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ORIGINAL ARTICLE

Attitudes towards eating disorders clinicians with personal experience of an eating disorder

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Abstract

Purpose This study explores the perspectives and opinions towards ED clinicians with lived experience of ED.
Methods Three hundred and eighty-five ED clinicians and 124 non-clinicians from 13 countries, between 18 and 76 years of age completed an online survey about attitudes towards ED clinicians with a personal ED history. Almost half the respondents ($n=242$, 47.5%) reported a lifetime ED diagnosis. Survey items included ten multiple-choice and three open questions about clinician disclosure, employer hiring practices, and perceived advantages and disadvantages of clinicians with a personal ED history practicing in the ED field. Multiple-choice responses from clinicians with and without a personal ED history were compared with responses from non-clinicians with and without a personal ED history. Open questions were examined using thematic analysis.
Results Clinicians with no ED history, whose responses often differed from both ED-history groups (clinicians and non-clinicians), were more likely to indicate that clinicians with an ED should not generally treat ED patients, and that clinicians should self-disclose their ED history to employers but not to their patients. Thematic analysis of the open-ended questions revealed that advantages of having clinicians with an ED history include a deep experiential understanding and the ability to be empathic and non-judgmental, whereas disadvantages include the lack of objectivity and the risk of clinicians being triggered.
Conclusion Further research informing guidelines for ED clinicians with a personal ED history, their colleagues and employers are needed to protect and empower the significant minority of ED professionals with "lived experience" of EDs.
Level of evidence Level III, case-control analytic study.

Keywords Eating disorders · Personal history · Attitudes · Clinicians · Non-clinicians · Lived experience

Introduction

Many therapists choose their career in part because of personal struggles [1, 2] and wish to give back to others after overcoming such challenges. There are large variations in reported statistics around the incidence and prevalence of past and current mental health issues amongst clinicians. For example, between 35 and 76% of therapists may have experienced depression [3–5]. While some have reported that up to 75% of clinicians across mental health fields have received psychiatric treatment [6], such studies are plagued by low response rates. Wide variation in reported rates and methodological issues reveal, in part, the difficulty of assessing mental health amongst mental health clinicians—clinicians may have fears associated with speaking out about their struggles given the stigma that surrounds mental health, even within their own field [7, 8].

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Similar challenges exist within the ED's field in terms of assessing the extent to which people treating EDs have past or current eating distress, and there are wide variations in reported ED history amongst ED professionals. For example, only two of 800 therapists surveyed by Pope and Tabachnick [5] mentioned having experienced an ED. Yet within the ED field, a significant minority of clinicians report having experienced the disorders they treat [9–12]. Estimates of lifetime ED prevalence among ED providers range from 1/4 [13] to almost half [14]. A survey of 298 ED treatment providers found that 47% ($n=139$) reported a personal ED history [14].

Debates abound regarding whether, when, and in what ways recovered ED clinicians should practice. Whereas little research has focused on this population, the existing literature raises phenomenological, clinical and ethical questions concerning therapists with "lived experience" [15] of an ED [16–20]. There is an ongoing debate about whether and when it is appropriate, advisable, or even mandatory for therapists to self-disclose to clients about a personal ED history [16, 21, 22], and decisions about therapist disclosure differ between schools of psychotherapeutic thought. For example, psychodynamically-oriented therapists tend to disclose less often than feminist, humanistic or cognitive-behavioral therapists [23]. Opinions are also divided about the right of ED clinicians to withhold information about their ED history from employers, and whether employers are ethically permitted, or even obliged, to ask potential employees about an ED history [9, 13, 16, 20]. While some employers actively recruit ED clinicians with a personal ED history, others refuse to hire them [16, 20]. Furthermore, the lack of a consensus definition of recovery from ED [18, 24] makes it unclear when people with EDs are "recovered enough" to practice.

Norcross and Farber [25] reflected on how treatment provision by therapists with a personal ED history might be framed as either a problematic desire for self-healing or a positive, mature desire to give to others. Zerubavel and Wright [26] discussed the concept of "wounded healer", a Jungian archetype "that suggests that healing power emerges from the healer's own woundedness" [26 p.482]. Although they framed the "wounded" status as a strength, they pointed out that stigma, shame, and silence can be reinforced by seeing the "wounded" status as an impairment to practice. Within the ED field specifically, we continue to see the aforementioned debates about the appropriateness of those who might be framed within that "wounded" optic treating clients with EDs [10, 27]. Perceived advantages of having recovered clinicians practicing in this space include increased capacity for empathy, and instilling hope [10]. Disadvantages include relapse [28] and a tendency to overidentify with clients [19]. Johnston et al. [10] examined the beliefs, attitudes and opinions of ED patients, carers, and ED therapists towards ED clinicians with lived experience. All 32 ED therapists with lifetime ED, but only 46 out of 64 (71.9%) without, believed it was appropriate for ED clinicians with an ED history to treat clients with these disorders [10]. Patients and carers saw the experience of an ED as predominantly positive, whereas clinicians tended to perceive fewer advantages and adopt a stance that was neither positive nor negative. Recovery experiences of clinicians might be used in therapy, for the benefit of the patient, as has been done in the Netherlands (e.g. [29]).

Several recent studies explore attitudes toward ED clinicians with an ED history, especially attitudes of clinicians treating these disorders [29, 30]. Therapist self-disclosure about recovery from an ED has been found to give patients hope and strengthened the therapeutic bond [31]. A survey of 205 ED patients found that 97% pointed out advantages of experiential knowledge, including empathy, safety, insight, authenticity and hope [29]. Barriers and stigma from clinicians may, therefore, be impeding a potentially helpful element of treatment.

