

Perspectives of Professionals on the Treatment and Service Delivery of Eating Disorders in Cyprus

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Abstract

This paper investigates the perspectives of care professionals on the treatment of eating disorders and the capacity of the existing settings in Cyprus, to treat eating disorders. Qualitative, semi-structured interviews were conducted with seven professionals, working in settings for treating patients with eating disorders. The investigation identified two themes: The first theme concerns the necessity to fulfill the complex needs of patients with eating disorders, as well as the needs of their families. In addition, it concerns the importance of adopting a holistic and multimodal approach towards treating eating disorders, in order to achieve successful treatment outcomes. The attitudes and feelings of care professionals working with patients with eating disorders, were also identified. The second theme that emerged is an acknowledgement of the necessity for a stronger collaboration between the existing settings, for coordinated monitoring of these settings, and for upgrading specialized training. These two themes are interrelated and create barriers, which may prevent effective service delivery, affect the attitudes of professionals, and hinder the process of treatment.

Keywords: perspectives of professionals, eating disorders, specialist settings, qualitative study

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Eating disorders, like Anorexia Nervosa (AN) and Bulimia, are serious and complex mental diseases, usually affecting young people. Treatment outcomes of eating disorders are often poor (Murray, Quintana, Loeb, Griffiths, & Le Grange, 2019). Steinhausen (2009) showed that only 46% of patients fully recovered from AN, a third improved with only partial or residual features of the disorder, and 20% remained chronically ill for the long term. In a study which followed patients admitted at a specialized hospital for eating disorders over a 25 year period, Fichter, Quadflieg, Crosby, and Koch (2017) found that eating behavior, as well as the general psychology of the patient, improved but did not reach the level of healthy controls. Remission was found in 30% (total sample) and in 40% (20-year follow-up subsample). Another recent study found that in a 22-year follow-up, 62.8% of patients with anorexia nervosa and 68.2% of patients with bulimia nervosa recovered, as compared to 31.4% of participants with anorexia nervosa and 68.2% of participants with bulimia nervosa in a 9-year follow-up (Eddy et al., 2017). Furthermore, eating disorders are increasingly recognized as an important cause of morbidity and mortality in young individuals. The lifetime risk of anorexia nervosa in women is estimated to be 0.3% to 1%, with a greater number of patients having bulimia nervosa (Hoek & van Hoeken, 2003; Preti et al., 2009). A meta-analysis of 36 studies reported that, the mortality rates of individuals suffering from eating disorders, have risen significantly; the highest mortality rates being those of anorexia nervosa, while the mortality rates for

bulimia nervosa and EDNOS (Eating Disorders Not Otherwise Specified) are similar (Arcelus, Mitchell, Wales, & Nielsen, 2011).

The complex nature of eating disorders, associated with medical complications and psychological comorbidities, has been found to cause various emotional reactions to professionals treating patients with eating disorders (Franko & Erb, 1998; Kaplan & Garfinkel, 1999). Due to the serious medical complications, professionals often have to organize inpatient stays, be on-call for emergencies, and stay in constant contact with other professionals involved in treatment (Walker & Lloyd, 2011). In addition, due to the secretive nature of people with eating disorders, it is a significant challenge for health professionals to identify and diagnose such disorders at an early stage and direct the course of treatment (Abell & Richards, 1996; Jacobi et al., 2004). Patients with eating disorders, often induce intense feelings of anger, devaluation, hopelessness, love or identification with their caregivers (Land, 2004).

Studies have mainly concentrated on the patient's experience (e.g. Bell, 2003; Reid, Burr, Williams, & Hammersley, 2008; Skårderud, 2007), or the carers' experience (e.g. Perkins et al., 2004; Whitney et al., 2005). These studies indicated that research, which further explores the needs expressed by carers, may best be translated into settings that effectively meet the requirements of both patients and carers and reduce the risk to carers' mental health.

