A THEISTIC INPATIENT TREATMENT APPROACH FOR EATING-DISORDER PATIENTS: A CASE REPORT

RANDY K. HARDMAN, MICHAEL E. BERRETT, AND P. SCOTT RICHARDS

Despite indications that religion and spirituality may be important in the treatment of eating disorders (Hall & Cohn, 1992; Hsu, Crisp, & Callender, 1992; Mitchell, Erlander, Pyle, & Fletcher, 1990; Rorty, Yager, & Rossotto, 1993; Smith, Richards, Fischer, & Hardman, 2003), spiritual interventions are rarely used in contemporary treatment programs. We have described elsewhere why we believe that spiritual treatment approaches and interventions hold promise for enhancing the effectiveness of eating disorder treatment programs (Hardman, Berrett, & Richards, in press; Richards, Hardman, Frost, Berrett, Clark-Sly, & Anderson, 1997). Briefly, we believe that some of the core issues that eating-disorder patients struggle with are spiritual in nature (e.g., lack of spiritual identity, negative images of God, feelings of spiritual unworthiness and shame, etc.), and that the most powerful way to resolve these issues is through spiritual interventions (Richards et al., 1997).

In this chapter, we describe an integrative, multidisciplinary inpatient treatment program for women with eating disorders. Undergirding the Center for Change (CFC) treatment philosophy and approach is the belief that
faith in God and spiritual self-understanding and growth can be crucial for those recovering from eating disorders (Richards et al., 1997). To more clearly illustrate the processes and potential outcomes of our nondenominational theistic treatment approach, we share the treatment history of one patient, Jan, whose faith in God and personal spirituality played a crucial role in her healing and recovery.

DESCRIPTION OF THERAPISTS

Randy K. Hardman

I completed a PhD in counseling psychology in 1984 at Brigham Young University (BYU). Since 1984, I have worked as a program director and clinical practitioner in university, hospital, specialized treatment center, and private practice settings in Indiana, Colorado, and Utah. I served as an adjunct faculty member at BYU in the Counseling Psychology program. I am currently an owner and codirector of Center for Change, an inpatient specialized eating disorder treatment center, in Orem, Utah.

I am a committed and active member of the Church of Jesus Christ of Latter-day Saints (LDS). I grew up on a farm in rural Idaho, and my own religious upbringing was without regular church attendance or participation by either my parents or by our family. In a real sense, I was on my own a great deal in both a literal and in a religious/spiritual way. I spent many hours alone in farming responsibilities, and in the quietness and isolation of this rural setting, I communed with God in personal prayer on a regular basis. I was a believer in God, and as a boy felt a connection with God spiritually before I became acquainted with and fully engaged in the religious teachings and tenets of my church as an older teenager.

Over the years, in many thousands of hours of face-to-face interactions with individuals, couples, and families, I have become more in tune with how relationships with self, God, and others are interconnected and need to be addressed and included together in successful therapeutic change. I believe that these relationship experiences, whether perceptual, emotional, or spiritual, have the greatest long-term impact on healing, change, and recovery. I listen closely to clients to understand where they are willing to go in the spiritual—religious experiences of their relationships. I have become more willing over the years to openly and directly discuss spiritual concerns and needs because clients are so eager to explore them. I have found spiritual recovery as the key for bringing hope, healing, and recovery for women with eating disorders.

Michael E. Berrett

I completed my doctorate in counseling psychology at Brigham Young University. I also completed a formal doctoral minor in marriage and family
therapy as well as a master's degree in school psychology. I began working in
the field as a school psychologist and then as a high school counselor. Follow-
ning these positions, I worked as a primary therapist in adult and adoles-
cent acute inpatient treatment and in an inpatient specialty eating disorder
program. In the more recent years of my career, I have served as a business
consultant, taught college courses in clinical and counseling psychology, di-
rected a clinical wilderness treatment program for troubled adolescents, op-
erated a successful private practice, and cofounded and codirected an inten-
sive inpatient treatment program for anorexia, bulimia, and coexisting
emotional disorders.

Throughout my career, I have noticed that those with spiritual beliefs,
and especially those who live congruent with their spiritual beliefs, seemed
to make more dramatic gains in the recovery process and in maintenance of
treatment gains. I have repeatedly heard from patients that their own focus
on religious and/or spiritual issues in treatment, whether within the ther-
apeutic relationship or "on their own," including their faith in their own spiri-
tual tenets and consequent life activities and choices, were some of the most
powerful catalysts for positive change.

As a result of this "personal learning" over time, which I consider a
blessing to me from the clients I have worked with, myself and several col-
leagues began conceptualizing those spiritual themes that were both recur-
rent and most powerful in our patients' lives. This led to designing a spiritu-
ality workbook, a spirituality group in treatment, spiritual interventions in
treatment, research on the efficacy of spiritual interventions in treatment
outcome, and several professional publications about spirituality and eating
disorders.

