction in a child/adolescent client or their family (46.6%, $n = 68$), followed by concerns about causing the family to disengage from treatment (36.3%, $n = 53$), and not having the right skills to help the family (35.6%, $n = 52$).

Table 2: Frequency of clinician concerns perceived to negatively influence clinical decisions ($n = 140$)

| Which of the following concerns do you believe have a negative influence on your clinical decision-making? | % | n |
|--|-------|-----|
| Arousing hostile reactions from the client/family | 46.6% | 68 |
| Causing the client/family to disengage from treatment | 36.3% | 53 |
| Not having the right skills to help the client/family | 35.6% | 52 |
| Being disliked by parents/family/client | 34.2% | 50 |
| Being blamed or being to blame for lack of treatment progress | 33.6% | 49 |
| Making decisions and/or recommendations that are unpopular with, or contrary to other team members | 30.1% | 44 |
| Causing excessive suffering to client/parent/family | 25.3% | 37 |
| Creating a negative impact on the client's life (i.e., missing out on sports, etc.) | 24.0% | 35 |
| Causing client to self-harm/commit suicide | 23.3% | 34 |
| Infringing on the client's autonomy | 21.2% | 31 |
| Creating an unfavorable impression on other colleagues | 19.2% | 28 |
| Putting too much strain on child-parent relationship | 17.8% | 26 |
| Creating an emotion in a client/parent and not knowing how to process it | 17.1% | 25 |

Predictors of the perception of negative emotional influence

A multiple regression analysis was conducted on the entire sample in order to determine whether the following clinician characteristics could predict the measure of negative emotional influence (described above): years of experience working with child and adolescent ED, level of perceived emotional drain (0 = not at all emotionally drained to 10 = very much emotionally drained), frequency of supervision (daily, weekly, bi-weekly, monthly, less than once a month), and work setting (whether or not one works as part of a multidisciplinary team). A significant model was observed, $F = 4.65$, $p = .002$. $R^2 = .13$ with level of emotional drain and working as

part of a multidisciplinary team representing significant contributions to the model (Table 3). This means that when considered among the other clinician characteristics examined, a high level of emotional drain and working with a multidisciplinary team are predictors of greater perceived negative emotional influence.

Table 3: Summary of multiple regression analysis to predict the perception of negative emotional influence from clinician characteristics

| Variable | β | SE(B) | <i>t</i> | Sig |
|-----------------------------------|---------------------------|--------------|-----------------|------------|
| Years of experience | -.09 | .05 | -.98 | .331 |
| Level of emotional drain | .22 | .13 | 2.51 | .013* |
| Frequency of supervision received | .14 | .20 | 1.64 | .104 |
| Multidisciplinary team | .17 | 1.24 | 1.99 | .048* |

* $p < 0.05$

DISCUSSION

This study revealed a number of important findings that may allow for a better understanding of the ways in which clinical decisions and practices are perceived to be influenced by emotion in the context of child and adolescent ED treatment. Taken together, the results suggest that there are specific emotions and emotional states that are perceived to be the most likely to negatively influence clinical decisions when displayed by clients and parents. Anger was a strong trigger, followed by flat affect and the expression of hopelessness and helplessness. It is interesting to note the parallels between these emotions and those commonly reported to be experienced by clinicians when working with individuals with ED (Franko & Rolfe, 1996; Thompson-Brenner et al., 2012). Specifically, Franko and Rolfe (1996) found that clinicians frequently reported feelings of anger, hopelessness and helplessness when working with clients with anorexia nervosa. It seems that client emotions that are perceived to be the most difficult to work with are also those with which clinicians struggle personally.

