PSYCHOLOGICAL FACTORS IN DETERMINING THE ALLOCATION OF A SCHOLARSHIP FOR EATING DISORDER TREATMENT

by

MELISSA A. WILL

(Under the Direction of Edward Delgado Romero)

ABSTRACT

Eating disorders can have deleterious effects on both an individual's body and mind. Additionally, the cost of treatment can be steep, often preventing individuals from receiving adequate, consistent, and necessary care. A non-profit organization in the southeastern United States has dedicated efforts to fully funding individuals through eating disorder-inpatient treatment, and accepts applications from individuals around the country. Funding recipients are then financially supported at an approved treatment site for as long as they need. As the financial need of applicants can range from a few hundred dollars to upwards of one-hundred-thousand dollars, the non-profit is limited in the number of scholarships they can provide at any given time. The application process is multi-level, and largely consists of measures self-created by the non-profit organization. There are also three validated measures included: Experiences in Close Relationships-Revised Questionnaire, Family Adaptability and Cohesion Evaluation Scale IV, and University Rhode Island Change Assessment Scale. The purpose of the study was to evaluate whether the non-profit based funding decisions on data collected from the three validated measures. This was examined through three hypothetical decision-making models. The three hypothetical models were: Egalitarian Model, Least Severe Model, and Blended Model.

Hypothetical funding recipients were selected from each model and compared to the two actual funding recipients. The non-profit aimed to use a Blended Model. Results indicated that those chosen by the non-profit were not selected based on the three validated measures as demonstrated through the three hypothetical decision-making models. The allocation of scarce resources demonstrates to be a challenge on any level, and understanding the decision-making process can further inform organizations on the effectiveness and consistency of their procedures. Implications for practitioners working with eating disorder clients, limitations, and recommendations for future research are discussed.

INDEX WORDS: Eating disorders, Allocation of funds, Dissertation, The University of Georgia

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by

MELISSA A. WILL

B.A., Ripon College, 2009

M.A., The University of Nebraska-Lincoln, 2013

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by

MELISSA A. WILL

Major Professor: Edward Delgado-Romero

Committee: Rosemary Phelps
Brian A. Glaser

Electronic Version Approved:

Suzanne Barbour
Dean of the Graduate School
The University of Georgia
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DEDICATION

This is simply dedicated to my family. Regardless of the many times I faltered, they provided comfort and encouragement. Completing this dissertation challenged me in ways that I never could have expected. It brought out every insecurity, hope for what could be, and self-doubt along the way. Many times I questioned whether I would finish. Now that I have, I owe endless thanks to my parents who never doubted me. To my sister who never hesitated to “give a little push.” And to my husband, who despite my flaws, never stopped supporting me.

With so much love, thank you.

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*Angels of Care and Dr. Angel are pseudonyms to help protect the organization's privacy.

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INTRODUCTION

Brief Overview of the Current Study

Eating disorders are the deadliest psychological diagnosis, and people living with eating disorders have an elevated risk for early mortality (Button, Chadalavada, & Palmer, 2010). Treatment cost estimates vary based on factors such as access to insurance, duration of the disorder, past treatment, and level of severity (Warren, Schafer, Crowley, & Olivardia, 2012; Stice, Marti, & Rode, 2013). Clients with eating disorders frequently have additional medical complications; these additional stressors increase levels of both financial and psychological strain (Calderon, Vander Stoep, Collett, Garrison, & Toth, 2007; Franko et al., 2013). Because of the treatment costs, both direct and indirect, many clients have difficulty obtaining or maintaining adequate care, which can result in worsening symptoms and a decreased likelihood of recovery (Gatt et al., 2014).

To help ease this burden, a non-profit organization in the Southeastern United States operated a scholarship program to assist clients seeking inpatient eating disorder care. Individuals who battle against an eating disorder could apply for a scholarship to alleviate the financial burden of treatment. The purpose of the current study was to determine if the non-profit selected funding recipients based on the three validated measures within their application. The overall application process included assessments largely self-created by the organization, and only incorporated three validated measures. By understanding the role of these assessments on funding allocation decisions, the application process could be further enhanced to better document and understand factors in the allotment of scarce resources for eating disorder treatment.

According to Wade, Keski-Rahkonen, and Hudson (2011), nearly 20 million women and 10 million men suffer from some sort of eating disorder (Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, or Other Specified Feeding or Eating Disorder) during their lifetime. As the deadliest psychological diagnosis (Miller et al., 2005) treatment and recovery can be a challenging path. Clients diagnosed with an eating disorder not only deal with the psychological and behavioral impacts associated with their particular disorder, but many suffer additional co-morbid medical complications (Calderon et al., 2007). The added means necessary to ensure health and recovery, which often include the use of an inter-professional team, speaks to the complexity of treatment and exponential costs of eating disorder care (Guarda, 2008).

Presently there is no consensus on what qualifies as the absolute best treatment approach. Commonly employed treatment plans include aspects of Cognitive Behavioral Therapy (CBT; Geller & Dunn, 2011), Acceptance and Commitment Therapy (ACT; Sandoz, Wilson, & Dufrene, 2010), nutrition and psychoeducation (Guarda, 2008), and the inclusion of family and group therapy (Kelly, Carter, & Borairi, 2014; Hardman, Berrett, Richards, & Black, 2015). Regardless of the strategy or techniques used, clients benefit most when approached with an individualized treatment plan that addresses their particular challenges, and takes into consideration the context of etiology, symptoms, environment, and personal experiences (Treasure & Wolff, 2008). Depending on a client’s need (and resources), treatment options can range from outpatient, intensive outpatient, partial hospitalization, inpatient, and hospitalization (Keel & McCormick, 2010). The level of care is influenced by a client’s severity and the treatment options available, which vary based on location.

Although there are a variety of techniques used in the treatment of eating disorders, there remains a void in what definitively constitutes recovery (Bardone-Cone et al., 2010). In Urbano's research examining clinicians who survived an eating disorder, findings revealed that, "recovery is an individualized and multidimensional process towards balance, freedom, and embodiment, which is perpetually influenced by societal standards and messages" (2011, p. 166). The experience and symptomology of eating disorders is not universal, thus neither is recovery. Furthermore, as noted by Hutchinson (1994), the eradication of eating disorders requires attention beyond the individual. Efforts must include a thorough examination and challenge of a culture in which bodies are objectified and access to resources are a privilege.

Eating Disorders in Context: A Feminist Perspective

The etiology of eating disorders are vast and varied. There have been links connected between disordered eating habits, thin-unrealistic ideals in the media, and the perpetual valuation of women's bodies (Kilbourne, 1995; Jhally & Kilbourne, 2010; Hesse-Biber, Leavy, Quinn, & Zoino, 2006). The hyper-sexualization of women and consistent objectification has not only been extremely lucrative in entertainment, it has directly impacted women's perceptions of themselves (Tiggemann, 2013; Slater & Tiggemann, 2015). Originally developed by Fredrickson and Roberts in 1997, Objectification Theory highlights the increased frequency of self-monitoring of size and appearance by women, particularly when engulfed in a society that promotes sex and women as inanimate objects. This heightened awareness of body and size has since been linked with disordered eating habits and eating disorders (Dittmar, Halliwell, & Ive, 2006; Slater & Tiggemann, 2010), which further emphasizes the need to consider context when examining the cause, experience, and elimination of eating disorders.

The United States was built on, and continues to exist as a patriarchal society. Power and privilege have a strong influence over what does and does not receive attention (and therefore monetary support); it also impacts the ways in which society addresses areas of concern. For example, in response to conservative attacks the leadership of Planned Parenthood spoke to congress in order to defend health services provided, and advocate for women's access to care (Shear, 2015). Whether women should have readily available and affordable access to medical care continues to be a debate in the United States. The issue of access extends to other groups beyond gender; racial and ethnic disparities exist in the allocation of medical treatment, and outright discrimination is common (Quach et al., 2012). The capitalist culture within the United States permits companies and those in power to determine how and when needed services are provided. Regardless of the issue, the personal (what individuals deem important) is always political (Brown, 2010). Whether money, equity, or health care, personal opinions bleed into politics, and the personal values of those in power, affect the nation.

Access to Resources is a Privilege

As noted, power and privilege influence policy and decisions across the country. With specific regard to health care, socioeconomic status can often be a determining factor of whether services are available (Green, Kerstetter, & Nylander, 2008). Even for individuals with access to insurance, many policies do not cover eating disorder treatment; and for those that do include some sort of coverage, what is reimbursed often varies (Anzai, Lindsey-Dudley, & Bidwell, 2002). In a study conducted by Escobar-Koch and colleagues (2010), participants indicated that it was not uncommon for their insurance company to determine what type of care they could receive. As a result, those individuals who are privileged enough to have insurance coverage, may still have their scope of care, and their treatment plan itself, determined by individuals with no medical or psychological training. Instead, treatment decisions may be dictated by an insurance company whose primary objective is financial stability, not the psychological or physical health of individuals. This has direct consequences for the person requiring services.

Because the treatment of eating disorders can be expensive, or even qualified as financially catastrophic by Gatt and colleagues (2014), the decision to seek out and engage in therapy is not taken lightly. Both the direct and indirect costs of treatment can be a deterrent to maintaining services. If individuals terminate prematurely (or refuse services all together), disordered behaviors often persist and worsen, as do any potential co-morbid medical complications (Gatt et al., 2014). Additionally, Vogel, Wade, and Hackler (2007) suggested that there is often more stigma and negative connotation affiliated with seeking psychological services as compared to visible and physical illnesses. The frequent invisibility of eating disorders often result in misunderstanding and skewed perceptions of etiology as a matter of will power. Societal messages, along with logistical barriers, can often result in many individuals living with an eating disorder having few options and limited access to adequate care.

A Gift of Opportunity

A non-profit organization in the Southeastern United States was founded in 2007 with the mission to provide funding for those people who were unable to afford inpatient eating disorder treatment. Founders of the organization worked with eating disorder clients and were frustrated with the systems in place, and lack of resources available for those who needed help; so they did something about it. Since their inception, the organization has raised over a million dollars and has fully funded 21 individuals through inpatient eating disorder treatment. The organization has networked with eating disorder facilities around the United States and has a list of approved sites; scholarship recipients are permitted to attend any site that is approved by the organization. As a result, applicants reside all over the county and are not geographically restricted.

At the time of data collection, those seeking a scholarship filled out an online application reporting on a number of variables including disordered eating behaviors, perceived impact of their disorder, and relationship history. A committee of eating disorder specialists evaluated applications and made recommendations on both recipients and the scholarship amount (the amount of funding was dependent on the organization's financial resources at the time and the applicant's need). An executive board re-evaluated the recommended applications, requested additional information from top candidates, and made the final decision. The organization aspired to fund a recipient every quarter, however, the frequency and scholarship amount were dependent on available resources. Individuals who received monetary support were then admitted into an eating disorder inpatient facility and could focus on recovery as opposed to the burdens of financial responsibilities. To protect the organization's privacy, they will be further referred to as Angels of Care (AoC).

Statement of the Problem and General Hypotheses

As stated, AoC's application process gathered numerous data points both through qualitative and quantitative means. In order to obtain a full and personalized perspective of the applicant, many variables were evaluated through open-ended response questions. During the time of data collection, the initial application included three validated measures: Experiences in Close Relationship- Revised Questionnaire (ECR-R; Fraley, Waller, & Brennan, 2000), Family Adaptability and Cohesion Evaluation Scale IV (FACES-IV; Olson, 2000); and the University Rhode Island Change Assessment Scale (URICA; McConnaughy, Prochaska, & Velicer, 1983). By understanding whether the validated measures predicted funding recipients could impact future decisions made to enhance the ease and standardization of the application process (saving time and money). Three hypothetical decision-making models were developed based on the validated measures incorporated. The present study intended to:

- identify whether AoC selected funding recipients based on data collected through the three validated measures included in their application as evaluated through three hypothetical decision-making models.
- provide recommendations on how to further enhance the standardization and ease of the application process (both for applicants and for the organization); and
- contribute to the scant literature on resource allocation within the eating disorder treatment community, through a feminist, strength based lens.

It was hypothesized that the decision-making model utilized by AoC took a blended approach selecting those applicants who were in need of inpatient treatment, and those that had supportive structures in place enhancing their opportunity for success. The three validated measures included in the application addressed: romantic and close relationship attachment styles (ECR-R; Fraley, Waller, & Brennan, 2000), familial cohesion and flexibility (FACES-IV; Olson, 2000), and personal levels of motivation (URICA; McConnaughy et al., 1983). There was no validated measure included that assessed for eating disorder severity (consistently across applicants). Therefore, an applicant's BMI range served to provide some severity context. Although BMI is *not* a sole indicator of eating disorder severity, it was a data point that was obtained through the application, and may indicate a need for medical observation.

As those individuals who are severely underweight often experience co-morbid health complications, it would be one factor in negotiating whether an applicant necessitated inpatient treatment (Kawai et al., 2011).