Thus far, there are only a few qualitative studies about the attitudes and experiences of care professionals treating patients with eating disorders in different settings. Walker and Lloyd (2011) identified that attitudes of care professionals in terms of treating patients diagnosed with eating disorders are related to lack of experience and negative countertransference reactions. Specifically, professionals may be feeling that they are doing a good job, but because they are not provided with adequate training, this results in feelings of inadequacy and subsequent negative attitudes that decreases their desire to work with these patients. Professionals also acknowledged a difficulty in empathizing with the service users, due to the fact that eating disorders are egosyn-tonic, and therefore, struggled to identify with them. In addition, professionals expressed confusion that something as pleasurable as food can lead to such a serious disorder. Furthermore, most participants expressed frustration accompanied with anger, because of the highly resistant nature of this disorder. They also felt ill-equipped working with this disorder, due to the complexity of its nature (Walker & Lloyd, 2011).

The qualitative study conducted by Reid, Williams, and Burr (2010), identified the practical difficulties of 18 professionals, to meet the complex needs of people with eating disorders. Participants felt that it is the limitations of resources that let to patients' needs being inadequately met. Interrelated practical issues, such as lack of training and skills, identifying the appropriate setting for treatment, increased demand for settings, challenges with allocating scarce resources, identifying which referral pathways are appropriate, and staff shortages, also affect treatment delivery.

Other studies have also determined that staff are receiving insufficient training to work with eating disorders (Wall, 2004), leading to a lack of competency and confidence when working with this group of patients (Jones & Lerner, 2004). It appears that, lack of training for health care professionals and scarcity of services for treating eating disorders are the most significant issues when it comes to the management of eating disorders in these settings (King & Turner, 2000; Lemouchoux, Millar, & Naji, 2001; Ramjan, 2004).

Qualitative studies allow the researcher to examine people's experiences in detail. One of the most distinctive features of qualitative research is that the approach allows one to identify issues from a participant's point of view, and understands the meaning and interpretations participants give to behaviors, events, or objects (Hennick, Hutter, & Bailey, 2011).

The aim of this study is to provide a broader perspective of care professionals on the treatment of eating disorders in Cyprus. This aim is considered of particular importance as the first hospital care center for eating disorders in Cyprus was only established recently (a little over five years ago). The study used the qualitative method, since there have not been any qualitative studies conducted previously in Cyprus, investigating the attitudes of care professionals concerning the treatment of eating disorders. Since the aim is the investigation of the views and perceptions of professionals on the treatment of eating disorders and the settings, rather than testing specific hypotheses, the adoption of an inductive approach, could lead to conclusions that go beyond the information that is directly observable (Singleton & Straits, 1999). Also, in order to view the case from a participant's perspective (Gillham, 2000), the use of an open discussion gave professionals the opportunity to freely express their views and perceptions on the research questions, thus allowing the collection of data be easily acquired.

It is believed that the opinions of the professionals concerning the multi-faceted aspect of treatment and setting delivery method of treating eating disorders, will reveal the most important issues, in terms of effective management of eating disorders in particular settings. This is the first known qualitative study to this day, that investigates multiple aspects of treating eating disorders, through a professional viewpoint, such as the consequences of the disorder on the child and the family, the different aspects of rehabilitation of the child and the family, as well as the attitudes and feelings of the professionals working with the patients and their carers.

Method

Setting and Participants

The sample was purposive, meaning that it was formed in 'a deliberate way, with some purpose or focus in it' (Punch, 1998, p. 193). It is also one which 'provides a clear criterion or rationale for the selection of participants, or places to observe, or events that relate to the research questions' (Ezzy, 2002, p. 74). Therefore, the sample was defined during the early stages of research planning as, all professionals who work in settings treating either inpatients or outpatients with eating disorders. Following the identification of the sample, seven professionals from seven different settings were selected to participate in the study. All seven settings were contacted for participation in order to explore the range of setting options available to patients. The specific professionals were selected based on the determination that they could provide appropriate and sufficient information regarding the treatment and setting provision of eating disorders, since all professionals worked in settings that are either specialized in the treatment of eating disorders, or their clientele includes these patients and their families. Given the small size of the country and the specialized nature of eating disorders in Cyprus, participants were generally well aware of the basic nature and functioning of all the settings.