With regards to practices, those most frequently reported (e.g., changing the topic, overemphasizing minor improvements, bartering, etc.) could be related to attempts to neutralize the negative emotion in the client as well as the associated clinician anxiety. These results are consistent with the models developed by Treasure and colleagues (2011) and Waller (2009), whereby clinicians are thought to be liable to anxiety related to client hostility and strong emotions which can lead to practices motivated to avoid or neutralize these reactions. A similar process has been noted in therapists delivering exposure and response prevention for individuals with obsessive-compulsive disorder (OCD). For example, Gillhan and colleagues (2012) discuss how clinicians can struggle to push clients to perform difficult exposure tasks and can be apt to change, postpone, or boycott an exposure procedure in the face of client discomfort. Just as failure to complete exposures can be related to lack of progress in clients with OCD, failure to make appropriate treatment decisions related to food and weight can impede recovery from an ED. In fact, Hildebrandt and colleagues (2012) have argued that exposure and subsequent habituation to fears around food and weight may be a mechanism of change underlying FBT for ED, thus lending support to the notion that treatment can be negatively affected when emotions lead to the avoidance or omission of therapeutic tasks.

A number of concerns felt to drive clinical decisions were endorsed in the context of this survey, mostly related to alienating the client in some way (i.e., causing a hostile or negative reaction, causing them to disengage from treatment). Clinician insecurities related to their skills also ranked highly as a concern thought to drive emotional decisions. In order to better understand this finding, a point-biserial correlation analysis⁵ was conducted examining the relationship between clinicians' years of clinical experience and their endorsement of this

⁵ $r_{pb} = -0.17, p < 0.05$.

concern. The analysis revealed that less experienced clinicians were significantly more likely to endorse concern about level of skill, suggesting that perhaps newer clinicians may require more training in order to improve their actual skill and in turn their sense of competency around the delivery of treatment. However, it is also possible that more novice clinicians experience more anxiety relative to the delivery of treatment of ED than do more senior clinicians (e.g., Turner, Tatham, Lant, Mountford, & Waller, 2014) and that concerns of this nature are perhaps also reflective of clinician anxiety (Thériault, Gazzola, & Richardson, 2007). As such, it could be argued that more is needed to increase both clinicians' actual skill levels and their feelings of competence in order to reduce the possible effects that lack of skill and feelings of incompetency may have on treatment delivery and clinician well-being (Thériault et al., 2007).

Finally, although a number of clinician characteristics may be associated with these phenomena, according to clinician perceptions our findings suggest that higher levels of emotional drain and working with a multidisciplinary team may increase the risk of negative emotional influence when working with child and adolescent ED. In terms of emotional drain, this pattern of results is consistent with other studies. Specifically, emotional drain has been associated with clinicians' experiences of more emotional reactions towards clients (Thompson-Brenner, 2012; Franko & Rolfe, 1996). It must be noted, however, that high levels of emotional drain may also have influenced clinicians' response patterns. For example, being more emotionally drained may have led clinicians to be more apt to report a negative emotional influence on decisions, which may need to be taken into consideration when interpreting results. Interestingly, working as part of a multidisciplinary team also emerged as a predictor of greater perceived negative emotional influence despite reports which attest to the benefits of this type of work setting (Mental Health Commission, 2006). Little is known about the potential weaknesses

of a multidisciplinary team approach to mental health treatment for children and families (Lalayants & Epstein, 2005), although some studies have reported that issues related to interpersonal dynamics (i.e., poor communication between team members, an increased sense of “scrutiny” from other team members) may negatively influence team functioning (Doyle et al., 2008; Kolbo & Strong, 1997). In a recent study of FBT for child and adolescent ED, Murray and colleagues (2014) observed a relationship between the quality of inter-colleague relationships and client outcomes. It seems that team dynamics may in fact play an important role in the delivery of treatment for children and adolescents with ED, and findings from the present study suggest that further research is warranted in order to identify specific team dynamics that may foster emotional decision-making and practices.

Despite these clinically relevant findings, we can only theorize regarding the processes that are placing clinicians at risk of anticipating, preventing and reacting to emotions in their clients in a way that may interfere with treatment delivery. A number of explanations are possible. For example, in terms of concerns regarding arousing a hostile or negative reaction, it is possible that clinicians take personal offense to client/parent reactions (Alves & Vandenberghe, 2012) or perceive them to be a “challenge to control” (Pemberton & Fox, 2013, p. 6), which can foster reactive or punitive practices (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010). Another possibility is that clinicians (like carers) fear that negative reactions will increase resistance in the client (i.e., refusal to eat), evoke new symptoms (i.e., self-harming behaviours), or worse yet, push the client “over the edge” (i.e., suicide) (Treasure et al., 2008). It may also be that these client reactions are difficult for clinicians because they activate a clinician’s own emotional vulnerabilities (Hayes, 2004), including a sense of failure or incompetence (Waller, 2009).