In our study, we elicited the perspectives of over 500 clinician and non-clinician members of professional international and national ED organizations towards ED treatment providers with lived experience through an online survey. Specifically, survey respondents were asked about the advantages, disadvantages and limitations of a personal ED history for clinicians and about implications for the employment of clinicians with an ED history. Open responses were analyzed, and multiple-choice responses were compared between: (1) clinicians and non-clinicians in the field of EDs; and (2) respondents with and without a personal ED history. Attitudes were explored and it was hypothesized that (1) attitudes of non-clinicians will be more positive attitudes than those of clinicians; (2) attitudes of respondents with a personal ED history will be more positive than those without.

Methods

Participants

A survey (see Table 3 in "Appendix") was sent to ~ 3000 members of ED organizations: the Academy for Eating Disorders, the International Association of Eating Disorder Professionals, the Binge Eating Disorder Association, the Michigan Academy of Nutrition and Dietetics, and the Israel Association for Eating Disorders (IAED). The survey was completed by ~ 17% of the link recipients (~ 509 individuals) aged 41.5 years (SD = 13.05, range 18–76). Most were female (91.4%, $n=470$) and clinicians (75.6%, $n=385$; mean length of practice 3.3 years, SD = 1.6): Social workers ($n=71$), clinical psychologists ($n=115$), physicians/psychiatrists ($n=28$), family/couples therapists ($n=30$), dietitians/nutritionists ($n=70$), counselors/expressive therapists (art, music and psychodrama therapists; $n=37$), nurses ($n=23$), and coaches ($n=11$). Non-clinicians ($n=124$) were advocates ($n=23$), students ($n=45$), researchers

($n=6$) and "other" ($n=50$). Respondents were from the US (68.1%, $n=346$), other English-speaking countries (8.6%, $n=44$; Canada [$n=22$], UK [$n=12$] and Australia [$n=12$]) and Israel (21.4%, $n=109$), with 2 respondents from Estonia and one each from Mexico, Latvia, Argentina, the Netherlands, Spain, Switzerland and Costa Rica. Most respondents had a degree (94.9%, $n=488$), and reported involvement with the ED field (84.8%, $n=436$).

Instruments

Survey

The survey (see Table 3 in "Appendix") focused on attitudes towards ED clinicians with a personal ED history. Items included (a) demographics (age, gender, country of origin); (b) professional characteristics (profession, degrees, length of practice) (c) personal ED history; and (d) ten questions about clinician disclosure, employer hiring practices, and perceived advantages and disadvantages. Three open questions were included: 1. Respondents who responded "Yes, conditionally" to the question "In your opinion, should clinicians who have recovered (or are in recovery) from an eating disorder be allowed to work with ED patients?" were asked for conditions that would allow this; 2. Respondents who saw advantages to ED treatment by a clinician with an ED history were asked to list them; and 3. Respondents who saw disadvantages were asked to list these.

Procedure

Participants were informed that the survey was about attitudes within the eating disorder treatment and advocacy community towards clinicians with a personal history of an eating disorder. The survey was administered online in January–February 2013 using Qualtrics® (www.qualtrics.com). The study was approved by the Internal Review Boards of the University of Michigan and Ruppin Academic Center in Israel. Informed consent was obtained on the first screen. Multiple choice responses from clinicians with and without a personal ED history were compared with responses from non-clinicians with and without a personal ED history. Statistical analyses were conducted using SPSS, version 23. Statistically significant between-group differences were tested with χ^2 tests with a Bonferroni correction (i.e. p-value multiplied by the number of questions [10] should still be below 0.05). Post-hoc analysis were only performed when the overall test was statistically significant. A Z-test was performed with Bonferroni adjusted p-values for the categories of answers for the post hoc analyses.

Open questions were examined using thematic analysis, to identify patterns in the responses speaking to themes relevant to the research aims [32]. RBM and JADV independently conducted the six-phase analyses [32]: 1. Reading responses; 2. Generating initial codes; 3. Systematically searching and labeling potential themes and codes; 4. Reviewing themes and codes; 5. Finalizing names and clear definitions for themes; and 6. Reporting the most frequent, relevant themes. Differences were discussed and resolved, together with AHZ, until a final set of consensus themes was reached [33].

Results

Almost half of the respondents (47.2%, $n=240$) reported a lifetime ED diagnosis (i.e., diagnosis of at least one ED in their lifetime), with 121 reporting anorexia nervosa, 94 reporting bulimia nervosa, 77 reporting binge eating disorder, and 108 reporting "another" ED (respondents could report a history of more than one ED). Of the 385 ED clinicians surveyed, 153 (39.7%) reported a lifetime ED diagnosis (25 with a current/active ED, 128 being recovered from a past ED). Of the 124 non-clinicians, 87 (71.8%) reported a lifetime ED diagnosis (46 with a current/active ED, 41 being recovered from a past ED).

Quantitative, multiple choice responses

Table 1 presents comparisons between the categorical responses of clinicians with ($n=153$) and without ($n=218$) an ED history and non-clinicians with ($n=87$) and without ($n=34$) an ED history.