Seven professionals were interviewed, using a semi-structured interview. All professionals approached agreed to participate in the study. Three psychologists, three social workers and one dietician/nutritionist were interviewed. One of the three psychologists, worked in an inpatient hospital unit specializing in the treatment of eating disorders, another in an outpatient center affiliated with a hospital specializing in the treatment of eating dis-

orders, and the third in counseling settings for youth. Social workers were employed in a community center and inpatient psychiatric clinic, respectively. The dietician/nutritionist worked in a center specializing in the prevention and treatment of eating disorders. Two of the settings participants worked in belonged to the public sector, one was private, and four were non-governmental settings. Although this sampling does not represent all types of professionals working with patients with eating disorders, this study includes the main professional staff involved in the treatment of eating disorders in Cyprus. Due to the similar nature of the perspectives and perceptions expressed by the professionals in accordance with their professional background and experience, the participants are only identified by their place of employment and an arbitrary ID number.

Procedure

Potential respondents were recruited through telephone contact. Respondents who initially agreed to participate were sent the informed consent, detailed information about the study, and the interview guide. After signing the informed consent, the interviews were scheduled and conducted in a private room at their workplace at the respondent's convenience. All interviews were tape-recorded with each participant's consent, and were later transcribed verbatim. The researcher conducting the interviews was based at a local university and not involved in setting provision, a factor which is believed to have increased the likelihood of an open reporting. The interview questions were developed based on a literature review on the specific subject matter and were designed purely for the purposes of the present study. The interview guide included thirteen questions and was divided into two parts. The first part, requested information about the specific setting. The second part included questions about the opinions and attitudes of professionals regarding the treatment of eating disorders, their professional role, and the overall evaluation of settings. It should be noted that questions addressed clinical forms of eating disorders which are prevalent in clinical settings, such as anorexia nervosa, bulimia nervosa, binge eating disorder, and otherwise unspecified feeding or eating disorder.

Data analysis

Content analysis was used to analyze the data and identify themes, using the six phase process as outlined by [Matzoukas \(2007\)](#). Data was reviewed by the second author who then discussed the themes with the first author. The final analysis was reviewed in depth by the first author, a researcher with experience in researching eating disorders, who also has clinical experience in working with patients with eating disorders. The first step involved the repeated reading of the entire transcript by the researcher and noting down the most relevant themes. The researcher read all the data set several times in a different order, so as to gain a comprehensive view of the participants' experiences ([Matzoukas, 2007](#)). The second step involved identifying and labeling similar concepts and features detected in the data set that seemed important. Initial codes were generated. Third, all relevant codes were grouped together into overarching themes. The fourth step, involved revising the themes to ensure they were representative of the entire transcript. The fifth step consisted of defining themes with a label that described the content of that theme. The sixth and final step involved the writing of the analysis, relating the findings of the investigation to the literature review. According to [Matzoukas \(2007\)](#), the final stage is important in that the researcher 'strives to give meaning, to relate unrelated points of reference, to interpret causes behind facts, and finally construct new knowledge' (p. 243). This procedure aims at putting the 'qualitative data into a more quantitative framework' ([Sharp et al., 2002](#), p. 122), but emphasis was put on meaning rather than on quantification ([Brewerton & Millward, 2001](#)).

Results

Two dominant themes were identified in the participants' answers after the analysis of data. The first theme focuses on the patient treatment and the needs of patients and their families. The second theme focuses on the adequacy of existing settings, referral pathways, coordination of settings, funding issues, and professional burnout. This issue was dominant in all participants' narratives. However, the two themes are interrelated, because the adequacy of existing settings and coordination between settings have an impact on setting delivery and the practical issues involved in the management of eating disorders. It has to be noted that for the purpose of this paper, participants' verbatim has been translated from the original language to English.

