TREATMENT OUTCOMES REPORT
2016 EDITION

Helping patients, families and professionals understand treatment results
One of the greatest frustrations that families report is trying to obtain outcome results from eating disorder treatment programs. A comprehensive review of treatment program websites indicates that very few programs report any data-based outcomes, and data that are reported often lack research rigor. The information that follows is designed to help patients, families, and professionals understand some of the difficulties researchers face in measuring eating disorder treatment effectiveness and how to critically evaluate data that is presented. Patient satisfaction and treatment effectiveness data from Eating Recovery Center is presented with the intention of reporting on our outcomes and providing examples of how to become a discriminating consumer of outcome data.

**Eating Recovery Center Outcomes at a Glance:**

**ADULT INPATIENT/RESIDENTIAL and PARTIAL HOSPITALIZATION PROGRAMS**

- 91% of adult patients report that treatment at Eating Recovery Center was helpful, and 89% would recommend Eating Recovery Center to other individuals in need of treatment.
- Eating Recovery Center significantly weight restored and reduced psychological problems associated with eating disorders among adult patients admitted between 2008 and 2015.
- Eating Recovery Center significantly reduced depression and anxiety among adult patients admitted between 2008 and 2015.

**CHILD & ADOLESCENT INPATIENT/RESIDENTIAL and PARTIAL HOSPITALIZATION PROGRAMS**

- 98% of parents of child/adolescent patients report that treatment at Eating Recovery Center was helpful, and 97% would recommend Eating Recovery Center to other families in need of treatment.
- Eating Recovery Center significantly weight restored and reduced psychological problems associated with eating disorders among child and adolescent patients admitted between 2011 and 2015.
- Eating Recovery Center significantly reduced depression and anxiety among child and adolescent patients admitted between 2011 and 2015.

**FAMILY EDUCATIONAL PROGRAM**

- 99% of families that attended a 3-day educational workshop on the causes and treatment of eating disorders rated the program excellent or very good.
Patient satisfaction refers to the level of satisfaction patients report following a course of treatment. Ideally, patients will feel good about the care they have received; however, it is important to note that there is very little research demonstrating any correlation between patient satisfaction and treatment effectiveness. In fact, in the field of eating disorders, full weight restoration of a patient with Anorexia Nervosa can result in patient dissatisfaction. This is particularly true if the patient does not have adequate time to psychologically integrate changes in their size and shape during their time in the structured treatment environment.

When evaluating patient satisfaction data, it is important to know what question is being asked, what type of scale is being used and what responses are being reported. Be wary of data where a segment of the program’s admissions have been systematically excluded, the most common of which are patients who leave the program early. These patients are often excluded from patient satisfaction data because they are the most dissatisfied with the program. There are no systematic exclusion of data in the results presented in this report.
Patient Satisfaction – Adult Inpatient/Residential and Partial Hospital Programs

Experts in the field of professional quality assessment focus on two questions: (1) Overall, was the treatment helpful and (2) Would the patient refer someone to the program?

Figures 1 and 2 present Eating Recovery Center’s adult Inpatient/Residential and Partial Hospitalization program satisfaction scores for these two questions for patients discharged between 2010 and 2015. Every patient who discharged from Eating Recovery Center was asked to complete a patient satisfaction survey, and no data were systematically excluded.
**Figure 1**

Adult Programs

Overall, my experience at Eating Recovery Center was helpful.

N=1725

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Somewhat Agree</th>
<th>Neutral</th>
<th>Somewhat Disagree</th>
<th>Strongly Disagree</th>
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<tr>
<td>60%</td>
<td>31%</td>
<td>6%</td>
<td>2%</td>
<td>1%</td>
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</table>

**Figure 2**

Adult Programs

I would recommend this treatment facility to others in need of its services.

N=1972

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Somewhat Agree</th>
<th>Neutral</th>
<th>Somewhat Disagree</th>
<th>Strongly Disagree</th>
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<tr>
<td>67%</td>
<td>22%</td>
<td>6%</td>
<td>1%</td>
<td>1%</td>
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</table>
Parent Satisfaction – Child & Adolescent Services

Eating Recovery Center collects satisfaction feedback from the parent(s) in the Child/Adolescent program. Figures 3 and 4 report the parent satisfaction findings on the questions (1) Overall, was the treatment helpful and (2) Would the patient refer someone to the program? All parents were surveyed, and no data were systematically excluded.
Figure 3