In general, attitudes did not differ significantly between clinicians and non-clinicians. Multiple choice responses of clinicians without an ED history tended to differ from responses of the other groups. Below are brief explanations of the between-group differences presented in Table 1:

1. In response to the question asking whether clinicians who are recovered from a past ED should be allowed to treat ED patients, the vast majority responded either "yes" (44.3%) or "yes, conditionally" (46.5%). Clinicians with no ED history were significantly less likely to respond "yes" than clinicians and non-clinicians with an ED history (34.1% vs 51%, 54.7%), and more likely than non-clinicians with an ED history to respond "not sure" (11.1% vs 2.6%).
2. In response to the question asking whether clinicians who have a current/active ED should be allowed to treat ED patients, the majority responded "no" (65.9%). Regarding statistically significant group differences, "yes" responses were more frequent among non-clinicians with an ED history than among clinicians with no ED history (10.3% vs 1.4%).
3. In response to the question whether clinicians recovered or in recovery from an ED should disclose their ED his-

Table 1 Survey responses: major group differences

		Total	Non-clinicians		Clinicians		Statistics
			ED hist (1)	No ED his (2)	ED his (3)	No ED his (4)	
		N (%)	*N* (%)	*N* (%)	*N* (%)	*N* (%)	χ^2
Categorical questions	Answers	509	87	34	153	218	
Allowed to treat when recovered?	Yes	223 (44.3%)	47 (54.7%)	17 (51.5%)	77 (51%)	74 (34.1%)	24.58*, 1 > 4, 3 > 4
	Yes, conditionally	234 (46.5%)	34 (39.5%)	12 (36.4%)	69 (45.7%)	113 (52.1%)	
	No	9 (1.8%)	1 (1.2%)	1 (3%)	1 (.7%)	6 (2.8%)	
	Not sure	37 (7.4%)	4 (4.7%)	3 (9.1%)	4 (2.6%)	24 (11.1%)	3 < 4
Allowed to treat with active ED?	Yes	22 (4.4%)	9 (10.3%)	2 (6.1%)	7 (4.6%)	3 (1.4%)	24.84*, 1 > 4
	Yes, conditionally	82 (16.3%)	11 (12.6%)	2 (6.1%)	35 (23.2%)	30 (13.8%)	
	No	332 (65.9%)	52 (59.8%)	25 (75.8%)	91 (60.3%)	158 (72.8%)	
	Not sure	68 (13.5%)	15 (17.2%)	4 (12.1%)	18 (11.9%)	26 (12%)	
Self-disclosure to patient?	Yes, always	7 (1.4%)	4 (4.7%)	0 (0%)	1 (0.7%)	2 (.9%)	44.45***,
	When appropriate	324 (64.4%)	61 (70.9%)	23 (69.7%)	115 (76.2%)	119 (54.8%)	3 > 4
	If asked by patient	36 (7.2%)	10 (11.6%)	4 (12.1%)	8 (5.3%)	12 (5.5%)	
	No, never	58 (11.5%)	4 (4.7%)	4 (12.1%)	11 (7.3%)	35 (16.1%)	1 < 4
	Not sure	78 (15.5%)	7 (8.1%)	2 (6.1%)	16 (10.6%)	49 (22.6%)	1, 3 < 4
Self-disclosure to employer?	Yes, always	26 (6.5%)	3 (3.5%)	3 (11.1%)	3 (2.3%)	17 (11.9%)	20.16
	When appropriate	237 (59.4%)	49 (57.6%)	17 (63%)	86 (64.7%)	77 (53.8%)	
	If asked by employer	43 (10.8%)	14 (16.5%)	1 (3.7%)	13 (9.8%)	15 (10.8%)	
	No, never	33 (8.3%)	5 (5.9%)	4 (14.8%)	11 (8.3%)	12 (8.4%)	
	Not sure	60 (15%)	14 (16.5%)	2 (7.4%)	20 (15%)	22 (15.4%)	
Employer allowed to ask? (ED)	Yes, always	93 (18.5%)	8 (9.2%)	9 (27.3%)	16 (10.6%)	57 (26.4%)	33.30***, 1, 3 < 4
	Yes, if appropriate	175 (34.8%)	45 (51.7%)	11 (33.3%)	52 (34.4%)	64 (29.6%)	1 > 4
	No	175 (34.8%)	21 (24.1%)	10 (30.3%)	64 (42.4%)	70 (32.4%)	1 < 3
	Not sure	60 (11.9%)	13 (14.9%)	3 (9.1%)	19 (12.6%)	25 (11.6%)	
Employer allowed to ask? (other disorder)	Yes, always	63 (12.5%)	7 (8.1%)	5 (15.2%)	12 (7.9%)	38 (17.5%)	28.63*
	Yes, if appropriate	173 (34.4%)	43 (50%)	15 (45.5%)	42 (27.8%)	68 (31.3%)	1 > 3,4
	No	191 (37.5%)	21 (24.4%)	8 (24.4%)	69 (45.7%)	84 (38.7%)	1 < 3
	Not sure	76 (14.9%)	15 (17.4%)	5 (15.2%)	28 (18.5%)	27 (12.4%)	
Advantages	Yes	404 (81.1%)	82 (95.3%)	26 (81.3%)	138 (92%)	145 (67.8%)	47.91***, 1, 3 > 4
Disadvantages	Yes	432 (87.1%)	72 (83.7%)	28 (87.5%)	131 (87.3%)	188 (88.7%)	1.36
Actively encourage hiring	Yes	81 (16.2%)	28 (57%)	6 (30%)	40 (26.5%)	7 (4.2%)	96.42***, 1, 2, 3 > 4
	No	247 (51%)	20 (23%)	14 (42.4%)	56 (37.1%)	157 (73.7)	1, 3 < 4
	Not sure	163 (32.6%)	39 (44.8%)	13 (39.4%)	55 (36.4%)	49 (23%)	1, 3 > 4
Actively discourage hiring	Yes	26 (5.2%)	1 (1.1%)	1 (3%)	0 (0%)	24 (11.3%)	45.93***, 1, 2, 3 < 4
	No	391 (81%)	79 (90.8%)	22 (66.7%)	138 (92%)	152 (71.4%)	1, 3 > 2, 4
	Not sure	69 (13.8%)	7 (8%)	10 (30.3%)	12 (8%)	37 (17.0%)	1, 3 < 2

