



Preliminary assessment criteria for prescribing exercise when treating eating disorders: What do the experts have to say?

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1. Introduction

For individuals with an eating disorder (ED) it is commonly recognized that engaging in exercise during the course of treatment can be problematic to both short and long-term prognosis (Calogero & Pedrotty-Stump, 2010). Abusive exercise behaviors (i.e., exercise dependence, exercise addiction, compulsive exercise) are prevalent in 80% of individuals with anorexia nervosa (AN), 55% of individuals with bulimia nervosa (BN) and 31.9% of individuals with eating disorder not otherwise specified (EDNOS), and influence the etiology, development and maintenance of EDs (Calogero & Pedrotty-Stump, 2010; Dalle Grave, Calugi, & Marchesini, 2008; Moola, Gairdner, & Amara, 2013; Penas-Lledo, Vaz Leah, & Waller, 2002; Vancampfort et al., 2014). When these behaviors are present over the course of treatment, they are linked to higher levels of psychological distress and longer time periods spent in hospital, relaying directly to illness chronicity and suicide risk (Calogero & Pedrotty-Stump, 2010; Carter, Blackmore, Sutandar-Pinnoc, & Woodside, 2004; Hausenblas, Cook, & Chittester, 2008; Meyer, Taranis, & Touyz, 2008; Meyer, Taranis, Goodwin, & Haycraft, 2011).

The effect of exercise abuse on EDs has resulted in health professionals recommending that individuals abstain from exercise during treatment (Davies, 2015; Ng, Ng, & Wong, 2013). The practice of completely restricting exercise during treatment undermines the important role (stress relief, decreasing anxiety, sporting teams, elite athletes etc.) exercise often plays in the lives of these individuals. Furthermore, this management practice has long been adopted without

supporting research (Davies, 2015). Clinicians and researchers alike continue to question this practice, resulting in a growing interest about investigating the effects of incorporating safe, monitored and nutritionally supported exercise into treatment of EDs (Quesnel et al., 2017). A variety of exercise protocols have been successfully incorporated into ED treatment including graded protocols, resistance training programs, adapted physical activity, basic body awareness exercises, yoga and cardiovascular routines (Carei, Fyfe-Johnson, Breuner, & Brown, 2010; Catalan-Matamoros, Helvik-Skyjaerven, Labajos-Manzanares, Martinez-de-Salazar-Arboleas, & Sanchez-Guerrero, 2011; Chantler, Szabo, & Green, 2006; Duesund & Skarderud, 2003; Fernandez-del-Valle et al., 2014; Lutter & Smith-Osborne, 2011; Neumark-Sztainer, 2013; Sundgot-Borgen, Resenvinge, Bahr, & Sundgot Schneider, 2002; Tokumura, Yoshida, Tanaka, Nanri, & Watanabe, 2002). These protocols have been successful in improving quality of life, body composition, central health markers of the illnesses (e.g., drive for thinness, weight and shape concerns, and eating restraint) and co-occurring illnesses (e.g., anxiety, depression, muscle degradation, body esteem issues, sleep disturbances, perceived stress) without adversely affecting weight restoration or treatment outcomes (Moola et al., 2013; Vancampfort et al., 2014). More specifically, Szabo and Green (2002) incorporated light resistance training into the treatment of individuals with AN (n = 7), after eight weeks they found improvements in body mass, body mass index (BMI), percent body fat, lean body and fat mass, and psychological wellbeing. In a study of individuals with BN, three treatment groups were examined, Group 1 (an exercise group combined with CBT and nutritional therapy), Group 2

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(CBT only) and Group 3 (nutritional therapy only) (Sundgot-Borgen et al., 2002). Study participants engaged in aerobic and anaerobic activity, when compared to Group 2 & 3, the exercise group showed significant improvements in bulimic symptoms (i.e., bingeing and bingeing and purging episodes) as well as drive for thinness and body dissatisfaction, promoted self-regulation, improved reactions to everyday stress and decreased bodily tension (Sundgot-Borgen et al., 2002).