Child & Adolescent Program – Parents
Overall, my experience at Eating Recovery Center was helpful.
N=418

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Somewhat Agree</th>
<th>Neutral</th>
<th>Somewhat Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
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<tr>
<td>2012-2015 Inpatient/Residential and Partial Hospital Programs N=418</td>
<td>88%</td>
<td>10%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Figure 4

Child & Adolescent Program – Parents
I would recommend this treatment facility to others in need of its services.
N=465

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<th></th>
<th>Strongly Agree</th>
<th>Somewhat Agree</th>
<th>Neutral</th>
<th>Somewhat Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-2015 Inpatient/Residential and Partial Hospital Programs N=465</td>
<td>92%</td>
<td>5%</td>
<td>2%</td>
<td>0%</td>
<td>1%</td>
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Family Education Program

Family Satisfaction with Family Education Program

Families play a crucial role in the recovery process. As a result, Eating Recovery Center has made a substantial commitment to involving families in treatment. Family Days is an elective three-day program for families that occurs each month. Families can attend as often as they like and most families attend several times during treatment. Family Days is designed to educate families about their loved one’s illness and their role in the recovery process.

**Figure 5**

Family Satisfaction with Family Days
Please Rate Family Days Overall
N=1790

- **Excellent and Very Good:** 99%
- **Good:** 1%
- **Excellent:** 80%
- **Very Good:** 19%
- **Fair:** 0%
- **Poor:** 0%
The Challenge of Measuring Treatment Effectiveness

Good outcome data usually contains assessments at the time of admission, discharge and annual follow-up. Unfortunately, almost all psychiatric outcome research is plagued by the fact that the majority of patients discharged from intensive treatment programs continue to receive multiple forms of treatment during the follow-up period. Treatment during this follow-up period is often delivered by professionals unaffiliated with the intensive treatment site.

A common year-long sequence of care for a patient seeking eating disorder treatment could include 60 days of intensive treatment (at the Inpatient, Residential, and/or Partial Hospitalization levels of care), followed by Outpatient care for ten months after discharge from the intensive care setting. During the follow-up treatment, they may see an individual and/or family therapist, a psychiatrist may adjust or change their medications several times, and they may briefly attend an Intensive Outpatient Program (IOP). In this common scenario, it is difficult to attribute the patient’s current functioning to any one aspect of their year-long treatment. There are simply too many treatments occurring and providers delivering care to be able to attribute the outcome at the annual follow-up to any one intervention. While follow-up data offers useful information on the patient’s “course of illness,” it does not speak to the treatment effectiveness of the intensive treatment program.

Programs providing comprehensive treatment services that deliver the full course of care over the year-long period can comment on treatment effectiveness, but this scenario rarely occurs. Most patients travel beyond driving distance of their home to receive intensive treatment and then receive follow-up treatment near their homes.
Evaluating Change from Admission to Discharge

The outcome data that warrant the most attention are those that address the change that occurs from admission to discharge, because follow-up data are usually confounded by the treatments patients receive after they discharge. The following pages present how Eating Recovery Center patients have changed from admission to discharge across a range of variables that can affect long-term recovery.

Treatment centers should use questionnaires that have been reviewed and accepted by the scientific community, and assess changes in both eating disorder symptoms and co-occurring illnesses such as mood disorders. Most treatment centers that publish their outcome data report these data in terms of average symptom levels at admission and at discharge. While this method is both common and easy to understand, it can be misleading because the reported averages may or may not accurately represent patient symptom levels due to variability within a given sample of patients. To address this issue, we report our treatment outcomes in terms of both admission and discharge scores, and in terms of effect sizes.[1]

Effect sizes are typically a more meaningful way to report outcomes because they are based on both the amount of symptom change from admission to discharge and the amount of variability in symptom levels at both admission and discharge. It is critical to note that all of the effect sizes reported here are based on statistically significant differences from admission to discharge.

All results reported in this section are statistically significant at the .01 or .001 levels except for the Overcontrol composite score on the EDI-3 for child and adolescent patients, which does not show statistically significant reductions from admission to discharge. A statistically significant reduction from admission to discharge means that it is very unlikely that the reduction from admission to discharge is due to random chance, and is very likely due to the effects of the treatment. If there is no statistically significant difference between admission and discharge for a given measure, the effect size is considered to be 0. Larger effect sizes indicate a greater degree of improvement. Effect sizes between 0 and .3 indicate a minimal improvement, with effect sizes between .3 and .5 indicating a small improvement, effect sizes between .5 and .8 indicating a moderate improvement, and effect sizes larger than .8 indicating a large improvement. Within this spectrum, a clinically significant effect size is considered to be .5 or greater, and this cutoff is clearly marked on all figures that report effect size.