In terms of implications, it is clear that clinicians are in need of specialized training to attend to and help process various emotions and emotional states in their clients in order to reduce reactive practices in the context of clinical care. Each clinician may be triggered by emotions and client/parent emotional states for reasons that are unique to themselves (Hayes, 2004; Tishby & Vered, 2011), which highlights the need for clinicians to reflect on their sensitivities and vulnerabilities so as to identify personally meaningful way to cope with areas of clinical practice that are more challenging personally (Alves & Vandenberghe, 2012; Corey & Corey, 2011). It will also be important for the field to create a space for clinicians to feel safe to reflect on and discuss the nature of their emotional reactions in order to help process and manage them in such a way that they do not affect treatment delivery. Brown (2004; 2005) found that clinicians that work with individuals with chronic pain are reluctant to discuss the importance to emotions when making treatment recommendations and it is possible that this may also be true in the field of child and adolescent ED. Furthermore, it may be that clinicians need to be provided with specific skills to manage immediate client distress in order to reduce their anxieties around this aspect of the therapeutic process (Waller, 2014).

Finally, the implementation of prevention and intervention programs for emotional exhaustion in ED clinicians has been suggested by other authors (Warren et al., 2013; 2012), and our results certainly support the potential benefit of such a program in reducing the negative influence of emotions on clinical practice. Furthermore, receiving clinical supervision, which has been reported as a protective factor against other therapy-interfering clinician variables (i.e., burnout; Warren et al., 2013; 2012; 2009), did not emerge as a significant predictor of negative emotional influence. Therefore future research should also examine whether emotional drain

mediates the effectiveness of supervision in protecting clinicians against the negative influence of emotion in order to guide the development of more effective clinician supports.

It is important to note the limitations of the present study. Patterns of participation associated with the recruitment methods employed have the potential to bias the results. That is to say that perhaps, for example, clinicians who chose to participate in the survey had more of an interest in this topic than those who opted not to participate. Also, although findings are interesting and shed light onto a largely understudied phenomenon, the self-report nature of the instrument limits the conclusions that can be drawn. Future research should utilize quasi-experimental and experimental methods in order to corroborate findings and further our understanding of this phenomenon. For example, studies of clinician emotional responses to case vignettes as measured by facial affect coding or other physiological responses may be beneficial. Additionally, utilizing in-session measures of clinician emotion may allow for a better understanding of the relationship between clinician emotion and treatment delivery. Furthermore, the clinician characteristics examined in the present study explain a relatively small proportion of variance in negative emotional influence, implying that other characteristics must be explored. For example, history of personal psychotherapy, degree of specialized training, type of supervision received, and interpersonal dynamics of the multidisciplinary team (e.g., culture around emotions and self-care) could be considered in future studies. Finally, it will be important to objectively determine how emotion-based decisions and practices influence treatment outcomes in child and adolescent ED populations.

Overall, the present study provides preliminary support for Treasure and colleagues' (2011) and Waller's (2009) theoretical models related to the role of clinician emotion in the delivery of treatment for ED. Specifically, findings suggest that clinicians, like carers (Treasure

et al., 2008; Whitney & Eisler, 2005) may be negatively influenced by emotions when delivering treatment for children and adolescent with ED. This new line of research holds promise for the discovery of unique ways to improve both clinician and client well-being via the delivery of treatment.

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CHAPTER FOUR
DISCUSSION

Stacey Kosmerly, M.A. Candidate.

Department of Psychology, Laurentian University, Canada

Chapter Four: Discussion

The present thesis examined clinicians' perceptions of the negative influence of emotions on clinical decisions and practices in the context of child and adolescent eating disorder (ED) treatment. Two studies were conducted in which clinicians reported on whether, and in what ways they perceived this phenomenon to occur. This study also examined for possible differences in clinicians' perceptions when reporting on themselves (*Self*) versus when reporting on their colleagues (*Other*). Furthermore, predictors of negative emotional influence were identified. This final chapter highlights the overall findings of these studies, in addition to their clinical implications, limitations and future directions.