Theme 1: Rehabilitation of the Person With an Eating Disorder

Participants in all settings expressed their concerns regarding the multiple needs of patients that must be met through specialized settings, tailored for this group of patients. In particular, participants described the serious medical issues and special dietary needs of this group of patients as having a significant impact on setting delivery, since these needs have to be dealt with first, before the professional manages other aspects of the treatment. Several social needs also emerge during treatment, such as the need to have social support, to remain socially competent, and to reintegrate into society. These needs are present during as well as after the completion of the treatment. Other needs that emerged were of psychological nature such as the need to focus on the patient's low self-esteem, low motivation for change, aggressiveness, and dependency. The need of a long-term therapy for this group of patients was also emphasized. Outpatient settings in particular, emphasized the need for multi-disciplinary support for effective management of eating disorders and the provision of financial support for the family. As one participant stated, "*the biggest need of these children is support, multi-professional support. Treatment needs to be long-term, especially psychological. Apart from this, families need financial support*" (P7, Specialist center for the prevention and treatment of eating disorders). Another point brought up by all participants as essential to the rehabilitation of people with eating disorders was the importance of managing the emotional aspects of eating disorders. As an example, one participant stated "*major issues that adolescents bring to therapy are depression, anxiety, and feelings of emptiness. They express as their primary need, the issue of controlling the emotional content of the disorder as opposed to minimizing the bulimic episodes. Often they do not realize that these emotions are consequences of the disorder*" (P4, Outpatient counseling center for youth). Therefore, patients should receive long-term, multi-disciplinary treatment, with a focus on emotional regulation and reintegration into the person's social environment.

Consequences of the Disorder on the Person

All participants recognized that eating disorders are associated with a variety of serious medical complications and emotional/psychological conditions such as denial, fear, obsessive thoughts, lack of pleasure, depression, anxiety, feelings of emptiness, emotional dysregulation, low self-esteem, and pessimism. For example, one participant stated that "*self esteem issues have a significant impact on these children's social adjustment as well as on family relationships. As a result, when they recover they need to rebuild their life from the beginning*" (P7, Specialist center for the prevention and treatment of eating disorders).

Cognitive changes were also discussed, such as decreased understanding of the problem, constant comparison with other people, low motivation, weak response to professional interventions, and poor decision-making.

In addition, behavioral changes were also addressed by participants such as concealing symptoms and/or lying about them, expressing persistence on being guided by the mother, and showing lack of cooperation when it comes to taking food and medication.

Several changes were also reported which related to social functioning such as social isolation, low performance in school, isolation from peers, showing dependency only on the mother, and expressing dysfunction in family and social relationships. As one participant indicated, *“The most important consequence of this illness is that they gradually lose friends, relationships, bonds they used to have around them fall apart... This in turn has an impact on their confidence”* (P5, inpatient psychiatric unit). Therefore, regardless of the setting, participants recognized that this disorder impacts the person on multiple levels which need to be targeted in treatment for effective recovery to take place.

Consequences of the Disorder on the Family

Participants reported a range of consequences on the family of the patient. Family members express feelings of guilt, inadequacy, helplessness, low confidence, anxiety, and anger. Some family members express the need to distance themselves from the problem, deny the fact that they share responsibility, and dispose all responsibility for the well-being of their children to professionals. Other parents show overprotectiveness and take responsibility for previous problems that existed in the family. Participants noted changes in the family structure and dynamics such as spousal conflict, family arguments, and blaming among family members for the disorder. Financial consequences were also noted due to long absences from work to support their child's treatment and forced termination of treatment due to lack of financial support.

The following extract exemplifies the emotional burden on the family:

‘Parents feel that their children reached this point because they did something wrong. Often, they express a lot of anger towards each other. Overall, it is a difficult situation within the family system, which causes disorganization of the entire family system’ (P1, Inpatient pediatric unit).

Needs of the Family

Participants in all settings supported that family therapy was a primary need for the family of the person suffering from an eating disorder. Aspects of family therapy discussed included parental role guidance, the management of the family dysfunction, working on reaching emotional stability, managing parental feelings of guilt, strengthening of the parental role and teaching parental skills. As one participant stated *“We provide a lot of support to the family... as well as provide reinforcement so that they can sustain the children's diet... often when they return home they regress”* (P1, inpatient pediatric unit). Another participant noted that *“In those families that emotional stability is lacking within the family, it is important to help the family gain this stability. It is important that a family counselor meets with the child and the family in order to discuss the thoughts of the child concerning his/her body as well as dietary habits”* (P3, inpatient psychiatric unit).