Although I believe that the spiritual approach is not the only worth-
while modality of treatment and indeed that the best treatment is multimodal
and multidisciplinary, I strongly believe that the spiritual is the most impor-
tant aspect of healing and recovery. I intend to continue to attend to this
understanding, and I hope that attending to it will help many individuals in
their road to recovery, healing, and peace.

TREATMENT SETTING AND PROGRAM

CFC is a private inpatient care facility for women with eating disorders.
Some staff members also provide outpatient psychotherapy services to women
and men with a wide variety of other psychological and relationship con-
cerns. The multidisciplinary inpatient treatment staff includes 2 medical
doctors, 2 psychiatrists, 5 PhD psychologists, 1 PhD marriage and family thera-
pist, 2 clinical social workers, 2 PhD psychology residents, 3 PhD psychology
interns, 1 director of nursing and health services, 9 registered nurses, 3 regis-
tered dieticians, 1 dietary technician, 1 PhD instructional psychologist/educa-
tion director, 5 experiential therapists, 18 care technicians, and 2 chefs; 81% of the treatment staff are women. Approximately 50% of the staff are members of the LDS church and the remaining adhere to a variety of spiritual traditions, including Protestant Christian, Jewish, and Muslim perspectives.

The CFC treatment program is grounded in current research findings and accepted clinical guidelines for treating eating disorders (American Psychiatric Association, 1993; Richards, Baldwin, Frost, Clark-Sly, Berrett, & Hardman, 2000; Yager, 1989). Treatment is customized to meet each patient's needs; thus, length of stay varies. However, as a general rule, patients and their families commit to a minimum of 12 weeks of inpatient treatment for anorexia and 8 weeks for bulimia. The treatment team continuously evaluates ongoing needs and adjusts treatment length when needed.

Once admitted to CFC, each client receives a medical assessment. The evaluation includes a complete medical history, physical assessment, necessary medical procedures, and medications. Throughout the treatment program, the physician oversees the physical aspects of recovery including the medical progress of each client, her diet, and her weight gain. In addition, at the time of admission, a psychiatrist, psychologist, or social worker gathers an eating disorder history and assesses the patient’s emotional condition.

Along the recovery path, patients work their way through a four-phase treatment program. The four phases of recovery represent distinct stages of growth and change. Each phase has clearly defined guidelines, assignments, and therapy tasks, as well as increased privileges and responsibilities.

Phase one: The patient recognizes and acknowledges the presence, reality, severity, and effect of her eating disorder and other emotional disorders. She also begins to understand herself and the development of the eating disorder.

Phase two: The patient takes responsibility and ownership for her eating disorder and other difficulties; learns to take responsibility for her recovery; and regains a sense of choice, power, control, and hope.

Phase three: The patient increases in desire to let go of her eating disorder, deals with her difficult feelings, and makes a personal commitment to do the work necessary to overcome her eating disorder.

Phase four: The patient actively works to decrease her feelings of shame and self-criticism, and to increase patterns of self-acceptance and self-correction. She also begins to share with others some of what she has gained in treatment.

Each patient advances individually through each phase as soon as she is ready, and great care is taken to ensure that each patient progresses at her own pace. Her privileges and responsibilities increase over time as she demonstrates readiness to move ahead. This stepped-care approach to treatment gently helps patients gain confidence as they advance through the phases of change at their own pace.
Patients participate in a variety of needed therapies to assure comprehensive treatment and progress toward recovery. These include (a) individual psychotherapy sessions (4 times weekly); (b) group psychotherapy (7 times weekly) and body image group (2 times weekly); (c) experiential and expressive activities, including music, dance, movement and recreation therapies (8 to 12 times weekly); (d) family counseling (frequency varies per patient needs); (e) nutrition monitoring and counseling (3 times weekly); (f) medical evaluations and treatment (frequency varies per patient needs); (g) eating disorders education classes on a variety of topics, including diet and nutrition, self-esteem, healthy exercise, assertiveness, communication skills (3 times weekly); (h) individualized academic management and tutoring (as needed depending on patient needs); and (i) spiritual exploration and growth activities, including spirituality groups (3 times per week), spiritual readings, and service activities.

SPIRITUAL COMPONENT OF THE TREATMENT PROGRAM

We believe that a spiritual component is an essential part of a multidimensional, multidisciplinary treatment approach for women with eating disorders. Our integrative, theistic approach to using spiritual interventions is consistent with the recommendations of numerous professionals that spiritual interventions should not be used alone, but integrated with standard psychological and medical interventions (Richards & Bergin, 1997; Richards & Potts, 1995; Shafranske, 1996).

We use a nondenominational spiritual emphasis that has proved helpful to patients from a wide variety of religious backgrounds. Two research studies conducted at CFC have provided evidence that spiritual growth and healing during treatment is positively associated with better patient outcomes (Richards, Berrett, & Hardman, 2001; Smith et al., 2003).