Major findings

The Iatrogenic Maintenance Model of ED (Treasure, Crane, McKnight, Buchanan & Wolfe, 2011) and the Therapist Drift Model (Waller, 2009) both suggest that clinicians' emotions, among other clinician factors, have the potential to negatively influence treatment delivery when working with individuals with ED. Specifically, with respect to clinician emotions, these theories posit that clinicians may experience anxiety and other emotions during the delivery of treatment, which can lead them to engage in certain practices in order to reduce or avoid these negative emotions (Treasure et al., 2011; Waller, 2009). The results from the current study lend support to these theories in that some child and adolescent ED clinicians perceived emotions to have at least some degree of negative influence on clinical decisions and practices, although differences between groups (*Self/Other*) were noted. Specifically, findings suggest that clinicians may be more prone to negative emotional influence when it comes to decisions related to the involvement of critical or dismissive parents in treatment and when clients or parents present as angry, flat (emotionless), hopeless or helpless. In response to emotion (their own or

those of clients/parents/colleagues), results suggest that clinicians are aware (at least to some degree) of their tendencies to engage in potentially unhelpful practices. Furthermore, clinicians reported on a number of anxieties having the potential to drive emotion-based decisions. Finally, with respect to clinician characteristics, it seems that emotional drain and working within a multidisciplinary team seemed to increase the perception of negative influence of emotions on therapeutic practice.

General Discussion

In addition to Treasure et al.'s (2011) and Waller's (2009) theories, the general medical literature suggests that the delivery of care is vulnerable to being influenced by a clinician's emotions (Croskerry, 2002; Kimerling, Zeiss, & Zeiss, 2000; Zinn, 1988). This is said to be particularly true of clinicians working with individuals with chronic and life-threatening illnesses due to the increased level of stress and uncertainty associated with these types of illness (Bellon & Fernandez-Asensio, 2002). Therefore, it is perhaps surprising that only 30.5% of the overall current sample endorsed some degree of negative influence of emotion, especially given the nature of ED in children and adolescents. Differences in reporting between *Self* and *Other* conditions provide some insight into possible reasons for such low endorsement.

It is worth drawing connections between the differences noted between the *Self* and *Other* conditions in the present study to the studies conducted by Brown (2004; 2005) with clinicians who work with individuals who experience chronic pain. Specifically, Brown (2004) conducted a survey assessing the factors clinicians perceived to be important to consider when making treatment recommendations. Results revealed that approximately twenty percent of surveyed clinicians reported that emotions were an important factor to consider. Brown (2005) conducted an open-ended follow-up survey inquiring into clinicians' reasoning for not previously endorsing

emotion as an important factor to consider. Findings demonstrated that clinicians were reluctant to state the importance of emotions, often for belief that emotions were unprofessional (Brown, 2005). In fact, one clinician reported “perhaps we feel too macho to admit [emotion] could influence us” (Brown, 2005, p. 222). Although it is difficult to draw comparisons between these studies and the present thesis, the 21% of clinicians in the *Self* group who self-reported being negatively influenced by emotions is comparable to Brown’s findings (2004). Furthermore, it is worth noting the differences between the *Self* and *Other* condition in the present study and the reluctance to endorse the importance of emotion in one’s treatment recommendations noted in Brown’s (2005) study. Perhaps clinicians are more apt to see emotional influence on clinical work in their colleagues than they are to see it in themselves because they do not want to perceive themselves as acting “unprofessionally”.