Financial support was also mentioned as an important need for the family, such as covering the cost of transportation from one city to another (since the only center is in the capital), covering the cost of treatment locally as well as covering the cost of treatment abroad.

Overall, participants recognized that the family holds a central role in the management and treatment of an eating disorder. Moreover, including the family in the treatment plan and supporting the family financially, both issues emerge as important in the discussion related to the needs of the family of the patient.

Theme 2: Adequacy of Existing Settings

Participants from all settings described that settings are adequate but they also agreed that further improvements could be made. The setting that was reported by most participants as meeting the needs of patients and their families was the inpatient pediatric unit. The importance of dealing with all the problems of the patient, (psychological, physical, social) was also an important point brought up by most participants.

Overview of Settings

Positive aspects of settings provision were that settings are staffed by professionals who received specialized training abroad and are using evidence-based treatments that ensure positive treatment outcomes in these settings. Main areas for improvement discussed, were for the services to expand to all main cities, to include more staff with specialized training in eating disorders, to provide a holistic approach to treatment, and provide continuing education for professionals working with this group of patients. As one participant described, *“Patients with eating disorder, are a unique group of patients, therefore, staff working with these individuals, need to have specialized training”* (P2, Outpatient Counseling Center).

The Importance of a Multi-Disciplinary Approach

Professionals from all settings felt that working with a multi-disciplinary team is one of the most important factors in achieving positive treatment outcomes. As one participant described, a multidisciplinary approach leads to high success rates in treatment outcomes with these patients:

‘They receive medical treatment from child psychiatrists, pediatricists and endocrinologists. Very often we refer them to the gynecologist. We also have a close cooperation with the nutritionist in the hospital, because she has to adjust their nutrition to their changing needs. We also offer psychological and psychotherapeutic treatment and work closely with the family and, we use family treatment and occupational interventions’ (P1, Inpatient pediatric unit).

Participants whose setting included a multidisciplinary approach to the management of eating disorders spoke with confidence about their work, *“Since we constantly have new cases, and our rehabilitation rates are high, then we can conclude that we are offering the most appropriate treatment for each case”* (P6, Hospital outpatient center for eating disorders).

Other participants felt that their setting cannot fully manage cases because they require specialized interventions that they cannot offer. These settings were those based in the community and without any links to hospital programs. In such cases, patients are being referred to other settings or sent to specialized centers abroad, either at the beginning of treatment or during treatment, depending on the severity of the case.

Professional Interventions

Participants discussed a range of methods they apply in the settings they provide for the management of eating disorders. These include individual therapy, motivational interview, dietary education, family therapy, couple

counseling, group interventions, therapeutic groups for children, and counseling for social integration. All participants discussed the importance of including the family in the therapeutic planning, but also supporting the family whose member suffers from eating disorders. As it was expressed by one participant, “*Family therapy has been found to be the most effective intervention, especially for anorexia... Therefore, we do offer family therapy, and then, after we carefully evaluate the person and possible comorbidities, we offer a range of individual therapies such as cognitive-behavioral therapy, acceptance and commitment therapy, dialectical behavior therapy*” (P6, Hospital outpatient center for the treatment of eating disorders). It appears that each setting uses a range of interventions, depending on their level of specialization, specialized staff, and theoretical orientation.

Collaboration Between Settings

One participant expressed that there is a satisfactory level of coordination between the different settings. Elements of effective collaboration identified, were frequent communication, common clinical meetings for the purpose of coordination and sharing information, participation of professionals in treatment teams of different settings, and collaboration with other settings abroad (e.g. UK, Greece). According to one participant, “*Collaboration between settings appears to be excellent. Which means that when a person with bulimia or anorexia leaves our setting, he/she is not left alone because he/she is being referred to other settings*” (P5, Inpatient psychiatric unit).