During treatment, patients are encouraged to explore their own spiritual beliefs and to draw on their faith to assist in their recovery. We believe that as patients align their behavior with their own spiritual beliefs, they will benefit from improved confidence, self-respect, and peace of mind. Patients are invited to explore spiritual issues related to their recovery if they desire during their individual psychotherapy sessions.

To further facilitate spiritual exploration and healing, patients attend a weekly 60-minute spiritual exploration and growth group, and read a self-help workbook (Richards, Hardman, & Berrett, 2000), which includes scriptural and other spiritual readings and educational materials about topics such as faith in God, spiritual identity, grace, forgiveness, repentance, faith, prayer, and meditation. Each patient utilizes the structure of the workbook and support of the group to help them come to an understanding of their own spiri-
tual beliefs and convictions, and to include those understandings in their recovery program.

Patients also participate in a biweekly, 12-step group, adapted for women with eating disorders. Patients are also given opportunities during the treatment program to attend religious services of their choice and to engage in altruistic acts of service within the Center and community.

CLIENT DEMOGRAPHIC CHARACTERISTICS

Jan was a 19-year-old, Caucasian woman from the western United States. Before her admission to CFC, she resided with her parents and a younger sister. Jan was the second of three children. Her parents were in their first marriage. Their socioeconomic status was upper-middle class. Jan’s older brother was 22 years old and her younger sister was 8 years old.

A high school graduate, Jan had enrolled as a freshman at a university in a western state, but she was unable to successfully continue in the educational program because of the severity of her anorexia. Jan and her family of origin were members of The Church of Jesus Christ of Latter-day Saints (LDS church; Ulrich, Richards & Bergin, 2000). Jan considered herself an “active” (orthodox) member of the church.

Dr. Randy K. Hardman was assigned to be Jan’s individual psychotherapist during her inpatient stay at CFC. Jan met with Dr. Hardman four times per week. As the president and director of Clinical Services at CFC, Dr. Michael E. Berrett oversaw Jan’s treatment during her inpatient stay. He also served as the group leader for Jan’s weekly spiritual exploration and growth group.

PRESENTING PROBLEM AND CONCERNS

Jan had suffered with anorexia since the eighth grade and it had become extremely severe in the year prior to her admission. She had also had a long-standing, depressive disorder, with a general state of guilt and unhappiness. She had tried some outpatient therapy but had not persisted with it. She came to CFC following an assessment and referral by an outpatient therapist in her community. This was the first intensive therapeutic treatment that she had received.

In her first individual therapy session with Dr. Hardman, Jan said,

I’m at a stand still. I have no social life. I don’t see any way for a future family or career because of my eating disorder. My eating disorder controls everything. Health is a big concern. I’m very worried about it. I’m scared of a heart attack. I feel sick inside, tired. I’m aged. I’ve aged myself fifty years. I’m not okay.
CLIENT HISTORY

Significant Childhood and Family History

Jan grew up in a Latter-day Saint home, but her father was not active in the Church. Her mother was always very involved in the church. Jan described her parents' marriage as “stable.” She said that her parents have never been abusive to her or her siblings.

When she was a small child (6 or 7 years), Jan was placed in the care of a babysitter, and in that placement, the father of her babysitter sexually abused her. She also witnessed the father sexually abusing his daughters, and found pornographic pictures of the father’s children.

As she grew up, Jan felt like she could never please or satisfy the expectations of her mother in regards to cleanliness and behavior. She also felt that her parents were emotionally distant and rarely praised her or validated her worth and goodness.

Jan described her parents as strict and structured, but indicated that her younger sister got away with a lot of things that she and her older brother did not. Jan said that she felt like she “always had to be a good child. I was a pleaser.” Jan said that this pattern has not changed in her life.

Jan said that her mother viewed her as a very emotional child. Her older brother was more oppositional than she was and tended to break the rules. Jan did not feel that she got rewarded for being the compliant and obedient child.

Jan said that her father drank every day at home and got intoxicated on a somewhat regular basis. He ran a family business and her father’s relatives all consumed alcohol. As Jan got older, she had a lot of negative feelings about her father’s use of alcohol and his lack of religious participation. Jan said that her father made an effort to be close to her when he became aware of the eating disorder, but she emotionally pulled away from him.

Jan described her mother as a sensitive person, but said, “She’s not very sensitive to me.” Jan felt an emotional disconnection from her mother most of her adolescent life. Jan explained, “I am very sensitive when I’m talking to her. Instead of responding to me and what I’m saying, she will talk about something that she is worried about.” Jan described her mother as a poor listener. Jan said her mother was always worried and preoccupied with other things. Jan described herself as being “wanted, but not needed.”