CHAPTER 2

REVIEW OF RELEVANT LITERATURE

Eating Disorder Prevalence

Eating disorders (e.g., Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder) are biopsychosocial diagnoses for disorders that have numerous deleterious effects over the course of a lifespan (Ackard, Richter, Frisch, Mangham, & Cronemeyer, 2013). Anorexia Nervosa (AN) is defined as a disorder in which individuals frequently restrict or minimize caloric intake to prevent weight gain; AN may or may not include purging behaviors (e.g., vomiting, use of laxatives, or over exercise). Those with AN often struggle with altered perceptions of their bodies and can reach dangerously low body weights (American Psychiatric Association, 2013). AN has been speculated to impact somewhere between 0.4% and 4.3% of the world's population (Wade, Bergin, Tiggemann, Bulik, & Fairburn, 2006; Downs & Blow, 2013; American Psychiatric Association, 2013). Binge Eating Disorder (BED) was only recently (2013) recognized as a separate and unique diagnosis. BED is defined as frequent binging episodes in which abnormally large amounts of food are consumed in a short duration of time. Individuals often experience a 'loss of control' when eating with various feelings of regret or remorse post-binge. The prevalence of BED has been estimated to impact somewhere between 0.6% and 3% of the population (Smink, Hoeken, Oldehinkel, & Hoek, 2014; Smink, Hoeken, & Hoek, 2013; American Psychiatric Association, 2013). Bulimia Nervosa (BN) encompasses both aspects of binging and purging behaviors. Individuals with BN often oscillate between excessive caloric intakes followed by compensatory behaviors (e.g., vomiting, laxatives, fasting, or exercise) to prevent weight gain. As with AN, there is often increased emphasis or preoccupation with a desired body shape and/or weight. Prevalence rates are speculated to impact between 2% and 2.9% of the population (Downs & Blow, 2013; Wade et al., 2006; American Psychiatric Association, 2013).

For decades researchers have globally struggled to accurately account for the true pervasiveness of eating disorders. However, it has been hypothesized that estimates for both BED and BN remain conservative due to criteria changes in the Diagnostic and Statistical Manual of Mental Disorders- Fifth Edition (DSM-5; American Psychiatric Association, 2013; Belllows, DuVall, Kamauu, Supina, Babcock, & LaFleur, 2015; Stice, Marti, & Rhode, 2013), the expression of subclinical symptoms of one or more eating disorder diagnosis, and/or the inability or decision to not seek treatment, thus avoiding official diagnoses. Prior to the DSM-5, BED was classified under Eating Disorder Not Otherwise Specified (EDNOS), which accounted for the bulk of diagnosed eating disorders (Fairburn & Bohn, 2005). Hopefully a more accurate understanding of the prevalence of BED will become more apparent with additional research.

Traditionally, eating disorders have been believed to predominantly impact young women with a prime age of onset during middle to late adolescence (Smink, van Hoeken, Oldehinkel, & Hoek, 2014). However, the rates of middle-aged women (women over forty years old) diagnosed with eating disorders has drastically increased over the past few decades. Prevalence rates, encompassing all derivatives of eating disorder diagnoses, have risen from 4.7% (1989-2001) to 11.6% (2002-2006). Furthermore, middle-aged women are more likely to live with symptomology for a longer duration, and go without official diagnosis until later in life when compared with younger women and adolescents (Ackard, Richter, Frisch, Mangham, &

Cronemeyer, 2013). This fact is important because it highlights a potential shift in the understanding of *who* has an eating disorder.

Although it has been demonstrated by numerous researchers that eating disorders impact more women than men (Calderon, Vander Stoep, Collett, Garrison, & Toth, 2007; Eisenberg, Nicklett, Roeder, & Kirz, 2011; Hudson, Hiripi, Pope, & Kessler, 2007; Stuhldreher, et al., 2012), it has also been found that women are on average more likely to seek medical and psychological treatment, and maintain treatment for a longer duration (Stuhldreher, et al., 2012). This invariably accounts for at least some of the prevalence discrepancy between genders. Moreover, the DSM-IV's inclusionary criteria for an eating disorder diagnosis often excluded the experiences of men. In particular the necessity of amenorrhea for the diagnosis of AN eliminated an entire demographic from actuate diagnosis and treatment. Although the DSM-5 intentionally included more diagnostic criteria to capture men's experiences, including a specifier of muscle dysmorphia within Body Dysmorphic Disorder (BMDD; American Psychiatric Association, 2013), clinicians often miss signs and symptoms of disordered eating behavior (Raes & Stedal, 2015).

Aside from potentially underestimating the prevalence rates for men, there remains mixed data on the pervasiveness of eating disorders within non-White populations. According to Calderon and colleagues (2007), ethnic minority populations have a lower tendency to seek out and utilize traditional medical and psychological treatment for a variety of reasons. Factors associated with perceived shame, financial resources, inadequate treatment options, stigma, and adverse interactions with treatment providers were identified as barriers for non-White individuals who necessitated treatment. A qualitative study examining these perceived barriers revealed that stereotypes extended beyond social interactions and existed within the walls of treatment centers themselves (Becker et al., 2010). One woman explained that her therapist did not believe she had an eating disorder, because she didn't "fit the [racial] stereotype" (Becker et al., 2010, p. 641). Inaccurate diagnoses, regardless of gender and identity, along with barriers to care pose serious health risks to those surviving an eating disorder.

Overall, eating disorders are considered the deadliest psychological diagnosis (Miller, et al., 2005). It has been well documented that those diagnosed with eating disorders, particularly with AN, have an elevated risk of early mortality, with some estimates speculating a tenfold increase of premature death (Warren, Schafer, Crowley, & Olivardia, 2012; Stice et al., 2013; Smink et al., 2013; Button et al., 2010; Huas et al., 2011; Arcelus, Mitchell, Wales, & Nielsen, 2011; Crow et al., 2009). Specifically, the time frame within the first ten years of recovery has been identified as the most dangerous (Franko et al., 2013), with exponential risk existing within the first four to nine months post treatment (Carter et al., 2012). What makes eating disorders so deadly expands beyond the diagnosis itself and the actual disordered eating behavior. The high prevalence rate of comorbid psychiatric disorders, such as depression, anxiety, obsessive compulsive disorder, and personality disorders (Carter et al., 2012; Calderon et al., 2007; Eisenberg, Nicklett, Roeder, & Kirz, 2011; Deboer & Smits, 2013; Toto-Moriarty & Mastria, 2013; Smink et al., 2013; Button et al., 2010), in addition to added medical complications, such as cardiac dysrhythmia, protein-calorie malnutrition, hypokalemia (Calderon et al., 2007), kidney problems (Bouquegnequ, Dubois, Krzesinski, & Delanave, 2013), xerosis, and carotenoderma (Stumia, 2013) among others (Franko et al., 2013; Warren et al., 2012), exacerbate already difficult circumstances. These are just some of the variables that contribute to the complexity of eating disorder treatment.

Eating Disorder Treatment

The treatment of eating disorders is a multifaceted venture with only partial agreement on best practice. Presently, there is no one identified method for effectively treating eating disorders (Bergh et al., 2013; Treasure & Wolff, 2008; Guarda, 2008) nor agreement on what constitutes recovery (Urbano, 2011).

The experience of having an eating disorder has been compared to having an addiction regarding the intense urge or felt necessity to engage in disordered eating behavior (McAleavey & Fiumara, 2001). Yet, Wilson (2010) indicated that no such biological link exists. His evaluation concluded that the brain does not respond in the same way as someone who is addicted to drugs or alcohol. And although there is partial evidence that eating disorders tend to develop within families, there remains limited ability to distinguish between environmental and biological factors (Polivy & Herman, 2002; Munn-Chernoff et al., 2015). Therefore, the true etiology is a uniquely complex combination of environmental, social, and biological factors that impact the individual and contribute to treatment difficulties (McAleavey & Fiumara, 2001). Whether an individual is chemically addicted to food or restriction, the urge to engage in disordered behaviors (e.g., purging, fasting, binging, etc.) can be immense (Jenkins, Conley, Rienecke Hoste, Meyer, & Blisett, 2012). One main difference between a drug or alcohol addiction and a potential food addiction lies in the fact that drugs and alcohol are not required for survival. The human body can maintain health and prosper without alcohol and recreational drugs. Yet, humans require food. The mind and body require a consistent replenishment of nutrients in order to function properly. Therefore, an addiction to consuming (often unhealthy) foods, or the addiction of withholding food (real or perceived) makes treatment much more challenging (Jenkins et al. 2012). While other addictive substances can be removed from the environment, those who suffer an eating disorder must face triggers daily in order to survive. The approach taken to address symptomology depends on the recognition and understanding of unique experiences and etiology in order to best service client recovery.

Some of the more commonly accepted treatments include aspects of family therapy (Downs & Blow, 2013), motivational interviewing and Cognitive Behavioral Therapy (CBT; Geller & Dunn, 2011; Treasure & Wolff, 2008), Acceptance and Commitment Therapy (ACT; Sandoz et al., 2010), nutrition and psychoeducation (Guarda, 2008), compassion therapy (Kelly et al., 2014), and group therapy (Hardman, Berrett, Richards, & Black, 2015). However, as indicated by Treasure and Wolff (2008), the most important component of any treatment plan is the individualization to the client's particular needs. Moreover, the utilization of inter-professional treatment teams enhances a client's chances for reaching a desired (healthy) weight, and the reduction of disordered eating symptomology (Guarda, 2008). These teams often include a psychologist or counselor with specialization in eating disorders, psychiatrists, nutritionists or dietitians, nurse practitioners, and others with pertinent medical backgrounds. While most often utilized in inpatient treatment settings, they can also be highly advantageous in outpatient treatment facilities, provided the client has access (Dejesse & Zelman, 2013; Mitchell, Klein, & Maduramente, 2015).

Overall, eating disorder treatment has been demonstrated to be efficacious in assisting clients reach a healthy (healthier) weight and in the reduction of eating disorder symptoms (Guarda, 2008; Kazdin, Fitzsimmons-Craft, & Wilfley, 2017). However, there is also evidence to suggest that those individuals who do seek treatment rarely become fully asymptomatic and often experience a relapse in behavior (Woodside, Kohn, & Kerr, 1998). In fact, one study found that less than half of eating disorder survivors actually reached a point in which disordered eating behaviors were absent (Wade et al., 2006). This contributes to the difficulty in defining recovery or successful-long-term treatment.

If examined through a purely biological lens, one might argue that recovery only exists in the absence of sickness. According to Boorse (1975), a value free definition of health is that in which the health of a person is solely dependent on whether the body physically functions according to its design. While this perspective could theoretically make decisions easier (either one is healthy or not), realistically, according to this definition not much of the US population would qualify as healthy. With regard to eating disorders, clients who are able to gain enough weight to be considered within a healthy range, may continue to have medical complications. Furthermore, although someone may gain weight, and potentially restore normal bodily functions, they may continue to engage in unhealthy or disordered behaviors (e.g., binging or purging). Approaching recovery and a cure as strictly biological doesn't fit with the reality and complexity of eating disorders.

In order to understand the intricate and personal nature of recovery, Urbano (2011) sought out to study clinicians who had personally survived an eating disorder. Through a feminist oriented qualitative research methodology, Urbano interviewed nine women who previously met criteria for an eating disorder, held advanced degrees in the mental health field, treated clients with an eating disorder, and did not personally meet criteria for an eating disorder for one year prior to participating. Findings suggested that the definition of recovery is in fact complicated and multifaceted. According to Urbano, "findings revealed that recovery is an individualized and multidimensional process towards balance, freedom, and embodiment, which is perpetually influenced by societal standards and messages" (p. 166). Furthermore, what qualified as recovery, according to her participants, expanded well beyond the absence of eating disorder symptoms and behaviors. Healing occurred psychologically, socially, spiritually, physically, and emotionally (Urbano, 2011). Overall, findings were consistent with the research conducted by Peters and Fallon (1994) who reported that recovery was an evolutionary process that is individualized and personal on numerous factors. Thus, there currently does not exist a consensus on what constitutes as recovery or a definitive eating disorder cure (Urbano, 2011; Peters & Fallon, 1994; Bardone-Cone et al., 2010; Hoek, 2006; Pike, 1998)

For those in outpatient treatment, strategies for deceasing symptomology often include aspects of CBT, ACT, and interpersonal therapy (Geller & Dunn, 2011; Treasure & Wolff, 2008; Sandoz et al., 2010; Downs & Blow, 2013; Jones, Peveler, Hope, & Fairburn, 1993). Additionally, there is some evidence by Ghaderi (2006) to suggest that self-help methodologies can be effective in reducing symptoms. However, this study was conducted with participants who were self-selected, met diagnostic criteria for an eating disorder, and only participated in outpatient services. They did not require intensive outpatient, inpatient, or hospitalization, and did not present with any suicidal ideation. The sustainability and longevity of their findings remains uncertain. For those with more severe symptoms or complicated medical concerns, inpatient treatment is strongly preferred in order to best utilize inter-professional teams (if available; Guarda, 2008).