It is important to note that an effect size of .5 or greater on a particular measure does not indicate that patients achieved complete recovery with regard to those symptoms. Rather, an effect size of .5 or greater means that, on average, patients made clinically significant progress toward recovery, but that additional treatment will be needed after discharge to continue the recovery process.

[1] The Cohen’s D statistic was used to compute effect sizes. The formula for this statistic is: \[(\text{Average Admission Score} - \text{Average Discharge Score})/((\text{Admission Standard Deviation} + \text{Discharge Standard Deviation})/2)\].
Adult Weight Restoration

From 2014 to 2015, 667 admitted adult patients (80% of all adult patients) were identified as in need of weight restoration. At admission, the average patient in need of weight restoration was at 80% of ideal body weight (IBW). 20% of patients in need of weight restoration were between 90% and 99% of IBW at admission, 30% were between 80% and 90%, 31% were between 70% and 80%, and 19% were below 70%. Figure 6 shows the average percent of IBW at admission and discharge for patients of different weight categories at admission. Research has shown that a strong predictor of recovery from an eating disorder among adult patients with Anorexia Nervosa is achieving greater than 85.8% of IBW at discharge [2]. This threshold is identified in Figure 6. Of the patients in need of weight restoration who admitted at a weight below this threshold, 63% achieved this threshold by discharge. Figure 7 shows the average weight restoration from admission to discharge as an effect size.


Note that separate effect sizes for patients of different weight categories at admission are not shown here because doing so reduces the variability in these groups, resulting in artificially large effect sizes.
Adult Weight Restoration

From 2014 to 2015, of the admitted patients identified as in need of weight restoration, the average length of stay was 8.2 weeks and the average patient gained 2.1 lbs per week during treatment, which exceeds the 2 lbs per week threshold established by the American Psychiatric Association[3]. Figure 8 shows the average weight restoration per week for patients of different weight categories at admission. The average length of stay for patients at less than 70% of IBW at admission, between 70% and 80%, between 80% and 90%, and between 90% and 99% were 81, 63, 54 and 48 days, respectively.

Figure 8

Adult Weight Restoration per week by %IBW at Admission

![Figure 8: Adult Weight Restoration per week by %IBW at Admission](image)

<table>
<thead>
<tr>
<th>% of IBW at Admission</th>
<th>Weight Restored per Week (lbs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 70% n = 127</td>
<td>3.0</td>
</tr>
<tr>
<td>70%-80% n = 207</td>
<td>2.8</td>
</tr>
<tr>
<td>80%-90% n = 200</td>
<td>2.2</td>
</tr>
<tr>
<td>90%-99% n = 133</td>
<td>1.8</td>
</tr>
</tbody>
</table>

Average Length of Stay in Combined Inpatient/Residential/Partial Hospital Program

Eating Recovery Center uses the Eating Disorder Inventory – 3rd Edition (EDI-3) to assess psychological symptoms and traits that are characteristic of patients with eating disorders. It is one of the most widely-used eating disorder questionnaires in the field. Figures 9 and 10 show changes on the Risk Composite Index of the Eating Disorders Inventory (EDI-3). The Risk Composite measures Drive for Thinness, Bulimia and Body Dissatisfaction, which are three key features of eating disorders.

Of the 742 patients admitted to and discharged from Adult Services at Eating Recovery Center from 2009 to 2015:

- 426 patients (57%) admitted at a Typical or Elevated Eating Disorder Risk Composite (EDRC). Of those Typical or Elevated admissions, 202 (47%) had dropped from Typical or Elevated EDRC to a Low EDRC by the time of discharge.

- Additionally, 331 (45%) of patients lowered their EDRC score by at least 50% as a result of treatment.
Psychological Change on the EDI-3

The EDI-3 offers four composite scales that measure important psychological issues that have been shown to play a critical role in both the development and maintenance of eating disorders. Persistently elevated scores on each of these scales—Ineffectiveness, Interpersonal problems, Affective problems and Overcontrol Problems—have been shown to predict poor outcome. Since these issues have been proven to adversely affect outcome, the treatment program at Eating Recovery Center has been designed to address and improve these specific issues.

Ineffectiveness composite index
(includes the following subscales: Low Self-Esteem and Personal Alienation).