During the year prior to Jan’s admission to CFC, Jan felt like her parents’ focus was on her older brother, who was preparing for his church mission. Jan said that at one point she was afraid her parents might forget her high school graduation.

Jan said that she and her brother are close, but she believes her parents favored him. Jan admitted, “I feel selfish for saying things about that because I feel like I’m the expensive child. I go through money, braces, dance, and
now I’m here with therapy.” Jan said that her little sister is a worry for her, but that their relationship is good.

Jan had a good high school experience, except for her junior year when her eating disorder became extremely severe. She said that she was somewhat popular during high school. She had close friends and dated periodically, although she had no serious boyfriends. Jan was a very good student in high school, had a 4.0 grade point average, and received a scholarship to attend university.

Eating Disorder History

Jan said that she started her eating disorder when she was in eighth grade by restricting and going on a very rigid diet. When she started to lose weight, she increasingly restricted her eating. Jan would divide the food on her plate in half and eat only half of her food. She gradually eliminated all sugars, butter, peanut butter, and all fat foods from her diet. By the spring of 1996, she was eating only fruits and vegetables. Even then, she felt much guilt and self-incrimination about her eating. Jan also often fasted when she knew that she could not get out of eating a meal. She felt like she had to restrict and fast in order to feel deserving to eat. She would not eat to compensate for the times she did eat. Jan also participated in many dietary trends.

When Jan became a junior in high school, her eating disorder worsened. Jan said that school became much more difficult because her grandmother worked at the high school and she would “send her attack dogs—other teachers and administrators—out on me to make sure I’d eat. Everybody focused on my eating and my eating disorder.” Jan said it was very difficult and embarrassing to have her grandmother watching over her in that way.

Jan’s eating disorder continued through her senior year, although she viewed it as less severe than it was during her junior year. In her senior year, Jan was extremely unhappy, felt like her pants were too tight, and she stated that “everybody else thought I was doing great, but on the inside I was miserable. I was never happy. I felt dull inside. Because of that, I made a suicide attempt.”

Jan said that as her eating disorder continued to worsen she would not eat breakfast, yet eat a small lunch and a small dinner with the family. She indicated that the amount of food she would eat continued to decrease. She hated to eat in front of other people. When she was on dates, she would only eat a salad. She stopped going to social events because she could not stand to eat in front of other people and she could not have complete control over her food.

Jan said that she became consumed by her eating disorder. Every thought was about food. She began to hide things, lie a lot, keep secrets, deny things, and tell people she was eating when she was not. She stated, “I hate lying, but I got good at it. I’d fake that I had eaten meals, but I hated the fact that I lied all the time.” Jan said they she did not ever engage in laxative or diet pill
abuse. She did, however, overexercise somewhat during the 2 years prior to her admission at CFC.

Jan attended university for one semester, but she had a very difficult time with the eating disorder even though she did all right with her grades. While at college, Jan said she restricted every meal: “My roommates never saw me eat. My main meal in college was a Diet Coke.” Jan said that sometimes she would drink water and other times she would go days without drinking it because she hated the “full” feeling that drinking would give her. Jan dropped out of university because the eating disorder had escalated to the point where she could not function.

In spite of all of her weight loss efforts, Jan admitted on her admission to CFC that she constantly felt fat. Her hair was falling out. Her skin was pallid and white. She looked like she did not feel well physically. She lost her menses prior to her admission to CFC. She had also lost her menses for a year during high school. Jan admitted that for several months prior to her admission she was purging up to three times a day, and she continued to both restrict and purge up until the time of her admission.

**ASSESSMENT AND DIAGNOSIS**

When Jan was admitted to CFC, she underwent a physical and nutritional exam, and Dr. Hardman conducted a psychiatric evaluation and a mental status exam. Jan also completed a comprehensive battery of psychological tests, including the Minnesota Multiphasic Personality Inventory—2 (MMPI–2; Butcher, 1990), Eating Attitudes Test (EAT; Garner & Garfinkel, 1979), Body Shape Questionnaire (BSQ; Cooper, Taylor, Cooper, & Fairburn, 1987), Outcome Questionnaire (OQ 45.2; Lambert & Burlingame, 1996), Multidimensional Self-Esteem Inventory (MSEI; O'Brien & Epstein, 1988), Spiritual Well-Being Scale (SWBS; Paloutzian & Ellison, 1991), Religious Orientation Scale (ROS; Allport & Ross, 1967), and Spiritual Outcome Scale (SOS; Richards & Smith, 2000). She completed all of these measures again except the MMPI–2 and ROS when she was discharged from CFC. Jan’s admission and discharge scores on the EAT, BSQ, OQ 45.2, MSEI, SWBS, ROS, and SOS are presented in Table 3.1.

