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Eating Disorder Clinicians: From Personal Recovery to Supporting Others

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The Clinical Research Project is a graduation requirement for MSW
students at St. Catherine University/University of St. Thomas School
of Social Work in St. Paul, Minnesota and is conducted within a nine-
month time frame to demonstrate facility with basic social research
methods. Students must independently conceptualize a research
problem, formulate a research design that is approved by a research
committee and the university Institutional Review Board, implement
the project, and publicly present their findings. This project is neither a
Master's thesis nor a dissertation.

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Abstract

This qualitative study examined the experiences of clinicians at an eating disorder clinic who are recovered from their own eating disorders. The literature covered topics such as eating disorder types and symptoms, etiology, onset and duration, causes and risk factors, treatment interventions, therapeutic alliance, self-disclosure and burnout. The research questions for this study were: (1) What are the experiences of clinicians who treat clients with eating disorders after having recovered from their own? (2) How much self-disclosure is appropriate in the therapeutic relationship? (3) What type of accountability or support is in place for the clinician to be prepared for triggers or other emotions that may come up in sessions to prevent relapse? The research conducted for this study involved in-depth interviews of eight clinicians working in the same eating disorder agency who all self-identified as having had an eating disorder. The data was analyzed using open coding and developed into eight themes. The themes included: (a) body image acceptance, (b) views on the terms "recovered" versus "in recovery," (c) a desire to provide hope, (d) perceived higher levels of compassion, empathy and/or understanding, (e) approaching self-disclosure carefully, (f) lack of countertransference around the eating disorder, (g) agency support and use of humor and (h) the importance of self care to avoid burnout. Implications for future practice included agency emphasis on staff self-care, vacation time, consultation, ongoing trainings, staff retreats and support groups. Implications for future research included a larger-scale study with more specific questions, lack of a time limit, and more diversity among participants. Implications for policy included listening to the voices of recovered clinicians in order to gain perspective and understanding on the best treatment for clients with eating disorders.

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Eating Disorder Clinicians: From Personal Recovery to Supporting Others

Introduction

Eating disorders are a significant and potentially life-threatening problem that affects mental and physical health in both women and men. Up to 3% of the population is affected by eating disorders, in more females than males (Baker, Maes, Lissner, Aggen, Lichtenstein, & Kendler, 2009, p. 576). Costin (2007a) remarked that being an American female means one is automatically on a diet, and that the dieting trends have become more dangerous and deeply rooted. Costin also stated that as of 2007, only twelve states (i.e., Minnesota) have insurance coverage for the treatment of eating disorders and the remaining states are now under the radar to follow suit (2007a).

Currently, the DSM-IV TR diagnoses for eating disorders include the following: "anorexia nervosa (AN); bulimia nervosa (BN); and eating disorders not otherwise specified (EDNOS), which includes binge eating disorder (BED) as well as a variety of subclinical or more appropriately 'atypical' eating disorder presentation" (Costin, 2007a, p. 4). Eating disorders generally appear during adolescence, but can also develop during childhood or later in adulthood (U.S. Department of Health & Human Services, 2007). Contributing factors of eating disorders are thought to include biological, psychological and environmental reasons, and are often a combination of two or more reasons.

Recent studies between ethnic groups in the United States have not found substantial differences in terms of the symptoms of eating disorders. However, because of the stereotype that only Caucasian women develop eating disorders, it has been found that practitioners are less likely to inquire about disordered eating patterns with minority women (Gordon, Castro, Sitnikov & Holm-Denoma, 2010, p. 135).

Of the limited amount of research on clinicians' experiences working with eating disordered clients, the majority of the literature states that patients with eating disorders are among the most difficult to treat. Warren, Crowley, Olivardia, & Schoen (2009) found that clinicians find clients with eating disorders are unwanted as clients because of their infamous reputations for being resistant to treatment. Part of the reason they are so undesirable as clients is because of the negative consequences an eating disorder has on a person's health, and the fact that many are going through serious changes in their physical and mental functioning. Furthermore, a client with an eating disorder is more closely associated with suicidal ideation and attempts than someone without an eating disorder (Warren et al., 2009). Not only are clients with eating disorders battling society's pressure to be thin and beautiful, but clinicians are faced with these pressures as well. "Treatment providers living in Western cultures receive the same strong sociocultural messages about beauty, bodies, food, and attractiveness as their patients" (Warren et al., p. 29). Because of this, it is important to examine the self-care of clinicians treating clients with eating disorders, especially if they are recovered from an eating disorder themselves.