However, most participants expressed that there is no cooperation between the different settings, attributing this absence to the lack of information between settings and specialized settings, to a gap between the private and public sector in Cyprus in terms of setting delivery, and patients’ long waiting lists in the public hospitals. As one participant noted, “*It is very difficult as a professional to reach out to other settings, as there is no adequate information about their programs and their referral system*” (P4, Youth counseling center). Another participant stated:

‘There is a gap between the public and private sector settings. When a person is referred to the public sector there is immediately a lack of communication with the private sector and the therapist who treated the case before. This results in the patient feeling abandoned, which is not beneficial for his/her well-being. There is a need for the public and private sector to collaborate in such cases’ (P7, Specialist center for the treatment of eating disorders).

Professional Attitudes

Participants were asked to describe their professional attitudes towards patients and their families. All professionals recognized as a fact, that both the severity and chronicity of the disorder, have an impact on their professional attitudes towards this group of patients. For example, one participant stated that “*Our feelings and thoughts have to do with the fact that it is a difficult disorder, it is a disorder that you need to treat as a team...*” (P6, Hospital outpatient unit for eating disorders). Some general attitudes identified were the importance of maintaining professional boundaries and adopting a non-judgmental attitude.

Professionals also expressed that the most challenging aspects of working with patients with eating disorders was persuading the child patient to accept the disorder, to cooperate during treatment, to motivate and counsel him or her to set goals, and make decisions for their own life. Professionals also raised the importance of maintaining professional boundaries until the child patient gains introspection, recognizes feelings, and takes re-

sponsibility for their disorder. Important professional attitudes towards the family, included sustaining neutrality, avoiding blaming the parent, empowering the family in order to recognize their responsibility, and providing relief and support to the family. As one participant stated:

“It is very important to have lots of patience [...]. I feel that being sentimental, helps me understand, in greater depth, how the person and family feel, trying at the same time, to maintain professional boundaries, and not allowing the child to become manipulative or take advantage of the situation, to achieve any goals. Because, his/her goals are not the same goals as ours. The ideal professional attitude is to be non-judgmental and non critical (P7, Specialist center for prevention and treatment of eating disorders).

Feelings of Professionals

Professionals expressed occasionally feeling inadequate when handling difficult patients and their families. These feelings relate to unsuccessful attempts to communicate to patients what needs to be done in order to improve. As one participant expressed, “*It is disappointing to witness young people to lack goals and have a superficial attitude towards life. I feel sadness but I also feel that I need to be persistent to help them find a purpose in life*” (P5, Inpatient psychiatric unit). Professionals expressed their determination to keep motivating the patient to set goals, make decisions, and cooperate with treatment. Feelings of stress, anxiety and concerns were also conveyed, related to the patient’s recovery. Strong sentiments of sympathy were also expressed for the predicament of the parents, and wished that a speedy recovery of the child will bring relief and happiness to them.

Suggestions for Improvement of Settings

All professionals raised the importance of establishing new specialist centers for eating disorders, supported by specialized professionals for the treatment of eating disorders, in all main cities in Cyprus. It is necessary to evaluate the need for such centres, in order to develop the appropriate settings. A participant discussed the need to set up a committee responsible for monitoring the various settings and promoting their collaboration (public and private). Participants also expressed the need for developing a national strategy and action plan related to the prevention and effective management of eating disorders in Cyprus. Moreover, participants recommended the development of a specialized unit for adult patients since, up to this date, specialized inpatient treatment is only available for minors.

‘At least once a month, a monitoring committee could meet, so that all settings get to know each other, and what each one does in this area...to coordinate all settings, and create an action plan together, I think this is necessary’ (P4, Youth Counseling Center).

The psychiatric inpatient setting discussed the need for a national strategy in order to promote the prevention of eating disorders, an element that is currently missing from existing settings.

‘These children come for treatment when the disorder has already progressed. We can reach them at an earlier stage... Mental health settings can work together with school doctors, and social workers can visit schools, talk to teachers... so that these cases get detected early. Unfortunately, we manage the issue, but we do not prevent the problem, there is not adequate prevention’ (P5, Inpatient psychiatric unit).