Low self-esteem has consistently been found to be a predictor of poor outcome. High scores on this scale reflect persistent feelings of worthlessness and inadequacy. Since low self-esteem has been found to highly influence successful outcome, it is an issue that receives keen focus in Eating Recovery Center treatment protocols[4].

Interpersonal Problems composite index
(includes the following subscales: Interpersonal Insecurity and Interpersonal Alienation).

This scale assesses the extent to which a patient experiences social relationships as tense, disappointing and unrewarding. Studies have shown that successful interpersonal connections facilitate recovery[5].

Affective Problems composite index
(includes the following subscales: Interoceptive Awareness and Emotional Dysregulation).

This scale measures an individual’s ability to identify and manage difficult mood states. Deficits in this area frequently accompany eating disorders[6].

Overcontrol composite index
(includes the following subscales: Perfectionism and Asceticism).

Patients who score high on these scales have difficulty tolerating inexactness, have high standards of personal achievement and overvalue self-discipline, self-denial and self-restraint. The self-denial can be particularly focused on control of bodily urges such as hunger.


Adult EDI-3 Subscales

Figures 11 and 12 show that adult patients generally reported clinically significant improvement in all four areas at the end of treatment (2008-2015).

**Figure 11**
Admission to Discharge Change

**Figure 12**
Admission to Discharge Effect Sizes
67% of patients admitted to Inpatient/Residential treatment programs also struggle with mood disorders such as depression and anxiety. In fact, severity of depression has been found to be a predictor of poor outcome in several studies. Eating Recovery Center uses the Beck Depression Inventory—2nd edition, a widely-used questionnaire used to assess psychological mood disorders in patients with eating disorders.

Of the 1159 patients admitted to and discharged from Adult Services at Eating Recovery Center from 2008 to 2015:

- 925 patients (80%) admitted at a Moderate or Severe level of Depression. Of those Moderate to Severely depressed patients, 563 (61%) had dropped to Mild or Minimal Depression levels by the time of discharge.

- Additionally, 654 (56%) of patients lowered their Beck Depression Inventory score by at least 50% as a result of treatment.
Adult Change in Anxiety – State Trait Anxiety Inventory

As with depression, anxiety has been shown to be a poor predictor of outcome.

Figure 15
Adult Anxiety from Admission to Discharge

Figure 16
Adult Anxiety Effect Size

Of the 580 patients admitted to and discharged from Adult Services at Eating Recovery Center from 2012 to 2015:

• 65 patients (11%) lowered their State Trait Anxiety score by at least 50% as a result of treatment.
Of 439 patients who admitted to and discharged from Adult Services at Eating Recovery Center from 2012 to 2015 that completed the Obsessive Compulsive Inventory (OCI-R), a total of 182 (41%) reported obsessive compulsive thoughts and behaviors that met the cutoff (OCI-R > 20) indicative of a likely diagnosis of Obsessive Compulsive Disorder. At the time of discharge:

- 72 patients (40%) of those meeting the threshold indicative of Obsessive Compulsive Disorder at admission reported decreased obsessive compulsive thoughts and behaviors to the extent that they no longer met the cutoff threshold on the OCI-R indicative of a likely Obsessive Compulsive Disorder diagnosis.
Child and Adolescent Weight Restoration from Admission to Discharge

From 2014 to 2015, 264 child and adolescent patients were admitted. 89% of all child and adolescent patients were identified as in need of weight restoration. At admission, the average patient in need of weight restoration was at 84% of ideal body weight (IBW). 22% of patients in need of weight restoration were between 90% and 99% of IBW at admission, 46% of patients were between 80% and 90%, 24% were between 70% and 80%, and 8% were below 70%. Figure 19 shows the average percent of IBW at admission and discharge for patients of different weight categories at admission. Research has shown that a strong predictor of recovery from an eating disorder among adolescent patients with Anorexia Nervosa is achieving at least 95.2% of IBW at discharge\textsuperscript{[2]}. This threshold is identified in Figure 19. Of the patients in need of weight restoration who admitted at a weight below this threshold, 85% achieved this threshold by discharge. Figure 20 shows the average weight restoration from admission to discharge as an effect size.