* = < .05, ** = < .01, *** = < .001

Hist history

Percentages do not add up to 100, because of missing data

For post-hoc analyses: > means the score(s) of the group(s) (numbers appear above) is/are statistically significantly higher than the score(s) of the other group(s) and < means they are statistically significantly lower than the other group(s), after Bonferroni correction

tory to their clients, most respondents (64.4%) thought they should, "when appropriate". Clinicians with no ED history replied "when appropriate" significantly less often than clinicians with an ED history (54.8% vs 76.2%), "no, never" significantly more frequently than non-clinicians with an ED history (16.1% vs 4.7%), and "not sure" significantly more frequently than clinicians and non-clinicians with an ED history (22.6% vs 10.6%, 8.1%).

4. In response to the question whether clinicians recovered or in recovery from an ED should disclose their ED history to employers, most respondents (59.4%) thought they should "when appropriate". There were no significant differences between groups.
5. In response to the question whether employers should be allowed to ask potential employees /clinicians if they have a personal ED history, approximately half the participants responded "yes, always" (12.5%) or "yes, if appropriate (34.4%), 37.5% responded "no" and 11.9% "not sure". Clinicians with no ED history responded "yes, always" significantly more often than clinicians and non-clinicians with an ED history (26.4% vs 10.6%, 9.2%). Non-clinicians with an ED history responded "yes, if appropriate" significantly more often than clinicians with no ED history (51.7% vs 29.6%) and "no" significantly less often than clinicians with an ED history (24.1% vs 42.4%).
6. In response to the question whether employers should be allowed to ask potential employees /clinicians if they have a personal history of any mental illness, almost half the participants responded "yes, always" (18.5%) or "yes, if appropriate (34.8%), 34.8% responded "no" and 14.9% "not sure". Non-clinicians with an ED history responded "yes, if appropriate" significantly more frequently than clinicians both with and without an ED history (50% vs 27.8%, 31,3%). They also responded "no" significantly less frequently than clinicians with an ED history (24.4% vs 38.7%).
7. Fully 81.1% of the participants responded in the positive to the question of whether there are advantages to ED treatment by a clinician with an ED history. Clinicians with no ED history answered in the positive ("yes") significantly less often than both clinicians and non-clinicians with an ED history (67.8% vs 92%, 95.3%).
8. Fully 87.1% of the participants responded in the positive to the question whether there are disadvantages to ED treatment by a clinician with an ED history. There were no significant differences between the groups.
9. In response to the question whether employers should actively encourage the hiring of clinicians with a personal history of an ED, approximately half the participants (51%) responded "no", 16.2% replied "yes" and 32.6% "not sure". Clinicians with no ED history responded "yes" significantly less frequently than clinicians with an ED history and non-clinicians with and without an ED history (4.2% vs 26.5%, 57%, 30%). They responded "no" significantly more frequently than clinicians and non-clinicians with an ED history (73.7% vs 37.1%, 23%).
10. In response to the question of whether employers should actively discourage the hiring of clinicians with a personal history of an ED, the vast majority of participants (81%) responded "no". Clinicians and non-clinicians with an ED history responded "no" significantly more frequently than clinicians and non-clinicians without an ED history (92%, 90.8% vs 71.4%, 66.7%). Clinicians with no ED history responded "yes" significantly more frequently than clinicians with an ED history and non-clinicians with and without an ED history (11.3% vs 0%, 1.1%, 3%). Non-clinicians with no ED history responded "not sure" significantly more frequently than clinicians and non-clinicians with an ED history (30,3% vs 8%, 8%).

Qualitative, open responses

Themes identified in the thematic analysis of open responses are summarized in Table 2.

Notably, participants articulated that there were both positives and potential pitfalls associated with those in ED recovery working with clients with EDs. Participants articulated the timeframe and psychological work associated with becoming an effective ED clinician following one's own ED. They suggested that working in this space required ongoing training and supervision to help navigate any challenges that could emerge. A therapist who is able to take on this work, according to participants, would be one who was self-aware, and who had received treatment that helped them reach a state of recovery prior to becoming an ED clinician and/or while practicing.

Participants suggested that having an ED history can lend the clinician experiential knowledge that they would not have been able to obtain elsewhere. Similarly, these clinicians were described as having the capacity to be empathic and non-judgmental, leading to the potential for a strong therapeutic alliance with the client. Trust in therapeutic relationships might be enhanced by openness around lived recovery experiences, according to participants. Clinicians with an ED history may also be received as hopeful symbols of the possibility of recovery and/or as positive role models.