For those that enter inpatient facilities, the level of care and diversity of treatment modalities (e.g., individual therapy, family therapy, group therapy) increase to reflect more intense care. Due to the elevated medical risk with more severe eating disorders, medical observation and continuous access to emergency services can be the difference between life and death. Although some researchers have pointed out that the overall scope of treatment and duration of hospital stay has decreased since the advent of managed care (Anzai, Lindsey-

Dudley, & Bidwell, 2002; Wiseman, Sunday, Klapper, Harris, & Halmi, 2001), inpatient facilities continue to provide the most multidimensional care and utilization of inter-professional services, resulting in the enhanced *opportunity* for success (Guarda, 2008; Twohig et al., 2016). Treatment modalities and a client's experience can vary between different types of facilities. For example, due to high rates of comorbid diagnoses (Eisenberg, Nicklett, Roeder, & Kirz, 2011; Deboer & Smits, 2013; Toto-Moriarty & Mastria, 2013; Smink, van Hoeken, & Hoek, 2013), clients have the potential to be admitted to either psychiatric units or non-psychiatric units depending on their diagnostic combination and financial resources. This can impact both the extent and type of treatment a client receives. Calderon and colleagues (2007) found that those admitted into a non-psychiatric unit remained in inpatient treatment twice as long and received more eating disorder focused care. They also stipulated that those clients admitted to psychiatric units were less likely to have private insurance. This supports the notion that client experiences with treatment can frequently be determined by their financial access to various levels of care.

Despite the type of facility, clinical orientation, or methodologies employed, there remain additional factors that impact the effectiveness of treatment. Client characteristics, therapist variables, and therapeutic common factors have influence over treatment plans, dropout rates, and outcomes. These factors further interact with diagnostic variables such as duration of illness, diagnosis, and previous treatment.

Some of the more prominent personality factors associated with eating disorder clients are perfectionistic tendencies and obsessive-compulsive thoughts and/or behaviors (Bergh et al, 2013; Zerwas et al, 2013; Egan et al., 2015; Grave, Calugi, Brambilla, & Marchesini, 2008) at diagnostically clinical and subclinical levels. There is some evidence supporting the relationship of disordered eating behaviors and levels of shame and self-compassion. Researchers Kelly, Carter, and Borairi (2014) found that shame can help perpetuate disordered eating behaviors by influencing a person's willingness to seek help. However, they also found support for utilizing self-compassion strategies early on in treatment to help reduce shame, and thus symptomology. Other factors such as motivational levels, body mass index (BMI) upon entering treatment, desired BMI at post treatment, past hospitalizations, and age also contribute to one's potential for recovery (Grave et al., 2008; Carter et al., 2012; Hubert et al., 2013).

The research of Bourion-Bedes and colleagues (2013) found that adolescents in particular may experience more difficulties in treatment as compared to adults. Specifically, they highlighted that adolescents are under the direct care of a parent or legal guardian. Therefore, because seeking help may not be the adolescent's decision, motivation for improvement may be more externalized than intrinsic (Huber et al., 2013). As a minor, adolescents only have partial control over their course of treatment. Decisions for hospitalization, intensive outpatient, or treatment at any level lies with the legal guardian. This is one example of how age can impact investment in the treatment process and potentially influence recovery outcomes. However, just as age can be a factor inhibiting progress, youth can also be an asset. Dropout rates, or premature termination is often lower in adolescent populations. This is partially due to adolescent's inability to terminate care without parental or a legal guardian's approval (Hubert et al., 2013). Numerous researchers suggested that the older a client is upon entering eating disorder treatment, the more challenging it is to achieve recovery, primarily because older clients tend to have a longer disordered eating history than adolescents (Bourion-Bedes et al., 2013; Guarda, 2008; Miller et al., 2005; Keel et al., 2003). Finally, there is some evidence that a client's level of familial support and family dynamics are correlated with treatment outcomes (Downs & Blow, 2013; Grave et al., 2008). Stability and external sources of support reduce some of the psychological burden of treatment.

Clinician variables also matter in treatment outcomes. A major concern for clients, is the level of clinician expertise (Reid, Burr, Williams, & Hammersley, 2008; Escobar-Koch et al., 2010). Clients indicated that clinicians who were erudite in the field of eating disorders helped contribute to a sense of comfort and safety. Throughout training there exists limited opportunities for instruction on the proper treatment of eating disorders; many clinicians, particularly those who work with outpatient populations, would benefit from additional education (Mahr et al., 2015; Ried et al., 2008). Enhanced understanding of how to accurately identify and diagnose eating disorders (across genders), in addition to proper implementation of treatment interventions and prevention strategies, would likely bolster outpatient outcomes.

Regardless of treatment modality and clinician expertise, the common factors of therapy drastically impact the potential for success. As outlined by Wampold (2012; Imel & Wampold, 2008), factors such as empathy and the establishment of a strong therapeutic alliance can drastically impact the course of treatment regardless of the clinician's theoretical orientation. This alliance is particularly important with adolescent clients who may be reluctant to engage in treatment (Graves et al., 2017). More effective eating disorder care requires enhanced levels of vulnerability in order to discuss aspects of shame, potential trauma, and honest disclosure of disordered behaviors. As noted by Bourion-Bedes and colleagues (2013), the therapist's perception of alliance is not as pertinent as that of the client's. Although clinicians often feel empathy and concern for their client's welfare (Warren et al., 2012), the client's perception of care and support is more predictive of treatment outcomes.

Unfortunately, even with competent clinicians and motivated clients, many who seek eating disorder treatment, terminate services prior to completion of their program, or before recommended by their treatment provider (Grave et al., 2008). This termination may result from a change in client motivation, unresponsiveness to treatment, or a shift in client access to care (e.g., geographically and financially). Eating disorder treatment is expensive (Morris, Simpson, & Voy, 2015) and comparable to the treatment cost of schizophrenia (Simon, Schmidt, & Pilling, 2005). As with any medical condition in which extensive care is required, the cost of services has the potential to interrupt a client's path toward health.

Cost of Eating Disorder Treatment

One estimate in 2012 indicated that the annual cost of eating disorder treatment ranged somewhere between $1,288 and $8,042 for one individual (Stuhldreher et al., 2012). This study examined the scant literature that was available in an attempt to understand the average cost to clients. What they identified as particular challenges were client's variable access to insurance (and variable coverage in insurance policies), differentiations between eating disorder diagnoses, and the fact that most studies utilized different techniques to measure cost. Furthermore, while some researchers differentiated between disorders, there may have been a lack of clarity addressing: inpatient versus outpatient services, whether clients were prescribed medication, how many clients experienced comorbid diagnoses, and whether the cost range identified included expenses just associated with the eating disorder, or if the total included extraneous medical costs. Thus, the cost of treatment is difficult to estimate, but even at the lower ranges, it can be expensive when compared to other psychological disorders that benefit from short term therapy, or do not require medical observation.

According to Calderon and colleagues (2007), most people diagnosed with an eating disorder will be hospitalized at least once, and many clients are admitted to inpatient care multiple times. This increases the overall cost of care (long term) for the client, insurance companies, and anyone assisting with financial responsibilities. Moreover, due to the lower rate of men who seek and maintain treatment, the overall cost estimates are higher for women (Stuhldreher et al., 2012). In an Australian study that examined the financial cost of treatment (Gatt et al., 2014), researchers found that clients with a clinically diagnosed eating disorder spent greater than 10% of their income on illness related costs. This was qualified as *catastrophic* in terms of financial obligations. Furthermore, there has been some evidence that the financial cost varies between specific eating disorder diagnoses, and that BED may potentially require additional costs post care (due to elevated medical complications and the wider spectrum of symptoms; Bellows et al., 2015). Clearly, it is extremely difficult to definitively state the direct cost of eating disorder treatment due to a multitude of varying factors. However, the aforementioned studies predominantly only took into consideration *direct* costs.

When someone is diagnosed and treated for an eating disorder, particularly for those admitted into inpatient facilities, costs increase drastically to include additional financial and social expenses (Gatt et al., 2014). Some extra sacrifices include household responsibilities (e.g., bills, maintaining the home, the ability to complete daily chores), education (e.g., taking off semesters, not maintaining grades, physical/mental ability to attend to academics), employment (e.g., whether an employer is understanding, aware, or provides benefits; time away from work; physical ability to work), social (e.g., access to support networks while in treatment, stigma, shame), and familial (e.g., partnership stress, child rearing responsibilities, psychological support; Gatt et al., 2014). This understanding of additional indirect costs coincides with what

Meulen (1992) previously termed as burden of disease. Burden of disease highlighted the notion that quality-of-life post treatment, and the impact of treatment on one's wellbeing, should be taken into consideration on top of cost effectiveness. These are the added costs of being diagnosed with an eating disorder, and are in addition to direct financial treatment responsibilities.

Some researchers have suggested that the overall cost of treating an eating disorder, both financial and psychological, may contribute to the maintenance and rates of relapse of disordered eating behaviors (clinical and subclinical; Gatt et al., 2014). Negotiations with insurance companies regarding necessary care, and whether specialized treatment is required adds stress for clinicians, clients, and their families (Warren et al., 2012). Frequently the responsibility of advocating for, and fighting for, eating disorder coverage from insurance companies falls on the client (Escobar-Koch et. al., 2010). The range of services that are included varies extensively by insurance policy, but also by insurance providers (Anzai, Lindsey-Dudley, & Bidwell, 2002; Calderon et al., 2007).

In a study that examined client perceptions of eating disorder care, Escobar-Koch and colleagues (2010) found that clients' treatment was impacted by the variation in insurance coverage and inconsistent payment history (by insurance companies). Study participants stated that, "the extent of care they receive is often not determined by their health needs but rather by what their insurance companies are willing to cover;" (p. 557). This influence by non-service providers further contributes to the complexity of accessing proper care. Whether financial difficulties, perceived access, or the overall cost (direct and indirect), clients may be more inclined to terminate and re-initiate treatment based on availability of time and funds. Unfortunately, inconsistent treatment and premature termination often results in limited treatment success, relapse or maintained disordered behaviors, elevated potential for additional medical complications, and an overall increased financial and psychological burden (Gatt et al., 2014). As stated by Meulen (1992), “Mental illness is often seen as less important or less worthy of funding than physical illness which can be treated effectively by medicine, by way of surgery or medical drugs,” (p. 188). He further stated that even within mental illness, there exists a tendency to prioritize those disorders that are biologically-brain-based or medical in nature. This bias toward visible impairment and biology-based-disorders speaks to a larger cultural problem in which some people and illnesses, but not all, are considered valuable and worthy of assistance.

Cultural Context of Eating Disorder Etiology

Discrimination, privilege, access, and sexism are nothing new to the United States. If the epidemic of eating disorders is to be critically examined, the patriarchal society within which it breeds must also be scrutinized. The feminist movement, which officially began at the Seneca Falls Convention in 1848, began a national conversation about gender that continues to evolve and expand. The first wave, which predominantly occurred during the late 19th and early 20th centuries, focused on obtaining legal and political equality for middle-upper class white women. Then, from approximately the 1960s - 1990s, feminists began to focus on inclusivity and equality. From equality in the work place to equal reproductive rights, the main goal was equality between men and women. The third wave (1990s – arguably the present) focused on the multifaceted roles of power and privilege in various arenas including race and ethnicity, gender identity, and sexual orientation (Cole, 2009). Now, with global internet access, some argue that feminism has entered a fourth wave, where sexism and misogyny can be publicly called out with immediacy (Munro, n.d). Regardless of how the decade is defined, the history of feminism matters because it has consistently drawn attention to (and challenged) the patriarchal society in which the United States operates.

In an environment where males maintain a position of power and dominance, women, and all non-male gender identities, are left with the decision to either conform, perpetuate, or deny the existence of gender disparities. According to the World Health Organization in 2000, gender was a prominent determining factor in mental health, social position, and status. Further, gender influenced exposure to conditions that endangered psychological wellbeing, physical health, and stability. Currently there exists notable gender based discrepancies in health care (Read & Gorman, 2010), access to adequate medical coverage/insurance (Neisen, 2010), and in overall health (Hammell, 2011). The societal and psychological structures that perpetuate a gender disparity in terms of health have additional consequences with direct links to eating disorders.