There is a great deal of debate over the definition of "recovery from an eating disorder," with criteria ranging from physical, behavioral and psychological components to how long the behaviors have to be absent and whether or not the client is being truthful or not in their report of themselves (Bardone-Cone, Harney, Maldonado, Lawson, Robinson, Smith & Tosh, 2010). When Darcy, Katz, Fitzpatrick, Forsberg, Utzinger and Lock (2010) conducted a study on former anorexia nervosa patients' views on recovery, many of the patients reported the following criteria: eating comfortably, no distorted

thinking, higher body image, having higher confidence and more healthy relationships, and general healthy functioning. Some of the patients stated that recovery is an ongoing process, while others reported that they do not believe recovery from an eating disorder is possible. Costin (2007a) stated that clients with eating disorders can be fully recovered, but that it can take many years and the success of recovery cannot be predicted. Costin also emphasized the absence of a firm definition of recovery in research, and offered the following features as giving a client a better chance at recovery: early onset and intervention, fewer co-morbid diagnoses, less frequency of purging behaviors, and a higher support system. For the purpose of this research paper, the researcher will use the term "recovered" instead of the terms "in recovery" or "recovering" when referring to staff persons or others who report having past eating disorders. This is based off of a recovery definition in Bardone-Cone et al. (2010) which outlined recovery as being when a client with an eating disorder history is indistinguishable from a client without an eating disorder history and is able to demonstrate physical, behavioral and psychological health in regards to their past eating disorder.

The primary purpose of this project is to explore the experiences of clinicians at an eating disorder agency who are recovered from their own eating disorders. It will look at what they experience while treating clients who are currently struggling with an eating disorder, whether or not it is the same type that the clinician had. In addition, I will be exploring the recovered clinicians' views on how much self-disclosure in the therapeutic relationship is appropriate, and if it harms, supports, or does not affect the client to know that their therapist has also struggled with an eating disorder. The secondary purpose is to find out what type of support from the workplace the clinician feels is needed in order to

maintain his or her recovery. This information can be used by other eating disorder clinics or any type of social service agency, in order to better support clinicians and promote self-care for social workers dealing with difficult situations that may be related to experiences they have had in the past. Finally, this project serves to contribute to the existing literature on the topic of clinicians working with eating disorders.

Few studies examine clinicians' past experiences with an eating disorder and the process of working with clients who present with an eating disorder. Therefore, the following research questions are examined in this project: (1) what are the experiences of clinicians who treat clients with eating disorders after having recovered from their own? (2) How much self-disclosure is appropriate in the therapeutic relationship? And finally, (3) what type of accountability or support is in place for the clinician to be prepared for triggers or other emotions that may come up in sessions to prevent relapse?

Literature Review

Throughout the literature on eating disorders, much of the information outlines the types, symptoms, onset, risk factors and treatments involved in the diagnoses. In addition, some literature has been found that demonstrates clinicians' experiences while working with eating disordered clients, as well as the importance of self-care. The following review summarizes the literature on these topics.

Eating Disorder Types, Symptoms, & Assessment

Costin (2007b) defined eating disorders as "an illness that manifests itself in a variety of unhealthy eating and weight control habits that become obsessive, compulsive and/or impulsive in nature" (p. 2). Costin goes on to say that the majority of eating disorders start out as diets, and that those who have eating disorders often suffer from

compounding issues of self-worth, depression, anxiety and a variety of other

psychological symptoms. The U.S. Department of Health and Human Services (2007)

reported that eating disorders may begin by a person eating more or less than usual, but at

some point the push to eat more or less falls out of their control. Murphy, Straebler,

Cooper and Fairburn (2010) further defined eating disorders as "characterized by a severe

and persistent disturbance in eating behavior that causes psychosocial and, sometimes,

physical impairment" (p. 611).

The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*

(2000) currently lists three diagnostic types of eating disorders: Anorexia Nervosa (AN),

Bulimia Nervosa (BN) and Eating Disorders Not Otherwise Specified (EDNOS). The

diagnostic criterion for AN includes refusing to maintain a healthy body weight, fear of

gaining weight, disturbed body self-evaluation, and the absence of a menstrual cycle.

There are two subtypes for AN: Binge-Eating/Purging type, and Restricting type (not

engaging in bingeing or purging). The diagnostic criterion for BN includes episodes of

binge eating, compensatory behaviors (i.e. vomiting, laxatives, diuretics, exercise), and

self-evaluation based on body shape and weight. Two subtypes of BN are: Purging type

(uses vomiting, laxatives, diuretics or enemas) and Non-Purging type (uses fasting or

exercise but not purging). The diagnostic criteria for EDNOS includes characteristics of

AN and BN that do need meet full criteria, purging after eating small amounts of food,

chewing food and spitting it out without swallowing, and binge-eating disorder without

purging.