Conversely, some participants described the potential for clinicians with an ED history to "lack objectivity", identifying the potential for unconscious transference and countertransference and/or assumption-making about the client's pathway to recovery. Concerns were articulated around the potential for a lack of objectivity with either party in the therapeutic relationship. Further, participants identified that some actions on the part of the clinicians (such as self-disclosure) may be received negatively if the clinician is not perceived to be in solid recovery. Finally, participants

Table 2 Overall themes with a short explanation of the qualitative analysis and examples

Category	Theme	Description	Quotes
Conditions for clinicians recovered/in recovery from ED treating ED clients	Fully recovered or well into recovery	Commonly connected to a specific time period of between 1 and 10 years	"They must be at least 10 years completely symptom free." "As long as they have been through the process of recovery, free of symptoms & resolution of emotional/trauma issues"
	Training/supervision	Receiving training or regular supervision to use experiential knowledge therapeutically	"Should be recovered. Get ongoing supervision" "As long as they can maintain clear boundaries and receive proper supervision"
	Awareness of self	Able to handle triggers and being aware of boundaries and the impact of the clinician (and self-disclosure) on the patient	"Must be recovered and not triggered by clients." "[They need to have] self- awareness of possible weight bias"
	Treatment	Past or current treatment experiences impact their ability to provide treatment. Differences of opinion about whether having had extensive treatment is a benefit or a drawback	"Not a severe eating disorder (I.e., only OP therapy or no treatment; in recovery for 5 years without relapse)" "If they are far enough in their recovery that they are emotionally stable and in treatment themselves so that they can be aware of triggers."
Advantages of therapists with an ED history	Deep experiential understanding and knowledge	Understanding and knowledge of the disorder, recovery, what the patient is saying, cognitions, difficulties, struggles, lies/manipulativeness/secret behaviors	"If you truly recovered, you understand the depth and pain the client must go through to let go of her/his ED. You've taken the journey and understand the work and commitment the client must have to be in recovery." "Understanding the personal perspective of one suffering and the difficult challenges that recovery involves. Many more, but specific to patients."
	Being empathic/non-judgmental	Having compassion, empathy, sympathy. Feeling understood makes it easier for patient to establish good working relationship	"True empathy with the patient's difficulties" "An innate understanding of thoughts and feelings underlying and eating disorder, personal struggles can give a better understanding and unique insights; it can create a bond and level of trust with client
	Inspires trust and hope for recovery	Seeing the clinician as recovered leads to hope that recovery is possible and to motivation. Seeing the clinician as a role model	"Clinician can represent that recovery is possible and meaningful" "Trust that therapist knows what is best since they know what it is like"

Table 2 (continued)

Category	Theme	Description	Quotes
Disadvantages of therapists with an ED history	Lack of objectivity	Possible unconscious omissions in noticing transference and countertransference. Assumptions based own experience extended to patient as the only way to recover	"Clinician may assume too much understanding of client's experience" "Assuming we can identify with what someone is going through"
	Risk of being triggered	The clinician may be triggered in therapy, leading to relapse or negative emotions. The patient may also be negatively triggered	"Professional might be triggered back into ED behavior/attitude by clients" "Possibly retriggering a past history"
	Depends on how well the clinician is recovered	Actions or self-disclosures may be harmful if the clinician is not well recovered	"Inappropriate self-disclosure, seeing recovery through a narrow lens" "The risk of the client not reacting well to personal information about the clinician"
	Comparisons and blurring of boundaries	Risk of negative competition (i.e. patient or clinician negatively comparing own recovery or body appearance/weight). Risk of intense emotional connection and unclear boundaries	"If the staff person does not have good boundaries, is still struggling with even body image issues, if too young in the field" "Patient could compare history with therapist (are they as ill/capable) etc."

Themes are presented in descending order based on the frequency of examples in the text relating to the themes

discussed the potential for boundaries to become blurred within the therapeutic relationship and/or for competition and comparison to arise.

Discussion

In our survey of over 500 ED clinicians and non-clinicians recruited via five national ED organizations, participants expressed a wide range of opinions, attitudes and values regarding lived experience in professional practice, reflecting the complexity of these issues and the lack of clarity provided by extant guidelines. Fully 47.5% of the ED clinicians surveyed reported a lifetime history of an ED, as was found by Warren et al. [14]. Since participants in both studies were self-selected, there is a high chance of self-selection bias. Nevertheless, ED therapists reporting a lifetime ED diagnosis undoubtedly constitute an important minority within the ED field, which raises ethical and professional dilemmas.

Respondents in our study were nearly evenly split between those who thought this minority should be allowed to practice unconditionally and those who thought conditions should apply. Under 2% believed they should not be allowed to practice. With respect to the articulated conditions of practice, participants suggested that therapists should:

(1) be recovered – although definitions of recovery varied widely;
(2) receive training and supervision to use their lived experience beneficially;
(3) have high levels of self-awareness to manage potential triggers and boundary issues; and
(4) have present or past therapy.

Such conditions are potentially important because of the absence of written policies or guidelines for hiring and monitoring clinicians with an ED history [9]. There is a clear need for further work on the legal and ethical considerations associated with employing clinicians with a past, and particularly a current ED [20, 33]. Moreover, considerations raised by respondents rest in part on the definition of recovery they endorse. In the open responses, conceptions of recovery ranged from having "just a few symptoms" to being completely symptom-free for a decade. This underscores the current disagreement on what constitutes remission, recovery and full recovery from EDs [34] and whether the latter is attainable [35]. The large discrepancies in recovery definitions, and, therefore, in conditions for clinicians with an ED history to practice, also underscores the urgent need for a standardized definition of recovery from an ED, operationalization and measurement strategies [36].