The discrepancy between groups observed in the present study may also be reflective of clinicians’ level of self-awareness. For example, countertransference, a term commonly used in the psychoanalytic literature to describe a clinician’s experience of emotions towards their clients, is defined in part by a lack of conscious awareness about said emotions (Najavits, 2000). It is possible that participants from the present study are often unaware of their emotions and how these may play a role the way they deliver treatment, and are more apt to recognize these processes when they are occurring in their colleagues. One of the defining features of a “master therapist” is the ability to recognize one’s own emotions and how they affect one’s clinical work (Jennings & Skovholt, 1999) and it has been suggested that increasing clinicians’ awareness of these processes is important in terms of improving practice (Borrell-Carrio & Epstein, 2004; Gelso, 2002; Kaplan & Garfinkel, 1999; Najavits, 2000; Schlesinger, 2002). Results of the present study would suggest that clinicians may profit from increased training in specific skills

and strategies to identify and address strong emotions when they arise in themselves, their colleagues, and perhaps even in the parents with whom they work in order to reduce their possible negative effects on treatment delivery.

Implications

Findings from the present study allow for the understanding of how clinicians in the field of ED perceive emotions to negatively affect treatment and may be helpful in guiding the development of specific and targeted training and support programs for clinicians. Based on results related to specific clinical decisions and client expressions of emotion, it is recommended that clinicians receive more specialized training and supervision around working with families, particularly when parents present as critical and dismissive, and around attending to and helping process various client emotions (especially anger, flat affect, and hopelessness or helplessness) in order to reduce reactive practices in the context of clinical care. It may also be valuable for the field of child and adolescent ED to develop decision-making guidelines that clinicians and treatment teams could utilize as a reference for making the most evidence-informed choices possible in complex and emotionally charged situations, like those identified in the current study. Furthermore, clinicians should be encouraged to reflect on and seek additional training, experience, and supports around particular client emotions and family dynamic which they experience as personally difficult (Corey & Corey, 2011).

Aside from specific and tailored supports for clinicians around areas of practice identified to be difficult, it is perhaps also worth considering ways in which clinical care can be improved as a whole through formal education. Waller's (2009) Therapist Drift model is based on the premise that clinicians' emotions interfere with the capacity to deliver care the way clinicians were trained to deliver it (i.e., drifting away from protocol for evidence-based practice) and

findings from the present study further support this notion (i.e., practices used in response to emotion). Waller and colleagues (2012) found that seasoned clinicians were more likely to drift away from protocol when working with individuals with ED than were novice clinicians, suggesting that factors other than just skill and experience may be involved in effective treatment delivery. Therefore, it could be argued that clinical training ought to focus on developing clinicians' capacities for self-reflection and self-awareness, in addition to their clinical skills, so that clinicians are able to adapt to and address their emotions (or their client's) when they arise in a way that they do not affect delivery of care. In addition to training around self-reflection, it is possible that preparing future clinicians for the emotions they will likely experience once they begin to practice may also be helpful. For example, findings from a qualitative study by Thériault and colleagues (2009) suggests that preparing clinicians-in-training to cope with the anxieties and feelings of insecurity they will likely encounter as a new clinicians during formal training may be beneficial and results from the current study certainly also support this notion.

Based on the present findings related to the predictors of negative emotional influence, it could be argued that taking steps to reduce clinician emotional drain may be a particularly effective action against negative emotional influence. Clinicians who work with ED are known to be prone to emotional drain and burnout (Warren, Schafer, Crowley, & Olivardia, 2013) and therefore it is possible that efforts to reduce clinician emotional drain may be even more essential within this particular clinical field. Results also suggest that working as part of a multidisciplinary team is predicative of greater perceived negative emotional influence on clinical decisions and practices. It is possible that team conversations and consultation facilitate clinicians' awareness of any negative influence their emotions may have on their treatment delivery, which could explain why clinicians who work in this setting were more likely to report

a greater perception of negative emotional influence. It is also possible however, that working within a multidisciplinary team can lead to interpersonal conflicts, blame, scrutiny, and scapegoating (Harris, 1999; Lyons, 2005; Murray, 2013), which could lead clinicians to experience more negative emotions that have the potential to play out in their delivery of treatment. Given that working as part of a multidisciplinary team is considered best practice in the treatment of child and adolescent ED (National Collaborating Centre for Mental Health, 2004), it will be important to further examine team dynamics and their influence on treatment delivery in order to differentiate helpful and hindering aspects of this type of work setting.