As previously discussed, the prevalence of eating disorders has increased, not only in the United States, but also worldwide (Hesse-Biber et al., 2006; Smink et al., 2013). As noted by Maine and Bunnell (2010), a physical and biological shift has not swept the globe making people more genetically susceptible the development of eating disorders; however, Western standards of beauty and the thin ideal have. Cultures all over the world have more exposure now to the Western thin ideal than ever before, and the rates of disordered eating have followed. Researchers Jean Kilbourne and her colleagues have thoroughly documented the hyper-sexualization, dehumanization, and objectification of women and girls in mainstream media (Kilbourne, 2005). The documentaries *Killing Us Softly 4: Advertising's Image of Women* (Jhally & Kilbourne, 2010) and *Slim Hopes: Advertising and the Obsession with Thinness* (Kilbourne, 1995) highlighted the media's obsession with the female body. Movies depict thin princesses waiting to be rescued, and Barbie continues to represent the feminine ideal. Nations all around the world ascribe to this blonde-bombshell notion of beauty, with a particular preference for lighter skin (Franklin, 2013). Young children, particularly girls, play with Barbie, and like dolls, not realizing the potential impact the toy has on the internalization of beauty norms (Dittmar, Halliwell, & Ive, 2006). Mattel has consistently defended that the company in no way promotes unhealthy body image; they state that Barbie is merely a toy and that children playing with her understand the difference between fantasy and reality (Mosbergen, 2015). Unfortunately, it has been demonstrated that young children are very influenced by, identify with, and compare themselves against Barbie (Dittmar et al., 2006). Although impacts on body image and self-perception of young girls may not be the goal, it is an outcome.

The modeling industry, renowned for perpetuating unrealistic notions of thinness, has begun to take precautionary steps against promoting unhealthy standards. Spain, Italy, and Israel have implemented laws banning models that fall below an established BMI from participating in runway shows, and in some cases, print ads. France, noted as a fashion capital of the world joined this effort in April 2015. In France, it is illegal to hire models that fall below a BMI of 18. The movement to regulate models' weight in media has not gone without pushback. Some within the fashion industry have suggested that the rise in eating disorders has nothing to do with images in media, and that the push to regulate only discriminates against the thin (CNN, 2006). The United States has joined the international conversation, but there is no indication that any such laws or regulation will be enacted. Regardless of policy, it has been established that the consistent exposure to an unrealistic (and often unhealthy) thin ideal has links to disordered eating habits, eating disorders, and on average negatively impacts the mental health of women (Hesse-Biber, Leavy, Quinn, & Zoino, 2006).

Objectification Theory, as originally developed by Fredrickson and Roberts (1997) was developed to examine women's experiences of sexual objectification, and the impact that experience had on self-concept. They determined that perpetual exposure to objectifying experiences could result in women self-monitoring appearance, size (weight), and body image. At the time, Fredrickson and Roberts (1997) speculated that internalized objectification may correlate with elevated risk among women for depression, anxiety, and eating disorders. More recently, Tiggemann (2013) stated that there indeed exists *ample* support, both experimental and correlational, linking self-objectification and eating disorders. Slater and Tiggemann in 2015 found that the amount of media consumed by adolescent females was positively correlated with self-objectification, which has been linked to self-monitoring behaviors including disordered eating habits and body shame. They went further to explore the impact of appearance-based-comments on women's self-objectification. Results suggested that not only did negative-appearance-based-comments (such as insults) have repercussion, but that positive appearance comments (or compliments) had a slightly higher impact, resulting in elevated levels of self-objectification. This research provided additional support for contextual consideration when conceptualizing the formation and perpetuation of eating disorders. Through a feminist lens, no disorder can be examined within a vacuum; eating disorders are no exception. The patriarchy and distorted cultural expectations must be part of examining the development, maintenance, and impact of eating disorders (Hutchinson, 1994; Malson, 2009).

The Politics of Resource Allotment

In the United States health care has emerged as a controversial issue. There has been concern about the rising costs of health care, the government's role in providing health care, health care as a business (e.g., managed care), and outcome disparities influenced by income, gender, and race/ethnicity. Unlike Canada's socialized health care policies, the United States operates as a capitalistic business (through insurance and drug companies) with input from federal (Medicaid) and state insurance programs. Therefore, access to coverage, treatments, and preventative care varies greatly, and is often determined by social economic status (Green, Kerstetter, & Nylander, 2008). The United States does not provide universal health care, and many without financial stability go without insurance; therefore, insurance and medical coverage at any level is a privilege. Consequently, treatment often becomes a commodity rather than a basic human right. By definition, commodities are scarce, have value, and people compete for them (Fromkin, Olseon, Dipboye, & Barnaby, 1971). Thus, scarcity in the US healthcare system is a byproduct of capitalism where the cost of treatment is often subject to free market processes and greed.

For example, in mid-2015, a pharmaceutical company bought the rights to a drug used predominantly by AIDS patients that had been in production for over 60 years. Upon acquiring the rights, the CEO, Martin Shkreli, decided to increase the price of the drug from reportedly around $13.50 to $750; a 5,000% increase (Thomas & Swift, 2015). And although he reportedly claimed the cost would be lowered due to public outrage, the price increase remained (Ramsey, 2015). When companies are permitted to vary the cost of crucial medications in the name of profit, there is a clear message implied that monetary gains outweigh a nation's consistent access to healthcare. As previously stated, access to insurance is a luxury many cannot afford; with insurance companies determining treatment plans, and pharmaceutical companies aimed at profiting off the sick, individuals are left to advocate for themselves. These efforts require knowledge of how the system works, and contribute to the implicit cost of illness and the psychological burden of disease (Meulen, 1992).

Since healthcare is not universal in the US, scarcity is artificially created as a byproduct of capitalism. In contrast, true scarcity occurs in time of crisis, like a flu epidemic or natural disaster, such as hurricane Harvey or Irma in 2017. In those instances, health care was prioritized and rationed due to the inability of health care providers to meet the needs of everyone, out of sheer demand. From times of war and such crises emerged the concept of triage; the determination of what types of injuries, or circumstances required immediate intervention, and at what level (Sarmiento, Eckstein, & Zambon, 2013). When advocating for eating disorder coverage, early stages of the disorder may not receive the same consideration for care as compared with later stages and more severe consequences necessitating hospitalization. Subsequently, non-medical providers have influence over how eating disorder coverage is dispersed (triaged), which has undeniable influence over the ability to access necessary treatment (Escobar-Koch et al., 2010).

Aside from severity, bias (e.g., racism, sexism, and homophobia) frequently impacts the decision-making process about who receives treatment, and which types of treatment are offered. For example, Quach and colleagues (2012) found that patients experienced discrepancies between perceived discrimination and the level of care provided by medical practitioners. Yet to have accessible treatment, one must first be insured. As noted, health insurance is a privilege in the United States, and when it comes to medical coverage, men of color are the least likely to be insured (Satcher, 2003). This was speculated to be result of numerous facets, including access to higher paying jobs, lack of insurance for part-time-work, and institutional discrimination. The power to decide who has access to care and those implementing policy are often men in positions of power and privilege. Not all policy is detrimental nor all men ill-intentioned. However, it is necessary to reflect on the context that exists in a culture that encourages unhealthy ideals and then limits access to care. Female bodies, health care access, racial disparities in treatment, power, and privilege all play a role in the political tapestry of the US. As noted by Brown (2010), part of engaging with society through a feminist lens is to acknowledge that the personal is political, and that at a fundamental level power and privilege exist.

Resource Allocation

Ideally, practitioners and health providers aim to help and not hurt clients. Autonomy, non-maleficence, beneficence, and justice are the basic principles of biomedical ethics (Christen, Ineichen, & Tanner, 2014). The American Psychological Association (2017) further includes fidelity and responsibility, integrity, and respect for people's rights and dignity to their ethics code. However, as indicated by Christen and colleagues (2014), the social context within which those principles are applied matters. They found that the perceived morality of values and principles were influenced by various settings and social domains. Furthermore, they noted a particular interaction between the domains of medicine and business (or finances). This suggested that within health care, the ethical decision is not immune from the influence of money or corporate interests.

Despite ethical codes or business policy, individual people (or teams of people) ultimately determine the allocation of resources whether medical or otherwise. Just as various contexts influenced the perception of ethics (Christen et al., 2014), the role and position of the individuals with the power to make decisions also matters. The ultimate goal of an insurance broker may be to save money, distribute as few funds as possible, and reimburse only those evidence based treatments which reflect the client's particular diagnosis. Conversely, a clinician may advocate for distributing funds as necessary based purely on the client's particular need for care.

Regardless of position (e.g., insurance company, CEO, clinician), one must evaluate the relative priority of preventative services versus treatment when determining the distribution of resources. Various decision-making models reflect how an individual or organization implements that choice. Some models negate contextual considerations and operate based on the principle of first-come-first-served. Others prioritize a specific construct to determine allocation, such as: the anticipated outcome of treatment (Butler, 1999), the perceived burden of disease (including the direct and indirect cost of care; Meulen, 1992), or the selection of one population to receive resources while withholding from another (Tilburt & Cassel, 2013). Utilitarian approaches would dictate that decisions be based on the greatest outcome for the greatest number. And yet, egalitarian approaches would suggest that the most severe be given priority (Meulen, 1992). However, the definition of severity remains somewhat subjective, particularly for eating disorders.

Numerous confounding variables intersect to further complicate the understanding of severity. Significantly low or high BMI, familial support, duration of illness, former treatment history, and age contribute to severity differently based on the individual client. And although most service providers reject age considerations when determining the allocation of resources, quality of life after treatment is an imperative part of the conversation (Meulen, 1992). In circumstances with limited resources, Callahan (1987) found overwhelming support for prioritizing quality of life post treatment over the prolonging of life. Regardless of which triage methods are utilized (first-come-first-served, burden of disease, rationing, utilitarian models, or egalitarian models), each have varying effectiveness over the long term. Therefore, practical and ethical debates over limited resource allotment continue (Cao & Huang, 2012). Doctors, clinicians, insurance companies and government agencies that allocate funds or resources often make decisions based on both clinical and contextual information. By mechanizing decision-making policies in a clear and transparent manner, organizations demonstrate the ability to be consistent and intentional in fund allocation (Griffin, Claxton, & Schuphler, 2008). Specifically, for those organizations that rely on donations or grants, consistency and detailed methodology is vital. The practice of documenting and demonstrating effectiveness is referred to as Evidence Based Decision Making (EBDM; Sosnowy, Weiss, Maylahn, Pirani, & Katagiri, 2013). The use of standardized or objective means for gathering information further enhances the ability to analyze efforts and demonstrate EBDM.

For those seeking eating disorder treatment, clients may be requested to fill out various objective, validated, and culturally appropriate assessments documenting their particular experience. Information frequently gathered may include: past medical history, family history, financial stability, and overall lifestyle (e.g., work, academics, leisure). The use of validated measures assists in documentation of the decision-making process and provides justification for the final disposition. Standardized means of gathering information provide consistency and ease for data analysis. Furthermore, it offers valuable information for providers to ensure that clients receive a proper diagnosis, the most appropriate treatments or interventions, and enhances the opportunity to provide the least restrictive treatment available (saving both time and money). Yet, objective measures only provide a snapshot of a client's lived experience.

A clinician's expertise provides some additional guidance when the available data fails to suggest a certain form of treatment. Less informal and more interactive means of data collection help obtain supplemental information that may not be captured in objective measures and provide a more well-rounded perception of the client. Those clinicians that provide care often integrate information collected through objective means along with more narrative data to formulate decisions in the client's best interest. According to a study conducted by Butler, Guiso, and Jappelli (2014), those who made decisions based on intuition and expertise operated with confidence, particularly when faced with ambiguity and risk. This enhanced one's ability to deal with complex circumstances when outcomes were somewhat unpredictable, much like they are when working with eating disorders. The combination of experience, intuition, and bias of those with decision making abilities has a strong influence on the outcome of the final decision (Hertwig, 2012).

As previously noted, EBDM procedures and documentation are vital in organizations that receive funding or support from grants, government agencies, or public donations. Even so, EBDM strategies are often underutilized or inconsistently applied (Sosnowy et al., 2013). Due to a potential lack of resources, appropriate programing, data, man power, and/or availability (among other things), the consistent use of EBDM models varies. For institutions that work with eating disorders, operating from a strict evidence based model may be increasingly difficult because of each disorders' complexity. As a result, objective measures, professional experience, bias, and intuition collide to determine the most informed decision available, recognizing that all decisions inherently involve some level of risk (Hertwig, 2012).

Even with ample data, ethical considerations may directly influence how resources are divided up among clients. As previously discussed, organizations must determine how to prioritize care and whether preventative treatment outweighs severe need. In the case of eating disorders, clients may exhibit extreme severity in which they could potentially develop additional medical complications, or die, without immediate proper services or care. On the other hand, a client may present with early stages of an eating disorder that could easily worsen without proper interventions and become increasingly severe (necessitating higher levels of care), but the client would likely survive without immediate services. There is a full spectrum of risk and the obligation of an organization is to clearly determine the overall goal and purpose of allocating any resources at all.

Angels of Care: A Scholarship Non-profit

In 2007, a small group of clinicians who worked with eating disorder clients identified monetary resources as a significant barrier to accessing care. They came together and founded a non-profit organization in the Southeastern United States in order to address this overwhelming need. AoC provides a financial scholarship for select individuals to attend inpatient eating disorder treatment. They provide direct payment to inpatient and residential service providers to cover the exponential cost of specified eating disorder care. Their mission is to assist individuals with severe eating disorders by alleviating psychological distress and financial obligations. Those seeking financial assistance apply for the scholarship online. Although there are certain criteria the organization looks for, all ages, genders, and eating disorder subtypes are encouraged to apply. By easing financial burdens on individuals and their families, those in care can more effectively focus on healing and recovery.