Despite the existence of these programs, as well as general recommendations for prescribing exercise during ED treatment (Cook et al., 2016; Scott & Van Blyderveen, 2014), there are no clinical guidelines to consider prior to managing or prescribing exercise within clinical ED populations (Geller, Goodrich, Chan, Cockell, & Srikaneswaran, 2012, pp. 3–170). Despite the lack of information, clinicians recognize that exercise is an important clinical feature of EDs (Bratland-Sanda et al., 2009; Hechler, Beumont, Marks, & Touyz, 2005; Quesnel et al., 2017). Due to the importance of this ED symptom, it has been postulated that management practices including assessment, incorporation and prescription have been implemented into treatment informally on a global scale (Bratland-Sanda et al., 2009; Hechler et al., 2005; Quesnel et al., 2017). For example, health professionals who currently consent to individuals engaging in exercise as well as prescribe exercise during the course of treatment often make this decision based solely on an inconsistent and arbitrary marker of weight (BMI; % ideal body weight-IBW) (Davies, Parekh, Etelapaa, Wood, & Jaffa, 2008; McCallum et al., 2006). Specifically, Davies et al. (2008) found that various treatment teams resumed exercise at a BMI of 15 m/kg² whereas others required a BMI of 18.5 m/kg². However, health professionals have agreed that examining weight alone is not sufficient to ensure that individuals are ready, in terms of mental and physical health status, to safely engage in exercise (Calogero & Pedrotty, 2007, pp. 141–160; Davies, 2015). Thus, the aim of this study was to expand upon the current practice (i.e., course of treatment based solely on a marker of weight) by exploring specific health parameters that experts in the field believe should be examined prior to permitting adult individuals with an ED to engage in exercise during the course of treatment.

2. Methods

2.1. Study design

This qualitative study utilized an exploratory, descriptive approach and semi-structure interviews to elucidate the perceptions and opinions of ED experts concerning the health parameters that should be reviewed prior to prescribing exercise during ED treatment. Qualitative methodologies were used due to their ability to draw conclusions from a data set without a pre-existing framework or theory and when detailed information from a unique perspective is valued (Creswell, 2007; Mayan, 2009, pp. 11–103). The project used an exploratory descriptive approach to account for the early stages of the current topic as well as to observe a phenomenon and understand the parameters that interact with it. The Behavioral Research Ethics Board at the University of British Columbia provided ethical approval for this study (#H15-01276).

2.2. Participants and recruitment

Interview participants included international ED experts (i.e., clinicians and researchers) across Canada, the United States and Europe. Participants were eligible to take part in the study if they met the following inclusion criteria: 1) completed a minimum of three years of fulltime experience working in EDs, 2) professional credentials (e.g., university degree, professional diploma) and registration with their licensing body (e.g., registered social worker), and 3) able to speak French or English fluently.

Participants were recruited over a six-month period (August

2015–February 2016) by email and face to face through public and private ED treatment centres, at professional ED conferences and academic meetings, by recommendation from other professionals working in the field and via their published work on the topic area. A total of 44 individuals were contacted, and those who were interested were emailed further information about the study and asked to confirm participation with a reply email. Reply emails were received from 18 individuals: based on eligibility criteria and availability, a total of 13 interviews were completed. Individuals did not participate in the study due to unsuccessful contact (lack of working email to contact them or non-response), scheduling conflict, or referred the invitation on to other colleagues.

2.3. Procedure and measures

Upon email confirmation from participants (n = 13), an additional email was sent to schedule an interview date and time, as well as to obtain informed consent and participant demographic data. Demographic data collected included: age, profession, number of patients treated, most common ED treated and workplace setting. Participants were asked to read and complete the forms and return them to the researcher prior to their interview. Each interview was scheduled according to the preference of the participant and all efforts were made to conduct the interviews face to face when possible (subject to geographic location and resource constraints). Overall, three interviews were conducted face-to-face, seven were conducted via Skype and four were conducted by telephone conference. The interviews were conducted between August 2015–March 2016 and ranged in duration from 45 to 100 min.

An open-ended questionnaire was developed based on the study objectives and existing literature concerning ED and exercise. The interview guide aimed to address short-comings in the literature pertaining to introducing exercise during the treatment of an ED (Hechler et al., 2005). Further, utilizing an arbitrary marker of weight is postulated as being an insufficient health marker when reinstating exercise during ED treatment, as such the interview guide intended to provide additional information for clinicians to determine when it is safe for exercise engagement during ED treatment. Additionally, the interview guide intended to speak to the call for an expert consensus statement for evidence-based guidelines for resuming exercise during ED treatment (Achamrah, Coeffier & Dechelotte, 2016). The content of the interview guide was designed to capture aspects of EDs (mental and physical symptoms) that may influence future exercise prescription during treatment. The interview guide was based on the following main question; “What are the five aspects of a patient’s health you think should be considered prior to permitting them to do exercise during treatment of an eating disorder?”. Specific questions were included but were not limited to “Do you think these would be based on physical health” and “Would these aspects be different based on diagnosis?”. Each interview incorporated probes to elucidate and develop topics, and interviewees were encouraged to speak honestly about their perceptions and beliefs. The interview guide was pilot tested with five (5) health professionals from the field of mental health including two psychologists, a psychiatrist, an expert in qualitative methodologies as well as health promotion expert. The psychologists and psychiatrist both has expertise in eating disorder treatment, whereas the others had an understanding of mental health as it related to physical activity. After the pilot test, the essence of the question remained the same, however some modifications were made to the wording and probes. A trained researcher conducted each interview and recorded every session with a Sony™ digital recorder. The audio recording was transcribed verbatim and then sent to the interviewee to edit and approve prior to data analysis.

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