To paraphrase Dr. Glenn Waller (2014), in order for therapy to be effective there need to be three main variables in place: 1) the therapeutic approach/methodology needs to be effective, 2) the client needs to participate in the therapy, and 3) the clinician has to deliver the therapy (effectively). In the context of child and adolescent ED treatment, we, as a field, have developed a family-based therapeutic approach (Family-based Therapy) that is effective in bringing many children and adolescents with ED to wellness via the support of their parents who attend treatment (APA, 2006; NICE, 2004, Le Grange, Binford, & Loeb, 2005; Le Grange, Crosby, Rathouz, & Leventhal, 2007; Lock et al., 2010; Lock, Le Grange, Forsberg, Hewell, 2006). The current study begins to elucidate the third variable in this equation for effective therapy – clinicians' delivery of treatment. In examining how clinicians' emotions are perceived to negatively influence treatment, this study provides a new angle through which to examine ways that we, as clinicians, can potentially improve how we deliver therapy (and, hopefully, the outcomes for our clients).

Strengths and Limitations

As a whole, findings from the present study provide a unique contribution to the literature related to the negative influence of emotion on the treatment of ED in that they illustrate how child and adolescent ED clinicians perceive this phenomenon to occur. Given the nature of the sample (i.e., physicians and other medical professionals) and the challenges associated with recruiting participants of this nature (Flanigan, McFarlane, & Cook, 2008), we believe that 305 clinicians working in the field of child and adolescent ED represents a strong sample. Furthermore, despite discrepancies between the *Self* and *Other* groups in terms of the frequency with which this phenomenon was reported to occur, the fact that both groups reported this phenomenon to occur to some degree allows us to make a more confident assumption that it is a phenomenon that is worthy of further exploration. This study's methodology, however, is associated with some limitations. For example, results may have been influenced by patterns of participation associated with the recruitment methods used, and the self-report nature of the instrument limits our ability to draw conclusions regarding the occurrence of this phenomenon and its effects on clinical practice. Furthermore, although participants were often given the option to add their own response (i.e., the "other" text box) if they felt their response did not fit within the options provided, it is possible that a survey-style methodology limited the depth of the information collected on clinicians' perceptions of this phenomenon. Qualitative research will be important in order to deepen understanding of how clinicians in the field perceive this phenomenon to occur.

Future Research

Looking forward, future research on the negative influence of emotion on clinical decisions and practices in the field of ED is strongly encouraged in order to: 1) gain a more

complete understanding of how this phenomenon is perceived to occur; b) establish more concrete conclusions as to whether emotions negatively influence clinical decision and practices; and c) examine the implications of this phenomenon in relation to ED treatment outcomes.

Several suggestions are offered here. First, in order to more fully understand how this phenomenon is perceived to occur, qualitative interviews with clinicians, clients and families, and perhaps even supervisors is warranted. This qualitative data, in addition to the findings from the present thesis, could be used to guide the development of a measure of the influence of emotion on clinical decisions and practices related to ED treatment, similar to the Accommodation and Enabling Scale for Eating Disorders (Sepulveda, Kyriacou, & Treasure, 2009), which could then be used in both practice and research and as an in-session “check-in” for therapists. In terms of experimental design, one possibility would be to examine the effects of a clinical training program (designed to increase awareness about emotions and develop skills in effectively processing emotions so that they do not impact treatment) on measures of adherence to treatment protocol and treatment outcomes.

Building on the present findings, it may be worthwhile to conduct similar studies with clinicians who work with adult ED clients as well as other clinical populations in order to illustrate similarities and differences based on client population and to possibly highlight areas specific to child and adolescent ED that clinicians perceive to be problematic in order to reduce the occurrence of this phenomenon. It might also be worthwhile to investigate differences in clinician perception of the negative influence of emotions with respect to clinician (i.e., gender, age, and profession) and client characteristics (i.e., age, gender, and ED subtype) as other authors have noted differences in emotional reactions towards ED clients on the basis of these variables (Satir, Thompson-Brenner, Boisseau, & Crisafulli, 2009).