As the cost of treatment can range from a few hundred dollars to hundreds of thousands of dollars (depending on services needed), AoC became skillful in fundraising. Through individual donations, grants, corporate sponsorships, and fundraising events, the nonprofit organization has raised over $1,500,000 to date since its inception. They have been able to place 101 individuals into various levels of intensive care (e.g., partial hospitalization, intensive outpatient, inpatient), and have received over 1,000 applications since starting in June of 2007. Dissemination of scholarships and the amount of financial support are based on funds available at the time; however, the organization is dedicated to supporting individuals throughout their treatment as much as possible.

Those seeking financial assistance complete an online application providing information on: personal history, past treatment, specific disordered eating behaviors, and other pieces of information that contribute to a well-rounded picture of the applicant. Once applications are submitted, a committee, comprised of licensed clinicians specializing in eating disorders, evaluate and review all applicants for that financial quarter. The committee then makes recommendations to an executive board regarding which applications should be further evaluated. The executive board re-examine the selected applications, administer additional measures, and conduct a semi-structured interview before ultimately determining scholarship recipients and the amount of the financial award. Resources are then provided to the scholarship recipients to begin their treatment.

CHAPTER THREE

METHODS AND PROCEDURES

Purpose of the Current Study

The purpose of this study was to identify whether AOC's funding allocation decisions were based on the three validated measures included in their application. Many of the measures utilized in the application were self-constructed by AoC; three validated measures were used to analyze family relations, experiences in close relationships, and personal motivation. Although the first round of applications did not include a validated eating disorder measure, applicants did report their height (in feet and inches) and weight range (in 10-pound increments). This was used to calculate a body mass index (BMI) range for each applicant. As previously discussed, eating disorders often correlate with additional medical complications; those individuals who classified as underweight are often at a higher medical risk. Although information was gathered indicating applicant's disordered eating behaviors at the time of submission (e.g., restricting, binging, purging, over exercising, and laxative use), the frequency and duration (whether engaged in for two weeks or two years) was not available for most applicants. Therefore, to gauge some level of severity that would necessitate inpatient treatment or higher levels of care, the BMI range for each applicant was included for analyses.

Three potential decision-making models were constructed based on the three validated measures and BMI range. The models represented an Egalitarian Model (the most severe on all levels), a Least Severe Model (the least severe on all levels), and a Blended Model (which included aspects of support while necessitating/suggesting a need for medical care). From those three models, the respective top 5% of applicants were identified. After hypothetical recipients were determined by each of the three potential models, information on the actual two recipients was obtained from AoC. The correlation, or lack thereof, between hypothetical and actual recipients identified which decision-making model, if any, was supported through the data. This further informed the organization of whether decisions were based on the data collected through validated measures. Based on the outcomes, recommendations were provided to AoC regarding the potential for enhanced data collection and decision-making procedures.

Methods

The data examined for this study was collected by and through AoC; before the researcher was given access to any applicant data, all identifying information was removed. No additional data was collected during the study, and the researcher did not have influence over how data was collected. In addition, the researcher was not provided with information on which applicants received financial scholarships prior to the conclusion of this study. This was to prevent bias in the examination of decision-making procedures.

Although AoC had received over 500 applications at the time of this study, the application procedure, data collected, and online format limited the number of applications included for analysis. Only those applications that coincided with the current format (online portal) were included for this study to ensure consistency and data availability. Therefore, the final applications examined were submitted between January 7th and November 28th of 2014 through AoC's website. Prior to obtaining any data, approval was granted by The University of Georgia's Institutional Review Board (IRB).

Participants

Applicants were individuals who experienced a severe form of an eating disorder and desired, if not necessitated, inpatient treatment or higher levels of care. Individuals applied to be considered for financial assistance, specifically for admission to an inpatient eating disorder facility. Therefore, applicants were not recruited, but applied based on individual need. There were no restrictions based on eating disorder diagnosis (AN, BN, BED, and Eating Disorder Other Specified/Unspecified) or diagnostic manual criteria (DSM-IV, DSM-5). The application was available online and comprised of four sections; applicants were required to complete an entire unit before moving on to the next section. In order to apply, applicants required access to a computer and the internet. They also provided contact information (for AoC use only), and signed a waiver granting permission for their data to be utilized in research.

For this study, there were initially 84 applications. Two individuals skipped more than half of various measures, and thus were removed from the data set. Another applicant submitted two applications, neither of which was fully complete; both partial applications from this one applicant were removed from the data set. Additionally, eight individuals submitted applications twice. Six of those eight applicants started an application, stopped, and then later submitted a full application. Only the full applications were considered complete and included in analyses; the partial applications were removed from the data set (6 partial applications were removed). Finally, the last two applicants (of the eight) fully completed and submitted two separate applications- six months apart and were retained for analyses. Due to the policies set forth by AoC at the time, those applicants not selected for a scholarship remained in the pool for six months, after which they were removed from the pool. If applicants desired, they could submit another application to be considered during the next quarter. Therefore, individuals could have submitted up to 2 applications over a 12-month period. In all, ten incomplete applications were removed, resulting in 74 complete applications.

Of the 74 included applications, 3 applicants self-identified as male (4%) and 71 as female (96%). Regarding racial and ethnic identity, applicants were permitted to mark all relative descriptors. Applicants self-identified their racial and ethnic identity as follows: White-Non-Hispanic (*n*=67; 90.5%), Black or African American (*n*=2; 2.7%), and all other categories were endorsed by 1 (1.4%) applicant respectively (Hispanic; Native Hawaiian or Other Pacific Islander and White-Non-Hispanic; Black or African American and Hispanic; Hispanic and White-Non-Hispanic; and Other). The age of applicants ranged from 9-and-under to 49 years old; 7 applicants were under the age of 18. The mean age was 26.45 years with a standard deviation of 8.5; there was one applicant who indicated that they were 9-years-old or younger without an exact age provided. As previously indicated, data was obtained through AoC's online application portal; therefore, all data was collected prior to the design of the study without researcher influence. Before completing any section of the application, individuals provided consent for their personal information to be utilized in research; for those under the age of 18, a parent or guardian indicated their informed consent for use of data and information obtained. There was no contact between applicants and the author of this study.

Measures

The full application consisted of four sections which inquired about a variety of topics related to an applicant's disordered eating. Much of the application was comprised of measures specifically designed by AoC. Among the self-designed instruments, the organization also utilized three validated measures: Experiences in Close Relationships- Revised Questionnaire (ECR-R; Fraley et al., 2000), Family Adaptability and Cohesion Evaluation Scales IV (FACES-

IV; Olson, 2011), and the University Rhode Island Change Assessment Scale (URICA; McConnaughy et al., 1983). Other information was requested through qualitative-open-response prompts. Due to the varied nature of information provided by applicants, only completed validated measures were analyzed in the determination of potential scholarship recipients.

Eating disorder severity

Applicants answered numerous questions regarding their personal experiences with an eating disorder. However, much of the information was provided qualitatively and the amount of detail gathered from each applicant varied. Applicants did, however, provide their height and indicated a weight range, which could then be calculated into a range for BMI. The equation for calculating BMI was: [(weight in pounds) / (height in inches)^2] x 703. A BMI below 18.5 was considered underweight, between 18.5-24.9 constituted a healthy BMI, 25-29.9 was classified as overweight, and a BMI of 30 or greater was qualified as obese according to the Center for Disease Control and Prevention (CDC; 2017). Although BMI did not provide an in-depth history of each applicant's disordered eating experience, it did provide some insight into whether an applicant would benefit from medical observation or necessitate inpatient services. AoC also stated that it was one factor in their consideration of an applicant's severity.

Experiences in Close Relationships - Revised Questionnaire (ECR-R)

The Experiences in Close Relationships- Revised Questionnaire (ECR-R) was developed by Fraley, Waller, and Brennan in 2000, and was based on the original Experiences in Close Relationships Questionnaire (ECR) by Brennan, Clark, and Shaver in 1998. It was designed to identify individual differences in regard to attachment-related anxiety and attachment-related avoidance in adult romantic relationships (2000). According to Fraley and Shaver (2000), anxiety was described as, "vigilance concerning rejection and abandonment," and avoidance referred to, “discomfort with closeness and dependency or reluctance to be intimate with others” (p. 142-143). The ECR-R was comprised of 36 self-report questions on a 7-point Likert scale (1=*Strongly Disagree*; 2=*Disagree*; 3=*Slightly Disagree*; 4=*Neutral*; 5=*Slightly Agree*; 6=*Agree*; 7=*Strongly Agree*). Analyses provided researchers with two scores, an average Anxiety score and an average Avoidance score. Fraley and Shaver stressed that an individual’s attachment style was not a categorical factor, and should be considered a continuous dimension. For the purposes of this study, analyses rank ordered applicants on how they scored from the most anxious and most avoidant to the least. This eliminated placement of individuals into categories, and simply ordered applicants from more to less anxious and avoidant respectively. The ECR-R had demonstrated high reliability and stable estimates of trait attachment over time (Sibley & Liu, 2004; Ravitz, Maunder, Hunter, Sthankiya, & Lancee, 2010) in addition to good convergent and discriminant validity (Sibley, Fischer, & Liu, 2005).

Family Adaptability and Cohesion Evaluation Scale IV (FACES-IV)

The FACES-IV was a measure designed to evaluate family cohesion and flexibility dimensions from the Circumplex Model of Marital and Family Systems (Olson, 2000). The self-report measure was comprised of six scales: two scales which assessed balanced regions of the Circumplex Model (Balanced Cohesion and Balanced Flexibility), and four unbalanced scales which examined extreme low and high levels of the Cohesion Dimension (Disengaged and Enmeshed) and Flexibility Dimension (Rigid and Chaotic). The measure included a scale for family communication and family satisfaction for a total of 62 items. Each item was rated on a 5-point Likert scale (1=*Strongly Disagree*; 2=*Disagree*; 3=*Neutral*; 4=*Agree*; 5=*Strongly Agree*) and entered into a scoring system provided. Because the measure included numerous facets for understanding an individual’s experience, a Total Ratio score was also calculated. This score was specifically used for research purposes, and was intended to summarize the overall familial balance. The Total Ratio score was calculated by dividing the average of the balanced scales (Cohesion and Flexibility) by the average of the four unbalanced scales (Disengaged, Enmeshed, Rigid, and Chaotic; Olson, 2011). The FACES-IV had been used in a variety of populations, but had been sparingly utilized within eating disorder research. Fisher and Bushlow (2015) argued that the eating disorder community had been presumed to more often include families that were either enmeshed or dysfunctional; they proposed researchers challenge this assumption.

The FACES-IV psychometric properties were examined in a validation study conducted by Franklin, Streeter, and Springer (2001). They reported alpha levels for each of the six subscales that ranged between .77 and .89; the FACES-IV also demonstrated to have good content validity when compared with other family relational measures such as The Family Satisfaction scale (Olson & Wilson, 1983), the Family Communication scale (Barnes & Olsen, 1989), and the Self-Report Family Inventory (Hampson, Hulgus, & Beavers, 1991). After conducting a literature review, Hamilton and Carr (2016) determined that the FACES-IV was both reliable and valid for use in determining levels of family functionality and balance within a variety of populations.

University Rhode Island Change Assessment Scale (URICA)

The URICA was developed to assess an individual’s readiness for change and was formerly known as the Stages of Change (McConnaughy et al., 1983). The measure evaluated a person’s readiness to change a problem (left vague to be interpreted by the participant) and placed them in one of four categories (Precontemplation, Contemplation, Preparation/Action, and Maintenance). It contains 32 items on a 5-point Likert scale (1=*Strongly Disagree*; 2=*Disagree*; 3=*Neutral*; 4=*Agree*; 5=*Strongly Agree*); eight items loaded onto each category

(Precontemplation, Contemplation, Preparation/Action, and Maintenance). Results provide categorical averages, and a Total Readiness for Change score. The URICA had been used to assess individual's readiness for change with a variety of topics, including: alcohol (Hunt, Kyle, Coffey, Stasiewicz, & Schumacher, 2006; Penburthy et al., 2007), smoking behaviors (Stephens, Cellucci, & Gregory, 2004; Russo & Azevedo, 2010), and medical/ health behaviors (Lacey & Street, 2017). It had also been utilized to aid in the development of the Eating Disorder Recovery Self-Efficacy Questionnaire (Marinilli Pinto, Guarda, Heinberg, & DiClemnete, 2006). In order to obtain more specified information, some researchers modified the wording of the URICA to reflect specific behaviors. For example, when evaluating individual's readiness to change binge eating and compensatory behaviors, Dunn, Neighbors, and Larimer (2003) inserted the terms "eating behaviors," "binge eating," and "compensatory behaviors" into various questions to be more relevant for the sample population. For their sample, internal consistency ranged from .62 to .90 across the four subscales. In an overall study of the URICA's psychometric properties with an anxiety population, Dozois and his colleagues (2004) determined that both reliability and validity were supported as acceptable, with moderate goodness of fit within the subscales. They also reported that within their study, the URICA was useful in predicting treatment retention, and moderately effective in predicting treatment outcomes.