Jan’s physical exam at admission revealed that she was 5’ 6” tall and weighed 94.5 lbs. Jan’s physical, cardiac, and neurologic exams were unremarkable, although her heart rate was only 55. The physician also noted that Jan was “thin and somewhat cachectic appearing, occasionally gets some sharp chest pains and some constipation,” and her last menstrual period was in September of 1999.

The nutritionist estimated Jan’s Body Mass Index at 15.5. She also concluded that Jan’s body weight and somatic protein stores were below normal limits. She noted that Jan had “poor hair growth and falling out,” “skin bruises
TABLE 3.1
Jan’s Scores on the Battery of Psychological Tests Completed on Admission and Discharge From Center for Change

<table>
<thead>
<tr>
<th>Psychological test</th>
<th>Admission score</th>
<th>Discharge score</th>
<th>Normal range</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAT</td>
<td>80</td>
<td>7</td>
<td>&lt; 30</td>
</tr>
<tr>
<td>BSQ</td>
<td>162</td>
<td>57</td>
<td>&lt; 110</td>
</tr>
<tr>
<td>OQ 45.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total score</td>
<td>78</td>
<td>26</td>
<td>&lt; 63</td>
</tr>
<tr>
<td>Symptom distress</td>
<td>45</td>
<td>12</td>
<td>&lt; 39</td>
</tr>
<tr>
<td>Relationship distress</td>
<td>15</td>
<td>10</td>
<td>&lt; 15</td>
</tr>
<tr>
<td>Social role conflict</td>
<td>17</td>
<td>4</td>
<td>&lt; 13</td>
</tr>
<tr>
<td>MSEI (Global self-esteem)</td>
<td>33.6</td>
<td>46.3</td>
<td>40–59</td>
</tr>
<tr>
<td>ROS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrinsic</td>
<td>41</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Extrinsic</td>
<td>28</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>SWBS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious well-being</td>
<td>60</td>
<td>60</td>
<td>&gt; 47</td>
</tr>
<tr>
<td>Existential well-being</td>
<td>53</td>
<td>57</td>
<td>&gt; 43</td>
</tr>
<tr>
<td>Spiritual Outcome Scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>46</td>
<td>61</td>
<td>&gt; 54</td>
</tr>
<tr>
<td>Love of God</td>
<td>17</td>
<td>22</td>
<td>&gt; 19</td>
</tr>
<tr>
<td>Love of others</td>
<td>20</td>
<td>23</td>
<td>&gt; 19</td>
</tr>
<tr>
<td>Love of self</td>
<td>9</td>
<td>16</td>
<td>&gt; 15</td>
</tr>
</tbody>
</table>

Note. For the Eating Attitudes Test (EAT), Body Shape Questionnaire (BSQ), Outcome Questionnaire (OQ 45.2), Spiritual Well-Being Scale (SWBS), and Spiritual Outcome Scale, the estimates that are considered in the normal range are based on normative data. The Multidimensional Self-Esteem Scale (MSEI) subscale scores are all t scores, and so the normal range is between 40 and 59. ROS = Religious Orientation Scale.

easily,” “increased sensitivity in teeth and gums bleeding,” “stomach pain, bloating, and gas,” and “cold body temperature.” She concluded that Jan is “at risk for malnutrition.”

During her psychiatric interview with Dr. Hardman, Jan described her eating disorder symptoms, as well as symptoms of major depression that had been present for several years. There were no indications of psychotic features or thought disorders. Jan’s DSM-IV Axis I diagnosis was Anorexia Nervosa (Purging Type, Severe) and Major Depression (Single Episode, Moderate). Jan’s Axis II diagnosis was deferred.

Jan’s MMPI-2 profile confirmed that she was suffering from clinically significant levels of a variety of psychiatric symptoms such as depression, anxiety, fearfulness, obsessive thoughts, guilt, low self-esteem, self-blame, and feelings of worthlessness. Jan also suffered from multiple somatic symptoms, including poor appetite, fatigue, insomnia, and cardiac pain. Jan’s MMPI-2 configural code type was a 72. Her Pt scale was 94, D scale was 90, and her Hs scale was 86. Her F scale was also elevated at 82, although her L scale was 62 and her K scale was 46. We concluded that Jan’s profile was valid, but that she had exaggerated her symptoms somewhat in a cry for help.

Jan’s EAT score revealed that Jan was experiencing a clinically significant level of eating disorder symptomology, including restricting, binging,
purging, anxiety about eating, and preoccupation with food. Jan’s scores on the BSQ revealed that she was also experiencing a clinically significant level of distress about her body shape (e.g., feeling too fat, wanting to be thinner, and feeling ashamed of her body). Jan’s scores on the OQ 45.2 revealed that she was experiencing clinically significant levels of distress and symptoms in her (a) intrapsychic functioning (depression and anxiety), (b) interpersonal relationships, and (c) social role performance (e.g., as a daughter, student, and sister). Jan’s score on the MSEI global self-esteem scale revealed that Jan did not view herself in a favorable manner. More specifically, she was self-critical and self-doubting. She also viewed herself as being incompetent, unlikable, unassertive, and physically unattractive.