Discussion

The present qualitative study focused on the collection of data concerning the views and attitudes of professionals on the treatment of eating disorders in Cyprus. The findings of this study are of great value since they reflect the extensive experience of the professionals in treating patients with eating disorders and the interaction with the families, as well as, the participants' professional interaction with the existing settings in Cyprus for the treatment of eating disorders.

Participants noted the severity of the nature of eating disorders and the implications affecting the patient and the family, while stressing the difficulty in treating eating disorders. They identified the medical, psychological, and social consequences of eating disorders suffered by the patient, and emphasized the impact they have on the family. The complexity of these disorders has been acknowledged in previous research (Kaplan & Garfinkel, 1999; Katzman, 2005). Participants did acknowledge that a holistic approach to the treatment of patients with eating disorders is essential, which covers medical, dietary, psychological, social and other rehabilitative needs. The importance of adopting a holistic approach, especially when dealing with severe cases has been emphasized by researchers in this area (Treasure, Schmidt, & Macdonald, 2010). Severe cases present a multi-faceted treatment challenge, so management and treatment have to address the multiple risk factors that contribute to the problem.

They also acknowledged that the families of patients suffering from eating disorders, are in need of psychological and financial support. Through family therapy, families are expected to readjust their behaviors in a way that supports the treatment of their family member. It has been supported that family members are often excluded by adult settings and are given no information or support with their caring role (Treasure, Sepulveda et al., 2007). This is mainly because health professionals are reluctant to include the family, often citing confidentiality as the reason. Thus, carers' needs often go unmet in adult treatment settings. This adds to their distress which contributes to a negative atmosphere at home, consequently causing the eating disorder symptoms to persist (Treasure, Sepulveda et al., 2007; Treasure, Smith, & Crane, 2007). Guidelines on the recognition and treatment of eating disorders, often, incorporate the need to be aware that family members or carers of a person with an eating disorder may experience severe distress and suggest the inclusion of family members or carers' assessment of their own needs, as treatment progresses (NICE; National Institute for Health and Care Excellence, 2017). Furthermore, carers have the right to be informed, valued and respected as a treatment resource, as well as, have the right to accessible, appropriate support and educational resources (National Center for Excellence for Eating Disorders, 2019).

Financial support is also very important, in that, it relieves the family from the burden of the financial cost of the treatment, which is often quite substantial. In many cases, patients and their families have to seek a more specialized treatment abroad, in addition to treatment settings offered in Cyprus, and that cost worsens the financial burden. People with eating disorders have the right to accessible, fully funded, specialized care (National Center for Excellence for Eating Disorders, 2019).

Furthermore, social work professionals emphasized the importance of social reintegration during and after completion of treatment, as the disorder has a significant impact on the social functioning of the individual, as well as the entire family. It is expected that continuing social difficulties could worsen existing emotional difficulties

and possibly lead to relapse. Therefore, a multi-systemic approach, with a careful and ecologically based functional analysis of identified problems, could be helpful (Treasure, Schmidt, & Macdonald, 2010).

In agreement with previous research (Jones & Lerner, 2004; Reid, Williams, & Burr, 2010; Wall 2004), participants recognized that eating disorders are challenging to treat. They acknowledged the complexity of the treatment of eating disorders and that change is often a protracted process; a fact that often causes frustration to the professionals. Participants' attitudes towards patients and their families seem to vary, depending on the participant's value system, professional role, and experience in the particular setting. Nevertheless, providing support, guidance and empowering both the patient and the family appeared to be the cornerstones in treating these disorders. All participants accepted the importance of the psychological component for the treatment and the need for settings to develop effective ways of using patient-staff contracts.