Hypothetical Selection of Scholarship Recipients

It is beneficial for organizations to demonstrate a clear and consistent procedure for making decisions, particularly regarding the allocation of scarce resources (Sosnowy et al., 2013). This procedure ensures consistency across time and helped demonstrate to donors that AoC followed through with their commitments. Additionally, understanding the variables that contributed to decisions could further enhance awareness of bias, influence of scientific research, and/or whether outcomes aligned with the non-profit's mission. At the time of this study, AoC did not have an established decision-making model in place; however, there were goals and values stated which reportedly guided their intent and process. Therefore, one purpose of this study was to contribute to the organization's knowledge of how they operated. AoC stated that they intend to assist individuals who were willing to make changes, who were in great need of eating disorder treatment, and who had the support of friends and/ or family throughout the treatment process.

Three simple hypothetical decision-making models were developed (outlined below) based on the validated measured included in the application. Data was then analyzed to identify the top 5% of applicants within each model that could have hypothetically received scholarship funding. Hypothetical-funding-recipients were then compared to those applicants that were actually selected.

The three validated measures included in the application assessed attachment styles (ECR-R), family cohesion and balance (FACES-IV), and motivation to make a change (URICA). It was speculated that those individuals who operated from a healthy attachment, and had low levels of anxiety and avoidance, were in the best position to address their disordered eating behaviors. Various treatments for eating disorders include open conversation about the client's relationships to other people and food. The ability to connect and depend on support networks through healthy attachment, may have contributed to higher levels of treatment success. Similarly, those with more effective support systems and families were anticipated to be more successful over the course of inpatient treatment. Finally, the assessment for an individual's willingness to change directly implied how cooperative the applicant may be while engaging with higher levels of care. However, due to the need for financial assistance, and the scarcity of resources, an applicant’s reported motivation to change may have been inflated to appear more attractive. This is further addressed in the study’s limitations.

Based on the validated measures available, three potential decision-making models were used to hypothetically select respective funding recipients. Those models were: Egalitarian (most severe on all measures with BMI’s in the underweight range); Least Severe (on all three measures and healthy BMI range); and a Blended Model (those applicants with less severity and underweight BMI) as seen in Figure 1. Details of each model follow:

- Egalitarian Model: anticipated that scholarship recipients experienced higher levels of anxiety and avoidance (as indicated by the ECR-R), a low Total Ratio score representing low levels of overall family balance (as indicated by the FACES-IV), a low readiness for change score (as indicated by the URICA), and a BMI range qualified as underweight by the CDC (calculated as 18.5 or below).
- Least Severe Model: anticipated that scholarship recipients experienced low levels of anxiety and avoidance (as indicated by the ECR-R), high Total Ratio scores suggesting more functional family balance (as indicated by the FACES-IV), a high readiness for change score (as indicated the URICA), and a BMI range deemed healthy by the CDC (calculated as between 18.5-24.9).
- Blended Model: this model anticipated applicants to have experienced low levels of anxiety and avoidance (as indicated by the ECR-R), high Total Ratio scores on family balance suggesting more functional family balance (as indicated by the FACES-IV), a high readiness for change score (as indicated by the URICA), and a BMI qualified as underweight according to the CDC (calculated as at or below 18.5), indicating a potential elevation in severity and need for inpatient treatment.

Applicants were scored respectively on all measures. To identify which applicants were considered most severe, least severe, and which may best benefit from inpatient treatment, all scores were individually ranked. For example, for motivation, applicants' scores on the URICA were rank ordered from most motivated to least motivated. Therefore, those with the highest motivation were assigned a low-ranking score (a rank score of 1 would indicate the highest level of motivation within the sample). This was done independently for each of the three validated measures. A Total Rank score was then calculated for each applicant. Because the ECR-R derived both an Anxiety score and Avoidance score, both were rank ordered and included in the Total Rank score. As a result, applicants received a rank score based on: ECR-R Anxiety (least anxious= 1 to most anxious= >1), ECR-R Avoidance (least avoidant= 1 to most avoidant= >1), FACES-IV Total Ratio (most family balance= 1 to least family balance= >1), and the URICA Readiness for Change score (most motivated= 1 to least motivated= >1). In the end, the applicant with the lowest Total Rank score was considered likely to benefit from inpatient treatment, both medically, emotionally, and psychologically.

It was possible for multiple applicants to derive the same score on any one measure; when this occurred, each applicant received the same rank score. For example, four applicants received a Readiness for Change score of 11 on the URICA, therefore all four applicants received a URICA rank score of 18. When computing each applicant's Total Rank score, the BMI was not included. Because the value or interpretation of BMI operated on a normal curve, both extremes (low and high) indicated negative health implications. Therefore, BMI was not included to prevent a skewed perception of applicants. It was taken into consideration post Total Rank score.

BMI operated as an indicator for applicant eating disorder severity. Again, BMI did not alone signify whether someone would benefit from inpatient treatment. However, due to the lack of data consistency amongst applicants, BMI was the only constant measure which implied severity and the potential need for medical observation. BMI ranges were calculated based on applicants reported height (in feet and inches) and weight range. Applicants selected a weight range from a drop down menu which were noted in 10 pound increments. BMI ranges were then rank ordered to identify those that fell within underweight, healthy weight, overweight, and obese categories as defined by the CDC (2017). Therefore, the BMI included for analysis was individually calculated for each applicant based on the information they provided. Due to the self-report format for both height and weight, there may have been inaccuracies in reporting. In context, applicants were applying for financial assistance in order to receive inpatient treatment for an eating disorder. Therefore, there may have been some social desirability effect (Ambwani & Chmielewski, 2013) or motivation on behalf of applicants to appear in greater need of treatment.

Composite rankings were used to then identify the top 5% of applicants within each model based on an applicant's Total Rank and BMI range. These respective 5% of applicants represented the most likely hypothetical recipients of financial assistance if decisions were made solely on the three validated measures and BMI. Two applicants actually received funding from AoC. The candidate pool for this study was based on those who completed all validated measures without narrative data considered for analysis. AoC had all data available when the board selected scholarship recipients. Therefore, those removed from analyses for this study were still considered by AoC.

Egalitarian Model (most severe)	Low FACES IV	High ECR-R	Low URICA	Low BMI
Least Severe	High FACES IV	Low ECR-R	High URICA	Healthy BMI
Blended Model	High FACES IV	Low ECR-R	High URICA	Low BMI

Figure 1. Three hypothetical decision-making models based on included validated measures and body mass index (BMI). FACES-IV= Family Adaptability and Cohesion Evaluation Scale IV. ECR-R= Experiences in Close Relationships- Revised Questionnaire (Avoidance and Anxiety). URICA= University Rhode Island Change Assessment.

CHAPTER FOUR

RESULTS

Body Mass Index (BMI)

BMI was calculated using the reported height (in feet and inches) and weight (in 10-pounds increments) of each applicant. The equation for calculating BMI was [(weight in pounds) / (height in inches)^2] x 703. Sixty-seven applicants reported their height and weight as instructed. Three applicants did not report their height appropriately (the format was open response with a prompt for applicants to enter their height in feet and separately for inches) or chose to leave the question blank. Four additional applicants did not report their weight range; weight was reported using a drop down menu with ranges consisting of ten-pound increments. As a result, BMI was calculated as a range. According to the CDC (2017), BMI was categorized as follows: below 18.5 qualified as underweight, 18.5-24.9 constituted a healthy range, 25-29.9 qualified as overweight, and those that fell at 30 or higher were termed obese. All BMI ranges were rank ordered from low to high and considered separate from applicant's Total Rank score.

Experiences in Close Relationships- Revised Questionnaire (ECR-R)

There were four individuals who left one answer blank, and two individuals who did not answer two questions. These missing scores were accounted for using the item's mean score as per recommendation (Parent, 2013). The reliability of the scale was calculated for only those applications completed in their entirety; thus 68 complete applications resulted in a Chronbach's Alpha (α) of .947. When broken down by subscales, relationship Avoidance resulted in α= .943, and relationship Anxiety measured reliability at α = .928. Reliability for this sample surpassed that of Tasca and their colleagues (2017) in their evaluation of the ECR-R with eating disorder populations. Their reliability measured at α = 0.86 for both Anxiety and Avoidance subscales, as Koskina and Giovazolias (2010) found α = .88 and 0.86 respectively for their sample. The overall mean within this sample for Avoidance was 4.44 with a standard deviation of 0.16; applicant's Avoidance scores ranged from 1.00-6.72. The mean for overall Anxiety was 4.55 with a standard deviation of 1.32, and applicant's Anxiety scores ranged from 1.28-6.61.

Family Adaptability and Cohesion Evaluation Scale IV (FACES-IV)

All applicants completed the FACES-IV scale in its entirety for a total *N*= 74. Measure reliability resulted in Chronebach's α= .82 which was congruent with other studies that examined eating disorders and familial relations (Cerniglia et al., 2017; Tafà et al., 2017). The mean Total Ratio score for applicants was 1.55, with a standard deviation of 1.10, and scores ranged from .28-5.71. As previously noted, those individuals with Total Ratio scores below 1 were qualified as perceiving low family balance and cohesion; those with scores exceeding 1 were qualified as perceiving healthier family balance and cohesion. The higher the Total Ratio score, the more perceived family balance and higher levels of presumed relational health.

University Rhode Island Change Assessment Scale (URICA)

All applicants filled out the URICA in its entirety for a total of *N*=74. Reliability was calculated at a Chronbach's α= .76. Reliability was slightly higher than that found by Hasler, and his colleagues (2004) who specifically examined the URICA's psychometrics with eating disorder patients; however, their Chronbach's α= .73 was close and demonstrated some consistency within eating disordered populations. The mean Readiness for Change Score within the sample was 11.19 with a standard deviation of 0.18, and ranged from 6.14-14.00. According to the URICA, scores lower than 8 qualified as Precontemplation, scores 8-11 were

Contemplation, and those scores that fell in the range of 11-14 were qualified as Preparation or Action Stages. Therefore, the sample expressed motivation to change across all domains with average scores in the Preparation or Action stage. Again, the version of the URICA within this study was not altered to include eating disorder language; it utilized the original language which assessed motivation for a general change.

The Ranking Process

All applicants were scored according to each assessment's protocol. Applicants were then ranked respectively, within each assessment, from positions of advantage for inpatient treatment to less advantageous (a rank of 1 would be most advantageous for treatment; as the rank number increased, the applicant was considered less prepared for inpatient treatment). Therefore, applicants with the highest rank represent those individuals who may have been positioned to best take advantage of inpatient treatment. Applicants were ranked on the ECR-R for both Avoidance and Anxiety, the FACES-IV using applicant's Total Ratio Score, and on the URICA using applicant's Readiness for Change score. BMI was not taken into consideration during this ranking procedure. Each applicant's individual assessment ranks were then totaled to compute a Total Rank Score. This Total Rank score was used to obtain an overall picture of which applicants were in preferred positions for inpatient treatment.

As noted previously, the aim of the study was to understand the role of the three validated measures in the AoC's decision-making process. Three potential decision-making models represented various ways the AoC could take that data into account. An Egalitarian Model in which applicants scored high on relationship Avoidance and Anxiety, low on family cohesion, low motivationally, and with a BMI classified as underweight. The top 5% of applicants that fit this model were identified in Table 1. The second potential decision-making model was a Least

Severe model in which applicants scored low on relationship Avoidance and Anxiety, high on family cohesion, high motivationally, and fell within a BMI range qualified as healthy. The top 5% of applicants that fit this model were identified in Table 2. The final potential decision-making model, and that which was intended by AoC, was a Blended Model. This again highlighted those applicants with low relationship Avoidance and Anxiety, high family cohesion, high levels of motivation, and fell within a BMI range that was classified as underweight. The top 5% of applicants who fit this model were identified in Table 3. Based on the expressed intentions of AoC, the Blended Model would have contained the actual funding recipients.

Outcomes

AoC provided funding for two applicants to receive inpatient eating disorder treatment from those that submitted an application within the timeframe of this study. AoC aimed to operate from a Blended Model perspective in which they identified applicants who were medically in need of inpatient treatment, due to a severe eating disorder, but possessed other qualities that would benefit them throughout the course of treatment (e.g., family support, high levels of motivation, etc.). The hypothetical funding recipients identified within each model did not correlate with any of the actual funding recipients. None of the potential decision-making models based on the included validated measures accurately predicted those applicants selected by AoC.