Jan’s scores on the ROS revealed that she was intrinsically religious, which suggests that she believed in her religion and was attempting to live it in her daily life. Jan’s scores on the SWBS revealed that she believed that God loved her and was concerned about the problems she was experiencing, and that she felt a sense of purpose in her life. Thus, based on the ROS and SWBS, Jan’s religious faith and involvement appeared to be a potential strength and resource in her life. However, Jan’s scores on the SOS subscales indicated that her feelings of love for God, others, and herself were below the normal range.

TREATMENT PROCESS AND OUTCOMES

Medical Issues and Outcomes

Jan participated in all of the aspects and components of the inpatient program at CFC. She received a medical consultation evaluation and a psychiatric evaluation. The Center’s physician placed Jan on 40 mg of Prozac for her depression and also prescribed Adivan (0.5 mg) for Jan to use as needed for her anxiety.

Jan ate three meals and three snacks a day throughout her stay. Toward the end of her stay, she ate in “family style,” which meant she was allowed to choose the type and portions of the food she wished to eat. Jan began menstruation in CFC and had two menses during her treatment stay. At the time of admission, she weighed 94 pounds, and at the time of discharge she weighed 117 pounds. At the time of discharge, Jan was no longer restricting her eating or binging and purging. She also reported that she rarely had thoughts about engaging in eating disorder behaviors.

Psychosocial Issues and Outcomes

Jan received individual therapy from Dr. Hardman 4 times a week, daily group therapy, and regular nutritional and dietary consultations. She took
part in nutritional classes, educational classes, art therapy, dance and movement therapy, music therapy, and recreational therapy. She participated in all four phases of the treatment program and successfully completed each phase.

Jan was extremely motivated and committed to the recovery process. She worked hard and faced her fears. She challenged herself to face her issues. Jan experienced much fear, guilt, and emotional conflict at times during treatment due to the emotional and traumatic issues of her past. But she was able to talk about and emotionally work through her issues in an appropriate fashion.

Jan worked on understanding and exploring the underlying causes of her anorexia and the contributing factors of the depression. She came to realize that the sexually abusive experiences she had gone through when being babysat had been traumatic and negatively affected her. She was able to address and resolve much of the affect of these negative sexual molestation and observation experiences.

Jan participated in family therapy on two extended weekend visits with her parents and younger sister. She was able to address issues and patterns from her own family of origin that had influenced her throughout her life, including her feeling that she was never “good enough” for her mother. Fortunately, Jan’s mother and father were responsive to treatment and made positive efforts and changes in their support of Jan’s recovery.

Jan also addressed her intense feelings of self-rejection and self-criticism and the underlying theme that she felt like she was always in trouble and had done something wrong. Jan also addressed her constant feeling of low self-esteem, not being good enough, and feeling weak. She was able to become more self-accepting and self-forgiving.

Jan was able to take risks and face fears related to her eating disorder and her social life throughout the course of treatment. Jan also addressed some sexual fears and concerns during treatment, including dating and social involvements. During her stay at CFC, Jan went on several dates and engaged in a variety of social activities while she was on therapeutic passes.

Jan also addressed future plans and living arrangement during her treatment stay. At the time of discharge, Jan was committed to continue her recovery on an outpatient basis. She had made arrangements to live with her cousin, someone who Jan viewed as a positive, noneating-disorder support person. Jan also made plans to have periodic visits with her parents and sister to continue to receive and develop positive support from them. Jan also made plans to return to her university studies several months after her discharge.

The Role of Faith and Spirituality

Jan’s faith in God and personal spirituality were frequently discussed during her individual psychotherapy sessions and spirituality group meetings.
and played a central role in her healing and recovery. Although Jan was active in her church and publicly expressed her belief in God, it became apparent during her individual psychotherapy that she privately harbored intense feelings of shame, irrational guilt, and unworthiness. Jan superficially or "theoretically" believed that God loved her and was concerned about her problems, but in her heart she felt that God viewed her in a disapproving, condemning manner.

During her individual psychotherapy sessions it became clear that the sexual abuse she had suffered at the hands of her neighbor was the origin and root cause of her feelings of shame and unworthiness in her relationship with God, her parents, and others. The experience of being abused had left her feeling like she had done something terribly wrong, and ever since that experience she had lived with the feeling that she was bad and unworthy. Her parents had further reinforced these feelings through their emotional distance and failure to praise and validate Jan's goodness and competence.

As these core spiritual identity issues surfaced during treatment, Dr. Hardman and Dr. Berrett implemented several spiritual interventions that they believed might help Jan address them. First, Dr. Hardman and Dr. Berrett acknowledged the spiritual nature of Jan's concerns and communicated their willingness to discuss religious and spiritual concerns with her. Once Jan understood that it was acceptable and safe to discuss her personal faith and spirituality during individual therapy and during her spiritual growth group, she frequently initiated discussions about these topics.