To conclude, the present study begins to examine the potential negative influence of emotion in clinical decisions and practices within the field of child and adolescent ED. Findings provide clinically relevant insight into the specific ways in which clinicians in this field perceive emotions to play a role in treatment delivery. Although working with young individuals with ED could be considered more vulnerable to the negative influence of emotion due to the high risk nature of the work (Borrell-Carrio & Epstein, 2004; Imhof 1991; Imhof et al., 1983), this is certainly a phenomenon that is worthy and in need of further study in all domains of health care.

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Appendix A. Consent Form



I agree to participate in this research study entitled “The perception of the influence of emotions in clinical decision-making in child and adolescent eating disorders: A Canadian study”.

Evidence suggests that it is not possible for clinical decisions to be made completely independent of emotion. I understand that the goal of this research study is to better understand clinicians’ perceptions of the influence of emotions in clinical decision-making when working in the field of child and adolescent eating disorders (in themselves and in others). I understand that this research study is being conducted by Stacey Kosmerly, Masters student in Psychology at Laurentian University, working under the supervision of Dr. Adele Robinson, C. Psych.

I understand that my participation will consist of the completion of a survey about emotions and clinical decision-making. The survey will take approximately 15 minutes to complete.

I understand that all my answers are completely anonymous and confidential. I understand that all data will be kept in a locked filing cabinet in an office in the Psychology Department of Laurentian University (A218) for a period of seven (7) years after the completion of this study. I understand that this research has been approved by Laurentian University Research Ethics Board.

I understand that although this study may not be of direct benefit to me, it may help inform better clinical decision-making practices in the field of child and adolescent eating disorders. I know that I do not have to participate in this study and that I can withdraw at any time.

I understand that as a thank you for my participation in this study, I have the option of being entered into a draw for one of three \$50 gift cards for Chapters. I understand that any information I give as part of the draw is confidential and will be kept separate from any of my survey answers.

Should I have any questions or concerns I may contact Stacey Kosmerly at sj_kosmerly@laurentian.ca, Dr. Robinson at 705-675-1151 extension 4205, and if I have any concerns about this research I may contact Laurentian University Ethics at (705) 675-1151, extension 3213.

Should I be interested in obtaining the results of this study I may contact Stacey Kosmerly at sj_kosmerly@laurentian.ca.

I have read the above statements and consent to participate in the survey

Name: _____ Date: _____

APPENDIX B. Ethics Approval

**APPROVAL FOR CONDUCTING RESEARCH INVOLVING HUMAN SUBJECTS**

Research Ethics Board – Laurentian University

This letter confirms that the research project identified below has successfully passed the ethics review by the Laurentian University Research Ethics Board (REB). Your ethics approval date, other milestone dates, and any special conditions for your project are indicated below.

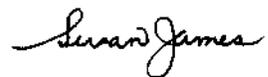
| TYPE OF APPROVAL / New <input checked="" type="checkbox"/> / Modifications to project / Time extension | |
|--|---|
| Name of Principal Investigator and school/department | Stacey Kosmerly - Psychology |
| Title of Project | <i>The perception of the influence of emotions in clinical decision-making in child and adolescent eating disorders: A Canadian study</i> |
| REB file number | 2012-08-03 |
| Date of original approval of project | August 28, 2012 |
| Date of approval of project modifications or extension (if applicable) | |
| Final/Interim report due on | August 28, 2013 |
| Conditions placed on project | Final report due on August 28, 2013 |

During the course of your research, no deviations from, or changes to, the protocol, recruitment or consent forms may be initiated without prior written approval from the REB. If you wish to modify your research project, please refer to the Research Ethics website to complete the appropriate [REB form](#).

All projects must submit a report to REB at least once per year. If involvement with human participants continues for longer than one year (e.g., you have not completed the objectives of the study and have not yet terminated contact with the participants, except for feedback of final results to participants), you must request an extension using the appropriate [REB form](#).

In all cases, please ensure that your research complies with [Tri-Council Policy Statement \(TCPS\)](#). Also please quote your REB file number on all future correspondence with the REB office.

Congratulations and best of luck in conducting your research.

A handwritten signature in black ink that reads "Susan James". The signature is written in a cursive, flowing style.

Susan James, Acting chair

Laurentian University Research Ethics Board