**Figure 19**

**Child and Adolescent Weight Restoration by %IBW at Admission**

Note that separate effect sizes for patients of different weight categories at admission are not shown here because doing so reduces the variability in these groups, resulting in artificially large effect sizes.
Child and Adolescent Weight Restoration from Admission to Discharge

From 2014 to 2015, of the admitted patients identified as in need of weight restoration, the average length of stay was 10.9 weeks and the average patient gained 2.3 lbs per week during treatment, which exceeds the 2 lbs per week threshold established by the American Psychiatric Association[7]. Figure 21 shows the average weight restoration per week for patients of different weight categories at admission. The average length of stay for patients at less than 70% of IBW at admission, between 70% and 80%, between 80% and 90%, and between 90% and 99% were 81, 71, 62 and 50 days, respectively.

Figure 21

![Chart showing weight restoration per week by %IBW at admission]

- **Average Length of Stay in Combined Inpatient/Residential/Partial Hospital Program**

Evaluating Change from Admission to Discharge – C/A Services

Child and Adolescent Change in Eating Disorder Risk:

Eating Recovery Center uses the Eating Disorder Inventory – 3rd Edition (EDI-3) to assess psychological symptoms and traits that are characteristic of patients with eating disorders. It is one of the most widely-used eating disorder questionnaires in the field. Figures 22 and 23 show changes on the Risk Composite Index of the Eating Disorders Inventory (EDI-3). The Risk Composite measures Drive for Thinness, Bulimia and Body Dissatisfaction, which are three key features of eating disorders.

Figure 22

Figure 23
Adult EDI-3 Risk Composite Effect Size

Of the 148 patients admitted to and discharged from Child and Adolescent Services at Eating Recovery Center from 2014 to 2015:

• 108 patients (73%) admitted at a Typical or Elevated Eating Disorder Risk Composite (EDRC). Of those Typical or Elevated admissions, 19 (18%) had dropped from Typical or Elevated EDRC to a Low EDRC by the time of discharge.

• Additionally, 33 (31%) of patients lowered their EDRC score by at least 50% as a result of treatment.
Adolescent Psychological Change
The EDI-3 offers four composite scales that measure important psychological issues that have been shown to play a critical role in both the development and maintenance of eating disorders. Persistently elevated scores on each of these scales—Ineffectiveness, Interpersonal problems, Affective problems and Overcontrol Problems—have been shown to predict poor outcome. Since these issues have been proven to adversely affect outcome, the treatment program at Eating Recovery Center has been thoughtfully designed to address and improve these specific issues.

Ineffectiveness composite index
(includes the following subscales: Low Self-Esteem and Personal Alienation).
Low self-esteem has consistently been found to be a predictor of poor outcome. High scores on this scale reflect persistent feelings of worthlessness and inadequacy. Since low self-esteem has been found to highly influence successful outcome, it is an issue that receives keen focus in Eating Recovery Center treatment protocols.

Interpersonal Problems composite index
(includes the following subscales: Interpersonal Insecurity and Interpersonal Alienation).
This scale assesses the extent to which a patient experiences social relationships as tense, disappointing and unrewarding. Several studies have shown that successful interpersonal connections facilitate recovery[4].

Affective Problems composite index
(includes the following subscales: Interoceptive Awareness and Emotional Dysregulation).
This scale measures an individual’s ability to identify and manage difficult mood states. Eating disorder patients’ inability to effectively express emotions has been a negative predictor of outcome.

Overcontrol composite index
(includes the following subscales: Perfectionism and Asceticism).
Patients who score high on these scales have difficulty tolerating inexactness, have high standards of personal achievement and overvalue self-discipline, self-denial and self-restraint. The self-denial can be particularly focused on control of bodily urges such as hunger.

Figure 24 shows that, with the exception of the Overcontrol composite, child and adolescent patients showed significant decreases in core eating disorder psychopathology. However, as seen in Figure 25, these changes were generally small in magnitude and fell short of what should be considered clinically meaningful. This may be due to the fact that, in contrast to the majority of adult patients, a majority of child and adolescent patients were treated involuntarily, thereby diminishing their motivation to undergo the psychological change necessary for recovery. In addition, research has shown that adolescents do not typically make large changes in core eating disorder psychopathology within the time frame reported here (average length of stay = 76 days)[8]. More substantial changes may be possible after longer treatments.

Child/Adolescent Change in Depression – Beck Depression Inventory-2

Of the 212 patients admitted to and discharged from Child and Adolescent Services at Eating Recovery Center from 2011 to 2015:

- 145 patients (68%) admitted at a Moderate or Severe level of Depression. Of those Moderate to Severely depressed patients, 63 (43%) had dropped to Mild or Minimal Depression levels by the time of discharge.
- Additionally, 75 (35%) of patients lowered their Beck Depression Inventory score by at least 50% as a result of treatment.