Second, Dr. Hardman suggested that Jan read some scriptural writings from the Bible and Book of Mormon (The Church of Jesus Christ of Latter-day Saints, 1981) about God's view of children, including God's affirmations about their innocence and His love for them. These scriptural readings proved effective in helping Jan begin to reexamine her assumptions that God held her responsible for the abuse she had experienced as a child or that God viewed her in a condemning, judgmental way.

Third, Dr. Hardman and Dr. Berrett encouraged Jan to use the private time that is provided for patients in the CFC's daily treatment schedule to engage in contemplation, prayer, and journaling about her feelings and spiritual impressions. Jan's "spiritual solo time" played a powerful role in her healing and recovery. On several occasions as she contemplated and prayed, Jan received personal spiritual witnesses that God loved her and that it was okay for her to speak the truth about the sexual abuse she had experienced, even if people chose not to believe her.

During these sacred spiritual experiences Jan felt deep reassurances of God's love come into her heart and mind. Jan said that during these times she felt comforted, uplifted and sustained, and loved and nurtured. Her feelings of hope and faith that she could face and overcome her problems were also strengthened. As Jan shared these experiences during therapy and group sessions, Dr. Hardman and Dr. Berrett communicated their belief in the value
and reality of Jan’s experiences, and they affirmed the validity of the personal insights about her identity, worth, and sense of life meaning and direction that came to her during these times. Over the course of her stay, Jan wrote down in her own words the spiritual impressions and feelings that came to her and these writings became a personal code of living that she used every day to comfort and encourage herself in the recovery process.

Once Jan felt safer in her relationship with God and knew in her heart that God was with her in her recovery, she became very willing to take significant risks in treatment to face her fears and to resolve issues with her family. The permission she had felt from God during her spiritual solo times to tell the truth about the sexual abuse gave her the courage to disclose what had happened to her parents. The security that Jan felt because of her growing faith that God loved her as a child and now as an adult helped her be honest and face her fears and pain. The growing sense of security about her personal spiritual identity and worth provided an anchor or foundation that enabled Jan to move forward with courage and confidence as she actively engaged in all aspects of the CFC treatment program. Jan described her spiritual healing as “bigger than her own thoughts and feelings.” She came to trust in a power beyond herself to help her change and overcome the problems in her life.

**Psychological and Spiritual Outcome Measures**

Jan’s scores at the time of discharge on the EAT, BSQ, OQ 45.2, MSEI, SWBS, and SOS confirmed our clinical judgment that Jan had improved a great deal during her stay at CFC. As can be seen in Table 3.1, Jan’s scores on the EAT dropped from being in the high clinical (abnormal) range (80) into the normal range for women (7). This indicates that Jan no longer suffered from eating disorder symptoms, such as restricting, binging, purging, anxiety about eating, preoccupation with food, and so on. Jan’s scores on the BSQ also dropped from the high clinical range (162) into the normal range for women (57). This indicates that Jan was no longer experiencing clinically significant levels of concern, worry, and distress about her body shape.

Jan’s scores on the OQ 45.2 also dropped from being in the clinical range into normal ranges. This indicates that Jan no longer suffered from clinically significant levels of distress and symptoms in her (a) intrapsychic functioning (depression and anxiety), (b) interpersonal relationships, or (c) social role performance (e.g., as a daughter, student, sister). Jan’s score on the MSEI global self-esteem scale also fell into the normal range at the conclusion of treatment, indicating that during treatment Jan became more self-accepting and self-confident. She also came to view herself as being more competent, likable, powerful, and physically attractive.

Jan’s scores on the religious well-being scale of the SWBS did not change during treatment, perhaps because her admission score of 60 is the highest
possible score on the SWBS. Jan’s scores on the existential well-being scale of the SWBS increased from 53 to 57, staying in the high normal range. This indicates that Jan continued to believe that her life had purpose and meaning, but again because of the ceiling effect of this measure her scores may not accurately reflect how much progress she experienced in this dimension of her life. Others have raised concerns about the ceiling effect problem of the SWBS and its lack of sensitivity to change among highly religious people (Hall, Tisdale, & Brokaw, 1994). With Jan, the SWBS provided a good measure of her cognitive, doctrinal beliefs about God, but it failed to sensitively measure the changes in the inner dimension of her spirituality.

Conversely, Jan’s scores on the love of God, love of others, and love of self SOS subscales all increased and fell in healthy, normal ranges at the time of discharge. Thus, it appears that the SOS was a more sensitive measure of the changes in the inner dimension of Jan’s spirituality—that is, her love of God and others, as well as her growing felt conviction based on personal spiritual experiences that she is a lovable and worthy person.