The emotions of the participating professionals towards patients and their families also varied. Some participants expressed feelings of sadness and a sense of inadequacy in their relationship with this group, due to the complex nature of this disorder, and all encompassing medical and psychological complications. The emotional toll of working with this group has been documented in several studies before (Franko & Erb, 1998; Kaplan & Garfinkel, 1999; Walker & Lloyd, 2011). Staff were well aware of the importance of maintaining professional boundaries with these patients, as an important therapeutic tool and also for preventing professional burnout. Furthermore, staff did acknowledge the fact that relationships between professionals and patients with eating disorders are often challenging, because they do not necessarily agree on the goals of treatment. Previous research has supported that the therapeutic relationship is widely recognized as crucial to care, but is often problematic in this setting (Wright & Hacking, 2012).

When it comes to professional interventions, participants' discourse revealed a range of interventions used in meeting the needs of this group of patients. Participants seemed to have a collective vision of the ideal setting where people with eating disorders would receive individualized long-term treatment in a facility supported by multi-disciplinary staff. A holistic approach to treatment was also discussed with a substantial psychological component from trained professionals in this area.

Participants identified a number of practical difficulties that they felt reduced the quality of care. One difficulty appeared to be the collaboration between the different settings involved with this patient group. In particular, outpatient counseling settings expressed the need for improved communication during treatment planning and follow up of patients. Settings affiliated with a hospital with more specialized treatment plans and a multi-disciplinary team on site did not identify this as a challenge as their operation is more autonomous than outpatient counseling centers.

Participants from outpatient community centers identified as major issue the lack of information about the various programs and referral system of treatment settings. Therefore, better planning and collaboration across the settings might be helpful. Such planning could include an organized referral pathway, so that treatment does not cease prematurely, nor continued inappropriately in outpatient settings because insufficient specialist community centers are available. These participants were also the ones who felt that settings on a national level, are not adequate and as a result, serious cases are being referred abroad for treatment.

On the contrary, specialized settings appeared confident that they meet the needs of patients and their families, as they are properly trained, and have the knowledge and necessary skills to work with eating disorders. Most

participants emphasized the gap that exists between the public settings and the private settings for treating eating disorders. Again, this suggests the need for both sectors to be able to work better together. The importance of coordination of care for people with an eating disorder is part of the guidelines of the National Institute for Health and Care Excellence (National Institute for Health and Care Excellence, 2017) and suggest that more than one setting is involved, such as outpatient and inpatient settings, child and family settings, but also that people need care in different places at different times (NICE; National Institute for Health and Care Excellence, 2017).

The participants expressed the necessity for prevention programs to be included in the setting focus to reach children at an early age. They acknowledged that cases reach the settings when the disorder has already progressed. Preventive efforts could focus on the collaborative work among mental health professionals and school personnel.

Recommendations included better training of staff, legal regulation of the specific profession, and the creation of a monitoring committee which could support and promote the coordination and communication between the various settings involved. The importance of training professionals working with this population was noted on similar studies in the past as well (King & Turner, 2000; Lemouchoux, Millar, & Naji, 2001; Ramjan, 2004).

To conclude, while this is a specific study of specialized staff in Cyprus, it is believed that the themes revealed may be relevant in other countries as well. It has been supported in other studies that eating disorders are complex disorders to treat and that a holistic approach to treatment is the cornerstone of effective management of eating disorders. The emotional challenges of these disorders have also been documented, especially on the caregivers, as well as the emotional challenges of the professionals. The importance of including the family in the treatment plan is a well documented fact, which has been supported by many studies in this area.

The current study is limited by the fact that only seven professionals participated in the study. A bigger group of participants would have enabled the researchers to collect more detailed data, thus, deepening their understanding of the issues under investigation. Finally, the current research involved personal interviews with professionals, which raises the question as to what extent the participants could fully reveal their views about their professional role, as well as their settings. A future study could include other professionals, involved in the treatment of eating disorders such as child psychiatrists, general practitioners, and nursing staff. Another qualitative study which focuses on the carers' views on the treatment could also shed light on their own needs.

The study is the first one to explore issues concerning the setting delivery and treatment of eating disorders in Cyprus from the viewpoint of the professional. These findings are important and could lead to policies and strategies to improve the existing settings, as well as help in maximizing the collaboration between settings. This, in turn, would translate into improved treatment outcomes.

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Competing Interests

The authors have declared that no competing interests exist.

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