The two individual's that actually received funding were applicant number 3098868729 and 3016754940003. The first applicant had been removed from analyses all together in the early stages of this study. The applicant did not have information provided for the URICA, and was removed from consideration due to incomplete data. Although the applicant did not complete this measure, they did complete much of the additional open-ended questions. This suggested that the reminder of their application contributed greatly to the board's decision on resource allocation with that particular applicant. The second recipient, applicant number 3016754940003, was ranked number 30 out of 74 total applicants. They had a BMI range of 23.5-25.0 (qualified as healthy according to the CDC, 2017), an ECR-R Anxiety score of 2.89, ECR-R Avoidance score of 2.44, URICA Readiness for Change score of 8.29, and a FACES-IV Total Ratio score of 0.81. This particular applicant fell below the sample mean on all validated measures. Thus, this applicant reported lower levels of Anxiety and Avoidance, lower levels of readiness for change, and lower levels of family cohesion when compared with the averages reported by other applicants.

This further suggested that the three validated measures examined above did not dictate the current decision-making model employed by AoC. One of the two recipients did not fully complete the application, which removed them from consideration under the constraints of this study. However, it did not remove them from the AoC's applicant pool and they were found worthy of financial assistance. Therefore, based on the current findings, the data collected through alternative means (e.g., open ended questions, interviews, recommendations, etc.) made a greater contribution to the decision-making process than validated measures alone.

The outcomes of this study indicated that AoC did not select funding recipients in accordance with any of the three proposed decision-making models. This did not, however, mean that the non-profit ignored the data from validated measures. As a reminder, because of the formatting and construction of the application, much of the data provided across applicants was inconsistent. As a result, this study only focused on the three validated measures included in the initial round of applications. Any additional medical information that may or may not have been provided by applicants later in the process, information obtained through interviews, and narrative data describing eating disorder symptomology was not considered for analyses. The intention was to identify if the decisions made by AoC were driven by the validated measures already included as suggested by three potential decision-making models. All potential models failed to hypothetically select funding recipients, which suggested that more weight was given to applications in their entirety, inclusive of qualitative data.

Recommendations

Based on the outcomes, recommendations were provided to AoC to further enhance their application process. First and foremost, it is recommended that AoC determine what type of decision-making model they would like to utilize. Identifying the values of the organization and whether they closer align with a utilitarian model, preventative model, blended model, etc., could then help inform the next steps. Although AoC originally aimed to use a Blended Model as previously described, identifying the specific information that contributes to that model would be advantageous. For example, how does AoC define severity, support, readiness for change, or the need for services? These definitions could inform the selection of measures to best provide that data. Utilizing valid and reliable measures help reduce reliance on intuition and clinical judgment. As noted by Dawes, Faust, and Meehl (1989), clinicians often do not have the opportunity to prove their diagnoses or predictions to be accurate. Clinical intuition develops over years of service and can quickly influence decisions that may, or may not, be grounded in accuracy. It is important for organizations to rely on data in order to demonstrate that each applicant receives the same consideration based on the goals and intentions espoused by AoC. From the collection of validated measures selected, it is recommended that AoC then utilize a procedure that sequentially and systematically integrates data to best inform the selection of funding recipients.

The following procedures are an example of how AoC could go about gathering data and using it to inform decisions if they were to use a Blended Model. After defining what constructs mean (e.g., severity, support, readiness for change) it is recommended that AoC identify valid and reliable measures that are normed on an eating disorder population. This may include eating disorder assessments such as the Eating Attitudes Test (EAT-26; Garner et al., 1982), Eating Disorder Inventory-3 (Garner, 2004), Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Beglin, 1994), or the Eating Disorder Symptom Severity Scale (Henderson et al., 2010). Family relations or support could be assessed through the FACES IV (Olson, 2000) as AoC did previously, or they could use additional measures assessing for other types of support. For example the Multidimensional Scale of Perceived Social Supports (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988) or the Social Provisions Scale (SPS; Cutrona & Russel, 1987), both of which have been used with eating disorder populations (Jackson, Weiss, Linquist, & Soderlind, 2005; Carter & Kelly, 2015). Readiness for change could be assessed for using a more specified version of the URICA (McConnaughy et al., 1983), or through the Autonomous and Controlled Motivation Questionnaire (ACMTQ; Zuroff et al., 2007). The scores of validated assessments could then be examined through the model selected by AoC. The top 5% or 10% of applicants could then be further reviewed by AoC's board.

To retain the personal and holistic element of recipient selection, AoC could continue to conduct interviews or request additional information (e.g., lab work or clinical recommendations). However, it is strongly suggested that any qualitative information gathered be done so as equitably and consistently as possible. Interview questions should be consistent amongst applicants, conducted by the same person(s), and if possible, audio or visually recorded. Board members could then select funding recipients based on the quantitative data obtained from the initial application along with the more nuanced and holistic picture gathered in the follow up interview. Overall, the quantitative data guides the board to those applicants that fit best with their intended decision-making model, and then preserves the opportunity to gather additional qualitative information to provide a more holistic picture of the applicant. This would ensure that AoC utilizes an approach based on data obtained through reliable scientific means while maintaining aspects of clinical intuition. Finally, it is suggested that AoC consider the language utilized in their procedures to reflect a more inclusive stance. For example, when obtaining demographic data permit individuals to specify their gender outside the binary.

In summary, it is strongly recommended that AoC further specify their goals and values as an organization, identify validated measures that coincide with their selected decision-making model, and then use that model to highlight potential funding recipients. The data collected informs the board of who they may want to consider further. If approached in this way, data and research support AoC's decisions, and can ensure that those selected truly fit with the organization's mission. This would help streamline the process for both applicants and those determining the allocation of funds.

Table 1

Egalitarian Model Top 5% of Applicants.

Applicant	BMI Range	ECR-R Avoidance score	ECR-R Anxiety score	FACES-IV score	URICA score	Rank Prior to BMI
3416988400001	15.9-17.2	5.67	5.94	0.8	6.86	166
3139302263003	15.5-16.6	6.11	5.06	0.37	11.86	156
3358264033	16.4-17.9	6.72	4.89	0.47	11.71	157
3030419245	11.9-13.7	4.5	5.83	0.76	11.29	135

Note. BMI = Body mass index. ECR-R = Experiences in Close Relationships-Revised Questionnaire. FACES-IV = Family Adaptability and Cohesion Evaluation Scale IV. URICA = University Rhode Island Change Assessment Scale.

Table 2

Least Severe Model Top 5% of Applicants.

Applicant	BMI Range	ECR-R Avoidance score	ECR-R Anxiety score	FACES-IV score	URICA score	Rank Prior to BMI
3374868185	22.8-24.2	3.06	2.83	2.88	10.14	54
3516954443	19.9-21.3	4.06	2.61	1.82	11.86	64
3290085098	19.1-20.6	3.61	3.72	2.19	10.86	64
3366463273	19.1-20.6	4.83	3.33	5.27	10.57	67

Note. BMI = Body mass index. ECR-R = Experiences in Close Relationships-Revised Questionnaire. FACES-IV = Family Adaptability and Cohesion Evaluation Scale IV. URICA = University Rhode Island Change Assessment Scale.

Table 3

Blended Model Top 5% of Applicants.

Applicant	BMI Range	ECR-R Avoidance score	ECR-R Anxiety score	FACES-IV score	URICA score	Rank Prior to BMI
3452892984	16.6-18.3	1	1.28	5.71	10.14	27
3445145952	12.8-14.4	4.28	3.5	3.86	13.43	45
3234586321	14.7-16.1	3.67	2	2	11.29	54
3005009635	13.4-14.8	2.89	3.94	2.9	10.71	57

Note. BMI = Body mass index. ECR-R = Experiences in Close Relationships-Revised Questionnaire. FACES-IV = Family Adaptability and Cohesion Evaluation Scale IV. URICA = University Rhode Island Change Assessment Scale.

CHAPTER FIVE

DISCUSSION

Findings within Context

The purpose of the study was to identify whether Angels of Care (AoC) made resource allocation decisions based on the three validated measures included in their application process. Although there was a wide variety of information collected from applicants through open response inquiry, there was great variability amongst applicants that resulted in much inconsistency. However, three validated measures were included. Three potential decision-making models were designed to reflect these measures that were included in the first round of applications. Thus, models were based on the Experiences in Close Relationships Questionnaire-Revised (ECR-R; Fraley et al., 2000), the Family Adaptability and Cohesion Evaluation Scale-IV (FACES IV; Olson, 2000), and the University Rhode Island Change Assessment Inventory (URICA; McConnaughy et al., 1983), along with a calculated BMI for each applicant. The three hypothetical models were respectively designed to identify the most severe applicants (Egalitarian Model), those applicants in a less serve position (Least Severe Model), and applicants who were potentially severe enough to necessitate medical observation, but also benefited from familial support systems (Blended Model). According to the goals of AoC, the board intended to allocate funds based on a Blended model.

All data was collected by the non-profit organization; there was no researcher influence on the modality or format of data collection. Additionally, no contact was had with applicants, and all data utilized was de-identified prior to the beginning of the study. All applicants consented to have their collected data utilized for research purposes; those under the age of 18 had expressed parental/legal guardian consent. Based on the information collected, the actual funding recipients were not identified utilizing any of the three models. Reasons for why the hypothetical models failed to identify funding recipients are discussed below.

As previously indicated, the full application included much more data, collected beyond the three validated measures. However, due to the open response format, there was great discrepancy between the amounts of information provided by applicants. As some applicants offered ample detail describing the consequences of their eating disorder, origin of their disordered habits, and familial relations, others offered little or no information. As previously discussed, those that were considered favorable were asked to complete additional measures, and from there, some applicants participated in interviews. The board which reviewed applications had full access to this additional material. The supplemental information gathered beyond the data included for this study could have greatly affected the decision-making process. Moreover, the sample for this study only evaluated those within a ten-month window, and did not include those applications that were incomplete (specifically regarding the validated measures). Consequently, further examination of the applications (in their entirety) along with access to an overall larger sample pool may suggest other trends or influences on the decision-making procedures utilized.

Eating disorder research is difficult because of limited access to such a vulnerable population and the lack of generalizability across diagnoses (Norris, Spettigue, Buchholz, & Henderson, 2007). Within this sample there were variations among etiology, duration of the disorder, age, and other multicultural facets. The variables that connected all applicants were the perception of severity and the felt need for financial assistance. Participants had not only suffered from an eating disorder, but they were severe enough to self-advocate for inpatient treatment. Historically, individuals who enter inpatient treatment often experience more severe symptomology when compared with those in partial hospitalization or outpatient services (White & Litovitz, 1998). Thus, the sample examined in this study represented a more severe and smaller portion of the overall eating disorder population. Furthermore, this sample included predominantly white women (*n*=65) and did not fully capture the experiences of men, gender non-conforming individuals/trans* people, nor various races and/or ethnicities. As AoC continues to receive applications the availability of more diverse perspectives will likely increase.

As evident, for those who completed the application, there existed some motivator to reach out, express vulnerability, and ask for help. Asking for help takes courage. For applicants, there was a lot on the line. While some applicants had requested financial assistance in the amount of a few hundred dollars, others speculated needing over one-hundred-thousand dollars. For many, receiving financial assistance may have been a determining factor in whether they received any treatment at all, which in severe cases could have been the difference between life and death. The awareness that resources are limited (not everyone who applied received funding), combined with a genuine need for help, may have influenced how applicants appealed to the board of individuals making decisions.

Researchers Becker, Eddy, and Perloe (2009) noted that particularly within the eating disorder population, individuals may not honestly disclose accurate experiences for a variety of reasons, one of which includes social desirability. They highlighted that perfectionism and the need to seem compliant (a trait frequently associated with eating disorders and particularly women) can influence how individuals report their experience, including symptomology and willingness to engage in treatment. Applicants may have felt pressure to appear in a particular way when addressing questions that focused on disordered eating behaviors, family relations, and traumatic experiences. Perhaps individuals wanted to highlight the severity of their specific condition (e.g., restrictive behaviors, purging practices, lack of resources for treatment, etc.), the impact had on relationships or their ability to adequately function in society (e.g., strained family/ romantic relations, challenges with academic or work responsibilities, etc.), and/or the appearance of cooperation (e.g., an expressed willingness to comply with treatment recommendations). Additionally, the fact that not all applicants received funding created a scarcity effect, which may have altered how individuals viewed the value and desire for financial assistance (Mittone & Savadori, 2009). The want to appear as a strong candidate may have influenced scores on the URICA, ECR-R, and FACES-IV. It is also possible that applicants were influenced by social desirability when reporting their weight as this was in an open response format; therefore, the accuracy of the BMI range may have been impacted (DeAndrea, Tong, Liang, Levine, & Walther, 2012). Thus, it is a possibility that some applicants may have worded or answered questions in line with what they anticipated the board would be looking for to increase their chances of receiving funding. The important thing to recognize, is that those who took the time to fill out the application in its entirety were, most likely, not trying to 'scam the system,' but were genuinely seeking assistance for a life-threatening disorder. This may be something to consider in future renditions of the application or with other circumstances in which scarce resources are allocated to few.