**Jan’s Postdischarge Functioning**

Follow-up phone interviews with Jan by Dr. Hardman and the CFC research staff and aftercare coordinator on periodic occasions since she was discharged 2 years ago have confirmed that Jan has continued to progress in her journey of healing and recovery. Jan did return to university several months after she was discharged from CFC and enjoyed success in her studies. During a one-year follow-up standardized phone interview conducted by a CFC research staff member, Jan indicated that she viewed herself as “mostly recovered.” Jan also indicated that during the previous month she had not binged or purged. She said that she had only restricted her eating by skipping meals about once a week during this time.

Life for Jan since her discharge has not been without challenges. Jan experienced two temporary relapses into her eating disorder behaviors (some restricting, binging, and purging) after her discharge. One of her relapses occurred 8 months after discharge when she returned home to live with her parents for a summer break from school. In this situation where so many of the “old triggers” were present, Jan went back into her feelings of shame and badness and her eating disorder coping mechanisms. This relapse lasted for about 3 months. After returning to university, Jan stopped engaging in her eating disorder behaviors and enjoyed positive psychosocial functioning for about 6 months.

Jan’s second relapse lasted longer—almost 6 months—and the “trigger” for this setback was an emotionally intimate relationship with a man. This relationship stirred up Jan’s fears about men and sexuality, which contributed to her relapse into her old ways of thinking, feeling, and viewing herself.
During both of her relapses, Jan was ultimately able to pull out of her shame and cease her eating disorder behaviors by reaffirming her faith that God loves her, she is not alone, her life has purpose and meaning, and God will support her. Thus, by going back to the “spiritual anchors” she discovered during her treatment at CFC, Jan has been able to overcome her challenges and relapses and move forward on her journey of healing and recovery.

Jan’s level of psychosocial functioning since her discharge has remained consistently higher than it was previous to her treatment, even during her relapses. Jan has enjoyed and functioned more effectively in her family and social relationships. She has dated more than she ever did before treatment, and has experienced two close dating relationships with men. Overall, Jan has reported that she is much happier and satisfied with herself and her life since her treatment. Currently, 2 years after her discharge, Jan is free of her eating disorder behaviors and is functioning well psychologically, socially, and spiritually.

THERAPIST AND AUTHOR COMMENTARY

Although we use many standard medical and psychological interventions at CFC, at the core of our nondenominational theistic treatment philosophy and approach is our conviction that God exists. Our approach is also grounded in other theistic assumptions about human nature and therapeutic change, including (a) God has the power and desire to help people cope, heal, and grow, and (b) people who have faith in God's healing power and draw on the spiritual resources in their lives during psychological treatment will have added strength and power to cope, heal, and grow (Richards & Bergin, 1997, p. 100).

As described in this case report, Jan’s personal faith and the spiritual experiences she had during her stay at CFC played a crucial role in her healing and in the process of treatment and recovery. The spiritual assurances Jan received of her spiritual identity, worth, and goodness, along with the affirmations of her worth and goodness that she received from Dr. Hardman and other members of the treatment staff, helped heal her shame, guilt, and distorted sense of identity. Jan’s faith in God’s love and support gave her added courage to face the pain of the sexual abuse she had experienced, as well as the pain she felt over her parents’ emotional neglect. It also helped her recommit to recovery and health on those occasions after her discharge when she relapsed into her old behaviors and ways of thinking.

We doubt that a secular treatment approach that did not value or honor Jan’s faith in God and personal spirituality would have been as effective in helping Jan heal and recover. If Jan’s individual psychotherapist had not encouraged her to engage in times of spiritual contemplation and prayer, it is
unlikely that Jan would have engaged in such practices on her own. By the
time Jan entered treatment, the progression of her eating disorder and self-
contempt had so undermined her feelings of worthiness and acceptability to
God that she would most likely not have felt deserving of seeking God’s
assistance in her treatment and recovery. As a result, she may not have opened
her heart and mind to the spiritual experiences she had during treatment
that so powerfully assured her of God’s love and of her goodness. Without
these powerful and emotionally healing experiences to serve as her anchor
and strengthen her faith and confidence, we doubt that Jan would have en-
gaged so courageously in the treatment process and in facing her pain and
fears.

For Jan, God was the first to validate her worth and goodness in a way
that made her feel and know deeply in her heart that she was lovable and
good. Receiving a spiritual assurance of God’s love, and of her lovability and
goodness, changed the way Jan thought and felt about herself. She began to
heal from the inside out. Once Jan had felt God’s loving and healing valida-
tion, it became much easier for her to feel and accept Dr. Hardman’s love
and validation, as well as love from other treatment staff members. From our
theistic perspective, God is the ultimate healing power in patients’ lives.
When patients open their hearts to God’s love and healing presence, then
psychotherapists simply become facilitators and witnesses to a healing pro-
cess that transcends ordinary psychological change processes.

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