Figure 26
Child and Adolescent Depression from Admission to Discharge

Figure 27
Child and Adolescent Depression Effect Size
Child/Adolescent Change in Anxiety – State Trait Anxiety Inventory

Of the 229 patients admitted to and discharged from Child and Adolescent Services at Eating Recovery Center from 2012 to 2015:

- 198 patients (87%) admitted at an anxiety level above normal. Of those patients, 37 (24%) had normalized their anxiety at the time of discharge.
- Additionally, 11 (5%) of patients lowered their State Anxiety score by at least 50% as a result of treatment.

**Figure 28**
Child and Adolescent Anxiety from Admission to Discharge

**Figure 29**
Child and Adolescent Anxiety Effect Size
Comparing Apples to Apples:

Not all eating disorder treatment programs treat the same level of severity and the field of eating disorders has yet to adopt a universal method for indexing illness severity. Realistically, programs that are willing to treat more severely ill patients will likely report poorer results compared to programs that systematically select less ill patients for admission. If treatment programs are using standardized measurement instruments—like the Eating Disorder Inventory (EDI-3) and the Beck Depression Inventory—2nd edition (BDI-2)—there are usually normative data for Mild, Moderate and Severe illness acuity that can help gauge severity. For example, if two different programs are presenting results from the BDI-2, it is important to note the level of severity of depression at admission.

Definitions of Recovery: Watch Out for “Sort of True”

Another area in which the field of eating disorder treatment has struggled has been reaching consensus regarding the definition of “recovery.” The closest the field has come to consensus is the definition of “remitted.” For Anorexia Nervosa, remitted is defined as being weight-restored above 90% ideal body weight (IBW) and normalization of thoughts and attitudes that relate to the psychological aspects of the illness, such as drive for thinness and body dissatisfaction. For Bulimia Nervosa, remitted is defined as having zero binge/purge episodes over the last three month period (note: controversy remains regarding the necessary length of time that constitutes abstinence) and normalization of the same thoughts and attitudes as mentioned with Anorexia Nervosa.

This lack of clarity around a universal definition of recovery creates a vulnerability for what is referred to as “sort of true” criteria for recovery. For example, programs will report the percentage of patients who no longer meet criteria for Anorexia Nervosa and Bulimia Nervosa, the implication being that they are remitted since they no longer meet criteria for a diagnosis. The threshold weight criteria for Anorexia Nervosa is below 85% IBW, while the threshold criteria for the diagnosis of Bulimia Nervosa dictates that the patient is binging and purging two times per week over the last three month period. Technically, if a patient is 86% IBW or bingeing once per week, they no longer meet the diagnostic criteria for the respective diagnoses. While this is technically true, it may not be clinically meaningful. Very few clinicians believe that someone who is 86% IBW and/or engaging in binge/purge episodes once a week is remitted.
Percentage Reduction in Symptoms:

Some programs will report a percentage reduction in symptoms without reporting the actual frequency of the behaviors. If a patient reduces their binge/purge episodes from ten times per day to one time per day, the treatment program can claim having reduced their binge/purge frequency by 90%. While this outcome is statistically significant and looks quite impressive as a measure of treatment efficacy, the fact remains that the patient is still binge/purging daily. This is an instance where the change may be statistically significant, but less clinically meaningful.

Final Comment:

It is important for patients and families to know that clinicians and scientists in the eating disorders field are equally frustrated with the lack of empirical data on effectiveness of intensive treatment of Anorexia Nervosa and Bulimia Nervosa. Fortunately, two developments are occurring that will hopefully advance the field on these issues. More research funding is being directed to eating disorders, and organizations are emerging that can create benchmarks that allow for cross-program comparisons. There is also a movement to regularly monitor treatment program websites for misleading representations of outcome data.
About Eating Recovery Center

Eating Recovery Center (ERC) is the only national, vertically integrated, health care system dedicated to the treatment of serious eating and related disorders at any stage of the illness. ERC offers best-in-class treatment programs for all patients, no matter their age or gender, struggling from: anorexia, bulimia, binge eating disorder, eating and weight disorder, unspecified eating disorders, as well as comorbid, co-occurring and dual diagnoses. Led by the world’s leading experts in eating disorder treatment, ERC provides a full spectrum of eating disorder recovery services through an unmatched network of multiple locations across seven states.

www.EatingRecovery.com