As a reminder, this study did not focus on comparing applicants across groups, nor was the goal to identify what makes a 'good candidate' for inpatient treatment. The goal was to identify whether AoC made allocation decisions based on the three validated measures imbedded in the application. None of the hypothetical decision-making models accurately predicted funding recipients. Furthermore, one of the actual recipients did not fully complete the application. This suggests that despite AoC's best efforts, decisions were not based strictly on data, nor were applications completed as intended. Although AoC planned to have each applicant complete measures in their entirety before continuing, the format permitted questions to be skipped and information missed.

It is recommended that AoC consider whether the current application and its format reflect their goals and values regarding resource allocation. Validated instruments provide the opportunity to compare data across individuals with consistency. Furthermore, the use of measures validated within the eating disorder population may ensure that findings contribute to the decision-making process within an accurate context. For example, the URICA permits the use of tailored verbiage to more intentionally reflect the examined population. Because eating disorders often coincide with other mental and health disorders, statements inquiring about one's "motivation to make a change" may be interpreted within a variety of contexts, and not relate to eating disorder behaviors specifically. And, although later stages of the application process include more structured eating disorder assessments, incorporating a validated measure early on may paint a more accurate picture of applicants from the start. In order to fairly and consistently select funding recipients, it is suggested that AoC reexamine the application process and included instruments to create a more streamlined process based on scientific research. Yet, the emphasis on science and data does not have to exist within a void. Maintaining interviews and qualitative aspects of the application will preserve the human element, and further inform final decisions. Overall, despite the hypothetical model's failure to accurately predict funding recipients, findings did: contribute to a more thorough understanding of AoC's decision-making procedures, highlight potential areas for improvement (both within the application process and in selection of funding recipients), and enhance self-awareness on behalf of the organization.

Implications for Practice

When any organization permits researchers to evaluate their process, it opens the organization to scrutiny and criticism. It also demonstrates a commitment to their passion. Evaluating whether a non-profit, or any company/ organization does what they claim can have important outcomes. Access to grants, federal assistance, and fund raising are vital to many organizations that serve vulnerable populations. By willingly examining their procedures and evaluating their process, the organization becomes more informed and better equipped to adjust and improve (Parrish, Harris, & Pritzker, 2013). This willingness for exploration and evaluation becomes even more important when attempting to allocate scarce resources.

There are many non-profits across the country that aim to assist individuals through difficult times. While some provide direct services (e.g., medical or legal assistance), others provide information (e.g., seminars or workshops), and/or aim to alleviate distress through financial assistance, much like AoC. As resources become scarce, it becomes more important to understand how, what, and who influences decisions. This becomes even more pertinent with a changing political environment.

Health care is a complicated system that spans local communities, state-wide policy, and national/ federal input. And despite promotions of equality, there are vast differences in the level of access individuals have to insurance (Andrews, 2014). With politics consistently revamping the health care system, there may be unanticipated changes to federally funded programs and the role of insurance companies. Whether people have universal *access* to insurance will not determine whether they can *afford* insurance. Debates regarding the legitimacy and necessity of mental health coverage, limitations on services, and access to resources (e.g., clinics or treatment providers), suggest no clear indication of how eating disorder treatment will be impacted. The political climate and perceptions of mental health effect the lived reality of those who suffer from the impacts of disordered eating behaviors. Changes in coverage and access to resources may increase the financial burden of the individual, and perpetuate the cycle of care (Meulen, 1992). For those economically hindered, consistent care may not be an option. This may result in individuals dropping in and out of treatment deterring their recovery (Thompson & Park, 2016). In more severe circumstances, it may result in individuals not being able to afford treatment at all. Although the direct consequences of health care policy are yet to be determined, it is possible that the need for financial assistance may rise. This would directly impact AoC in a variety of ways; most importantly, they may see a rise in applications. The more people that need financial assistance for inpatient eating disorder care, the more applications the organization must process, and the more valuable the funding becomes. Essentially, while the supply fluctuates depending on grants, donations, and fundraisers, the demand may exponentially increase. Understanding how scarce financial resources are allocated bolsters the credibility and consistency of any organization.

The non-profit examined in this particular study is not perfect; there are considerations that could improve their process. The important part was that they were willing to look and learn about how they were doing; particularly because they are currently one of few organizations providing eating disorder financial assistance. Specific recommendations for how to improve and simplify the application process were communicated directly to AoC. Some of the broad suggestions include: the development of a clear and intentional decision-making model to guide selection of recipients, utilization of validated measures (specifically those validated within eating disorder populations), consistency with data collection (particularly regarding interview and qualitative data), and the integration of measures to better assess for eating disorder severity. As AoC moves forward in streamlining their procedures, and conducting future research, the organization will undoubtedly become more advanced and consistent in how they determine financial recipients.

Recommendations for Future Research

There are many potential avenues for future research endeavors. A more thorough understanding of what constitutes best practice for eating disorder treatment would be highly beneficial. At present, there is a lack of consensus on what qualifies as best practice and how to define recovery (Bardone-Cone et al., 2010). Due to the massive variations in etiology, experience, medical circumstances, financial resources, etc., treatment currently is most effective when tailored to the individual (Schaffner & Buchanan, 2008; Freudenberg et al., 2016). This makes insurance companies reluctant to cover or contribute to eating disorder treatment. Furthermore, as money often determines level of care (both type of care and duration), the sooner clinicians have access to a preferred treatment, the less time can be spent with experimentation. Although there are a variety of treatment modalities that have demonstrated to be effective in the treatment of eating disorders (Swenne, Parling, & Ros, 2017), clinicians, clients, and insurance companies alike would benefit from identifying a treatment that works with the majority of eating disorder clients (Couturier et al., 2015).

In addition to identifying best practices, knowing what makes a ‘good candidate’ for eating disorder treatment would assist eating disorder treatment facilities, and organizations such as AoC. Understanding how much individual motivation, personality, trauma, resiliency, etc., do or do not contribute to treatment outcomes may help identify those who are best positioned to benefit from treatment, and those who may struggle. There are many facets that contribute to whether someone survives and thrives beyond an eating disorder. Financial and social resources, cultural currency (e.g., privileged statues), and genetics are just a few variables that influence the sustainability of recovery. For organizations aimed at helping people access treatment and thrive through recovery, this information could greatly contribute to logistical procedures (such as AoC's application process) and decision-making policy.

The process for determining those best suited for higher levels of care should be informed by validated measures and contextual considerations. Due to the nuanced etiology of eating disorders, individual client experience and identity statuses inform a more thorough understanding of behaviors and impact (Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003). Psychology is a people based science; utilization of assessments and objective measures serve to support and enhance clinical intervention.

Finally, eating disorder research that addresses financial burdens is still nascent. The recognition of societal and cultural impacts on eating disorder trends and the toll eating disorders take on families deserves more attention. Recently, the political climate has sparked renewed debate over people's rights, access to affordable health care, federal protections (or lack thereof) for various genders and orientations, and women's bodies. As a result, people across the nation are engaging in conversations about politics and recognizing how people and policy are interconnected. How, or if, this has an impact on the nation's health is uncertain. Future research could begin to examine trends, potential correlations with policy or politics, and/or environmental relations. Understanding how the culture and social climate impacts the intersecting identities of individuals and the etiology of eating disorders could greatly benefit both those addressing treatment and prevention (Pirie, 2016). There is clearly so much more to learn.

Counseling Values and Research

Many graduate programs train clinicians from the scientist-practitioner model and stress the importance of integrating research into clinical practice (Ridley & Laird, 2015). The more aligned research is with clinician's experiences, the more fluidly research outcomes can be utilized in clinical work (Goodheart, 2006). If both are based on the same set of counseling values, the ease of incorporating research into work with clients theoretically becomes easier. Ted Packard (2009) proposed nine Core Values to distinguish counseling psychology from other helping and clinical professions. This study aimed to align with many of those values either directly, or through providing feedback so that AoC could more effectively serve their clients.

The first value identified by Packard was altruism. Counseling psychology strives to make the lives of clients and participants better. By examining the decision-making model of AoC, the organization gained a deeper understanding of how they operated and whether their actions aligned with their stated intentions. The findings suggested that AoC may utilize their data inconsistently when selecting funding recipients. By becoming aware, they are now able to implement recommendations and further decide what data should inform recipient selection. Consistency and simplification of the process may reduce the time and money needed to screen applicants, granting clinicians more time with clients, and preserving funds.

Other values identified by Packard (2009) include the integration of science and practice, collaboration across disciplines, and social justice advocacy. This study was developed specifically to help bridge the gap between science and practice. The examination of data provided direct feedback to inform decisions made and the strategies utilized for processing applicants. This was done through a collaboration between Dr. Delgado-Romero's research team (BIEN) and AoC. Non-profit organizations may not have access to programs or the know-how to effectively perform a self-study. This collaboration provided AoC with an outside perspective that did not have influence over policy or their previously established protocols. In return, AoC granted access to valuable data and contributed to a consultation experience that greatly enhanced awareness and appreciation for the intricate nuances of eating disorder work. Together, the research and outcomes are a form of social justice.

Advocacy takes many forms. Although there exists ample research on the etiology and treatment of eating disorders, few have examined the cost and burden of treatment. Additionally, if AoC were to incorporate specific recommendations, they may develop a system that recognizes the intersectionality of applicants while obtaining the necessary information to make decisions. Although findings provided specific recommendations to AoC and may not be generalizable, this study contributes to the scant literature currently available acknowledging the financial resources needed to adequately engage with eating disorder care. The efforts made by AoC demonstrate advocacy in action as they connect individuals to potentially life-saving treatment. The politics and cultural tapestry of the United States contribute to eating disorder etiology and its perpetuation; engagement in research and service aims to influence that culture through consciousness raising and collaboration.

Due to the lack of personal contact with applicants, relational values, respect, and focus on treatment was not a part of this study. However, it is the hope that AoC can better serve those who seek financial assistance due to the outcomes of this study.

Conclusion

In the end, the three hypothetical models based on the application's validated measures did not accurately select which applicants received funding. AoC had intended, based on their communicated goals, to follow a Blended model in order to identify those individuals who may experience severe eating disorder symptomology, yet have familial support and high levels of motivation for inpatient treatment. Findings indicated that the selection of funding recipients was not based on the validated measures included in the first round of applications. The overall application included other qualitative inquiry and assessments developed by AoC. Additional research examining all applicants and information provided in the full application may further highlight AoC's actual decision-making model. Overall, there is still much to learn about eating disorders. As more is understood regarding etiology, treatment, and recovery, AoC will likely evolve their application process to better fit their values and streamline their resource allocation procedures.

Personal Connections

As someone who spent much of my time in a pool growing up, body comparing and body shaming was all too normal. Reflecting back, there were many friends who exhibited disordered eating behaviors, and I myself struggled to balance health and disordered habits. It wasn't until I entered my master's program until I realized how pervasive and damaging eating disorders were to so many young people. Learning about gender politics and the cultural influences that help sustain eating disorders for so many enraged me. This anger and frustration fueled my desire to learn more about inclusive feminism, and the impact of culture and society on different populations within the US.

I had the privilege of conducting body image workshops designed by Dr. Janice Deeds, where I worked with students (predominantly women) to address body shaming and the unrealistic expectations purported by society. I had one experience with a six year old girl who began sobbing as she compared herself to Barbie and described how she would never be as beautiful. As the young girl of Native descent held the blond-blue-eyed Barbie, her mother was speechless. At six years old she had already internalized cultural messages of what it meant to be thin and blond in America. It was moments like this that confirmed my passion for feminism, the importance of intersectionality, and the danger of unrealistic expectations. From there I became a member of the Eating Disorder Treatment Team at The University of Nebraska-Lincoln, and continued my education and advocacy at The University of Georgia.

One of my practicum experiences working in an eating disorder private practice highlighted the lack of resources many had for treatment. Clients would argue and debate with their insurance company in order to advocate for higher levels of care. Many took breaks from treatment and only resumed when they were able to financially afford it and when they were able to get help in other areas of their life. For a number of clients taking care of family, work responsibilities, and school interfered with their consistency of treatment. It made me sad and mutually frustrated as I sat with people who were doing the best they could to make their lives better, only to be faced with what seemed like never ending barriers. My experience working with these clients and witnessing first-hand the struggle to access treatment only enhanced my appreciation for AoC.

AoC was doing the best they could to help remove financial barriers to treatment and improving the lives of those they served. It was an honor to provide them with even the smallest contribution to their efforts. As someone nearing the end of formal education, I have begun contemplating how to best integrate the lessons learned from AoC, various treatment teams, and numerous mentors into my future practice as an early career psychologist. In the future, I may not engage with formal research, as it is a challenge for me to work with data instead of people. However, this study highlighted the numerous ways that people, including myself, can contribute to advocacy through research through collaboration. Although I may collect data or run complex statistical analyses, I do hope to continue advocating for clients, those with eating disorders, and strive to turn cultural sexism and objectification on its head.

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