A minority of respondents (15%) reported a current ED. Although this group was not large enough to allow

comparisons, it is ten-fold that found by Johnston et al. [10]. Since cognitive capacities [37] and emotional competence [38] necessary for self-evaluation and decision-making may be impaired in people with active EDs, this is complex. Arguably, the professional and ethical dilemmas raised with regards to ED clinicians with lived experience seem more relevant for actively symptomatic clinicians. Regardless of the ethics surrounding the practice of currently ill clinicians, our results indicate this is a reality, and clinicians with active ED symptoms should, therefore, be recognized and supported.

ED clinicians with a lifetime ED need to decide whether and under what circumstances to disclose their ED history to their clients [13]. An overwhelming majority of participants (76%) supported self-disclosure "when appropriate". This stance seems justified by a study that found that ED patients expressed qualified positive responses regarding their therapists' self-disclosure [29]. Yet patients and therapists felt that too much therapist self-disclosure can harm the therapeutic alliance, contribute to negative transference and countertransference, trigger symptoms and/or invite comparisons between patients and therapists [29].

Approximately 80% of respondents believed that ED clinicians with lived experience of an ED had advantages over others, and the characteristics of these advantages were identified. It was widely believed that lived experience of an ED deepens therapists' understanding of and empathy for clients and enhances resistance to manipulation. It was also believed that recovered therapists serve as positive role models and inspire hope for recovery. These themes echo the unique advantages described in previous studies [10, 16, 29].

The fact that most respondents perceived lived experience of an ED as being advantageous for clinicians in many ways did not prevent them from simultaneously perceiving disadvantages. In fact, over 85% of respondents believed that ED clinicians with an ED history had disadvantages compared to other clinicians, especially if recovery was tenuous. Disadvantages included a lack of objectivity, assumptions from personal experience, relapse risk, comparison and competition, and blurring of boundaries. Interestingly, the belief that there are disadvantages to treatment by a clinician with an ED history proved the least contentious survey item, with no between-group differences.

Many of the ethical concerns addressed in this study remain to be addressed. For example, when is a therapist with an ED "recovered enough" to treat ED patients and who should decide? How should/could degree of recovery be measured when there is no consensus definition of ED recovery or measurement strategy [18, 24, 36, 39]? What guidelines could be proposed for employers when hiring clinicians with an ED history [20]? How can employers and colleagues ensure safe practice and adequate support for clinicians in recovery from EDs [13, 27] without increasing stigma against them [40]? Are clinicians with a history of other psychopathologies also prone to specialize in this disorder, and is their competence to treat clients with the disorder they have experienced questioned in the same way? There is a pressing need for research and informed guidelines on these and other issues concerning ED clinicians with an ED history. Despite studies pointing to the need for such guidelines [13, 16, 29], we still have none. Similarly, resources are needed to guide ED clinicians without a personal ED history in their dilemmas and ethical considerations regarding colleagues with a past or present ED.

This study has several limitations. First, the data were collected in 2013 by the "Recovery and Professionals" Special Interest Group of the Academy for Eating Disorders, the changing membership of which caused a delay in analyzing and reporting the results. Attitudes towards ED clinicians with lived ED experience may have since changed. Importantly, however, the questions raised in the survey still remain unresolved and we still have no clear guidelines for the clinical practice of clinicians with an ED history. Second, the ED diagnoses of respondents were self-reported, so may not have been entirely accurate. By distinguishing between a 'current' and 'past' history of an eating disorder, our survey did not take into consideration that recovery is a process, and that there may be variance between categorical ED self-diagnoses. Third, response rate was low, so selection bias seems likely. The survey was presented as being about attitudes towards clinicians with a personal history of an eating disorder. It was written and initiated by members of the "Recovery and Professionals" Special Interest Group of the Academy for Eating Disorders, and many members of this SIG with an ED history completed the survey. Participants, therefore, no doubt included an overrepresentation of respondents with a history of ED and people with strong feelings and opinions about ED clinicians with an ED history.

Our study adds to the literature about ED therapists with lived experience by elucidating differences between the viewpoints of clinicians and non-clinicians with and without a personal ED history towards fitness to practice, self-disclosure, hiring practices and (dis)advantages of a personal ED history. These viewpoints have the potential to inform future guidelines, for example by suggesting that to practice, ED therapists with a personal ED history should be in solid recovery, receive training and supervision, and be encouraged to receive therapy to increase self-awareness. In addition to informing future guidelines, these insights into how clinicians with an ED history view themselves and are viewed by others should be used on a national and international level to help combat stigma, promote openness and dialogue, encourage the adoption of a consensus definition of recovery, and help develop an informed approach towards the employment of ED clinicians with an ED history.

What is already known on this subject?

ED therapy by clinicians with a personal ED history raises ethical and clinical dilemmas. Little is known about the

advantages, disadvantages, limitations, support and employment of such therapists.

What this study adds?

Opinions about ED clinicians with an ED history vary and some place conditions on their practice. They are widely seen as competent, with both advantages and disadvantages over other ED clinicians.

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Availability of data and material Data is available from the corresponding author.

Compliance with ethical standards

Conflict of interest On behalf of all authors, the corresponding author states that there is no conflict of interest.

Ethics approval Approval was received from the University of Michigan Institutional Review Board and from the Ethics Committee of Ruppin Academic Center in Emek Hefer, Israel.

Consent to participate All participants provided informed consent.

Consent for publication All participants understood and approved that the results of the study would be published (without any identifying information).

Appendix

See Table 3.

Table 3 Survey questions and response options

No	Question	Response options
1	Should clinicians who have recovered or are in recovery from an ED be allowed to work with ED patients?	Yes Yes, conditionally No Not sure
2	Should clinicians who have an active eating disorder be allowed to work with ED patients?	Yes Yes, conditionally (Open question 1: Please list conditions) No Not sure
3	Should clinicians recovered or in recovery from an ED disclose their history to their clients?	Yes, always Yes, when they feel it is appropriate Yes, if asked by client No, never Not sure
4	Should clinicians recovered or in recovery from an ED disclose their history to their employers?	Yes, always Yes, when they feel it is appropriate Yes, if asked by employer No, never Not sure
5	Should employers be allowed to ask potential employees/clinicians if they have a personal history of an ED?	Yes, always Yes, if appropriate No, never Not sure
6	Should employers be allowed to ask potential employees/clinicians if they have a personal history of any mental illness?	Yes, always Yes, if appropriate No, never Not sure
7	Are there advantages to ED treatment by a clinician with an ED history	Yes (Open question 2: Please list advantages) No
8	Are there disadvantages to ED treatment by a clinician with an ED history?	Yes (Open question 3: Please list disadvantages) No
9	Should employers actively encourage the hiring of clinicians with a personal history of an ED?	Yes Not sure
10	Should employers actively discourage the hiring of clinicians with a personal history of an ED?	Yes Not sure

References

1. Barnett M (2007) What brings you here? An exploration of the unconscious motivations of those who choose to train and work as psychotherapists and counselors. Psychodyn Pract 13:257–274. https://doi.org/10.1080/14753630701455796
2. Farber BA, Manevich I, Metzger J, Saypol E (2005) Choosing psychotherapy as a career: Why did we cross that road? J Clin Psychol 61:1009–1031. https://doi.org/10.1002/jclp.20174
3. Gilroy PJ, Carroll L, Murra J (2001) Does depression affect clinical practice? A survey of women psychotherapists. Women Ther 23(4):13–30. https://doi.org/10.1300/J015v23n04_02
4. Mahoney MJ (1997) Psychotherapists' personal problems and self-care patterns. Prof Psychol Res Pract 28(1):14–16. https://doi.org/10.1037/0735-7028.28.1.14
5. Pope KS, Tabachnick BG (1994) Therapists as patients: a national survey of psychologists' experiences, problems, and beliefs. Prof Psychol Res Pract 25(3):247–258. https://doi.org/10.1037/0735-7028.25.3.247
6. NICE (2017) Eating disorders: recognition and treatment. Natl Inst Health Care Excell 27:547–561
7. Alyousef SM, Alhamidi SA (2019) Factors contributing to mental health stigma among Saudi medical practitioners. J Ment Health Train Educ Pract 14(2):96–15. https://doi.org/10.1108/JMHTEP-08-2017-0051
8. Tay S, Alcock K, Scior K (2018) Mental health problems among clinical psychologists: stigma and its impact on disclosure and help-seeking. J Clin Psychol 74(8):1545–1555. https://doi.org/10.1002/jclp.22614
9. Barbarich NC (2002) Lifetime prevalence of eating disorders among professionals in the field. Eat Disord 10(4):305–312. https://doi.org/10.1080/10640260214505
10. Johnston C, Smethurst N, Gowers S (2005) Should people with a history of an eating disorder work as eating disorder therapists? Eur Eat Disord Rev 13(5):301–310. https://doi.org/10.1002/erv.659
11. Shisslak CM, Gray N, Crago M (1989) Health care professionals' reactions to working with eating disorder patients. Int J Eat Disord 8(6):689–694. https://doi.org/10.1002/1098-108X(198911)8:6%3c689::AID-EAT2260080610%3e3.0.CO;2-H
12. Warren CS, Crowley ME, Olivardia R, Schoen A (2009) Treating patients with eating disorders: an examination of treatment providers' experiences. Eat Disord 17(1):27–45. https://doi.org/10.1080/10640260802570098
13. Bloomgarden A, Gerstein F, Moss C (2003) The last word: a "recovered enough" therapist. Eat Disord 11(2):163–167. https://doi.org/10.1080/10640260390199370
14. Warren CS, Schafer KJ, Crowley ME, Olivardia R (2012) A qualitative analysis of job burnout in eating disorder treatment providers. Eat Disord 20(3):175–195. https://doi.org/10.1080/10640266.2012.668476
15. Burch R (1990) Phenomenology, lived experience: taking a measure of the topic. Phenomenol Pedagog 8:130–160. https://doi.org/10.29173/pandp15137
16. Costin C, Johnson C (2002) Been there, done that: clinicians' use of personal recovery in the treatment of eating disorders. Eat Disord 10(4):293–303. https://doi.org/10.1080/10640260214506
17. McGilley BH (2000) On the being and telling of the experience of anorexia: a therapist's perspective. Renfrew Perspect 5(2):5–7
18. McGilley BH, Szablewski J (2010) Recipe for recovery: Necessary ingredients for the client's and clinician's success. In: Maine M, McGilley B, Bunnell D (eds) Treatment of eating disorders: bridging the research practice gap. Elsevier, New York, pp 197–213
19. Rance NM, Moller NP, Douglas BA (2010) Eating disorder counsellors with eating disorder histories: a story of being "normal." Eat Disord 18(5):377–392. https://doi.org/10.1080/10640266.2010.511901
20. Jacobs JM, Nye S, Picot A, McClanahan S, Conviser J, Costin C, Rabinor JR, Hornstein R, Murray LE, Levine MP, McGilley BH (2010) The therapist's appearance and recovery: perspectives on treatment, supervision, and ethical implications. Eat Disord 18(2):165–175. https://doi.org/10.1080/10640260903585649
21. Bloomgarden A, Mennuti RB (2009) Therapist self-disclosure: beyond the taboos. In: Bloomgarden A, Mennuti RB (eds) Psychotherapist revealed: therapists speak about self-disclosure in psychotherapy. Routledge, New York, pp 3–15
22. Geller JD (2003) Self-disclosure in psychoanalytic-existential therapy. J Clin Psychol 59:541–554. https://doi.org/10.1002/jclp.10158
23. Gibson M (2012) Opening up: therapist self-disclosure in theory, research and practice. Clin Soc Work J 40:287–296. https://doi.org/10.1007/s10615-012-0391-4
24. Bardone-Cone AM, Harney MB, Maldonado CR, Lawson M, Robinson DP, Smith R, Tosh A (2010) Defining recovery from an eating disorder: conceptualization, validation, and examination of psychosocial functioning and psychiatric comorbidity. Behav Res Ther 48(3):194–202. https://doi.org/10.1016/j.brat.2009.11.001
25. Norcross JC, Farber BA (2005) Choosing psychotherapy as a career: beyond "i want to help people." J Clin Psychol 61(8):939–943. https://doi.org/10.1002/jclp.20175
26. Zerubavel N, Wright MO (2012) The dilemma of the wounded healer. Psychotherapy 49(4):482–491. https://doi.org/10.1037/a0027824
27. Wright S, O'Toole A (2005) Professionals with eating disorders. Paper presented at the Eating Disorder Research Society 11th Annual Meeting Toronto. https://www.drshelagh.com/papers/Profesionals_with_EDs.pdf.
28. Eddy K, Tabri N, Thomas J, Murray H, Keshaviah A, Hastings E, Edkins K, Krishna M, Herzog DB, Keel PK, Franko D (2017) Recovery from anorexia nervosa and bulimia nervosa at 22-year follow-up. J Clin Psychiatry 78(2):184–189. https://doi.org/10.4088/jcp.15m10393
29. de Vos JA, Netten C, Noordenbos G (2016) Recovered eating disorder therapists using their experiential knowledge in therapy: a qualitative examination of the therapists and the patients view. Eat Disord J Treat Prev 24(3):1–17. https://doi.org/10.1080/10640266.2015.1090869
30. Williams M, Haverkamp B (2015) Eating disorder therapists' personal eating disorder history and professional ethics: an interpretive description. Eat Disord 23(5):1–18. https://doi.org/10.1080/10640266.2015.1013393
31. Wasil A, Venturo-Conerly K, Shingleton R, Weisz J (2019) The motivating role of recovery self-disclosures from therapists and peers in eating disorder recovery: perspectives of recovered women. Psychother 56(2):170. https://doi.org/10.1037/pst0000214
32. Braun V, Clarke V (2006) Using thematic analysis in psychology. Qual Res Psychol 3(2):77–101. https://doi.org/10.1191/1478088706qp063oa
33. Ryan GW, Bernard HR (2003) Techniques to identify themes. Field Methods 15(1):85–109. https://doi.org/10.1177/1525822x02239956
34. Khalsa SS, Portnoff LC, McCurdy-McKinnon D, Feusner JD (2017) What happens after treatment? A systematic review of relapse, remission, and recovery in anorexia nervosa. J Eat Disord 5(1):20. https://doi.org/10.1186/s40337-017-0145-3
35. Bardone-Cone AM, Alvarez A, Gorlick J, Koller KA, Thompson KA, Miller AJ (2019) Longitudinal follow-up of a comprehensive operationalization of eating disorder recovery: concurrent

and predictive validity. Int J Eat Disord 52(9):1052–1057. https://doi.org/10.1002/eat.23128
36. Bachner-Melman R, Lev-Ari L, Zohar AH, Lev SL (2018) Can recovery from an eating disorder be measured? Toward a standardized questionnaire. Front Psychol 9:2456. https://doi.org/10.3389/fpsyg.2018.02456
37. Brand M, Franke-Sievert C, Jacoby GE, Markowitsch HJ, Tuschen-Caffier B (2007) Neuropsychological correlates of decision making in patients with bulimia nervosa. Neuropsychology 21(6):742–750. https://doi.org/10.1037/0894-4105.21.6.742
38. Bydlowski S, Corcos M, Jeammet P, Paterniti S, Berthoz S, Laurier C, Chambry J, Consoli SM (2005) Emotion-processing deficits in eating disorders. Int J Eat Disord. 37(4):321–329. https://doi.org/10.1002/eat.20132
39. Bachner-Melman R, Zohar AH, Ebstein RP (2006) (2006) An examination of cognitive versus behavioral components of recovery from anorexia nervosa. J Nerv Ment Dis 194(9):697–703. https://doi.org/10.1097/01.nmd.0000235795.51683.99
40. Williams M, Leichner P (2006) More training needed in eating disorders: a time cohort comparison study of canadian psychiatry residents. Eat Disord 14(4):323–334. https://doi.org/10.1080/10640260600796267