Murphy et al. (2010) found that the focal point of eating disordered thoughts and

behaviors is the same for anorexia, bulimia and eating disorders not otherwise specified:

they emphasize body image and weight. Clients with eating disorders seem to find their worth in their appearance and ability to maintain control over their bodies. Barth (2008) reported that eating disorders are very different for each individual, and that symptoms can occur in a variety of ways. For example, dieting, bingeing, purging and over-exercising can occur in temporary experimentation, or can be longer term, persistent habits that worsen over time. Even bingeing and purging can look different; one client may eat large amounts of food in a binge, while another client may eat a small amount and still view it as a binge. Purging can take the form of vomiting, over-exercise or using laxatives and diuretics, with a frequency of twice per week to numerous times per day. Weight can stay relatively the same, or it can go up and down in a short or long period of time.

Barth also described eating disorder symptoms as being both adaptive and maladaptive. They can be adaptive because they can calm uncomfortable affects and feelings. Often after a binge and purge or exercise, clients describe feeling at peace, if only for a short time. However, they are maladaptive because they force clients to participate in unhealthy behaviors that harm the client's body. It is the therapist's job to assist the client in seeing the both the maladaptive and adaptive components of their behaviors so that they can begin to practice sitting with their feelings without using disordered eating as a coping mechanism (Barth, 2008).

Assessing a client for an eating disorder can be done using structured or unstructured interviews, and should include questions about the client's history and status as well as specific questions about both current and past symptoms if clients are forthright with their concerns. Additionally, questions about the specifics of their

symptoms can be different depending on the symptom; binge eaters should be asked

about the types and amounts of foods consumed, as well as whether or not they purge,

and how. For those who restrict, questions should cover what foods are avoided, rituals

performed, and any other associated compensatory behaviors (Peterson, 2005). Peterson

also named several structured clinician-based interviews that can be conducted,

including: The Eating Disorder Examination (EDE), The Structured Interview for

Anorexic and Bulimic Disorders (SIAB-EX), and the Structured Clinical Interview for

DSM-IV (SCID) which is a general interview that assesses for Axis I diagnoses (p. 37).

Population, Onset, & Duration

It is unclear how many people suffer from eating disorders, since many cases go

unreported. Of the reported cases, the statistics are high and growing. The number of

clients with eating disorders and/or borderline disorders in the United States is three

times the number of people with AIDS, which is roughly 5-10 million Americans

(Costin, 2007b).

Age group and gender also come into play: adolescent and college ages are more

typical, with 5-10 million females and 1 million males suffering from eating disorders

(Costin, 2007b). The number of males suffering from eating disorders is likely higher, but

many choose to avoid seeking treatment as it is more commonly seen as a female

disorder. Cook-Cottone, Beck and Kane (2008) reported the average prevalence for

anorexia nervosa is 0.3 percent in females, while bulimia nervosa is 1 percent in females

and 0.1 percent in males. Schmidt et al. (2007) found that Bulimia occurs in 4-7% of

young women, while Shapiro et al. (2010) found a similar prevalence and noted that it

generally occurs in women of average body weight.

Baker et al. (2009) found that eating disorders occur in nearly .5-3% of the population, with a 10:1 ratio of females to males being affected. Yet another difference between male and female self-image is that females tend to be dissatisfied with their bodies when they are overweight, while males tend to be dissatisfied when they are either underweight or overweight. Males also tend to use enhancing supplements or steroids, excessive exercise instead of dieting, and some have been found to be obese in the past. In addition, homosexual orientation can be a risk factor for eating disorder behaviors in men while it can also be a protective factor in homosexual women (Baker et al.).

Other Definitions

Though eating disorders, AN, BN and EDNOS have been thoroughly defined, it is important to know the meanings of some other common terms in the eating disorder field, including body image, body image dissatisfaction, dieting, body checking, self-harm and triggers.

Simply put, body image is the perception a person has of their body in their own mind (Ogden, 2010). It is not uncommon for people to dislike their body image from time to time, but when they cannot see past their disappointment in themselves, body image dissatisfaction (BID) can occur. Cheng and Mallinckrodt (2009) stated body image dissatisfaction "involves the attitudinal and affective-evaluative facet of body image, and thus refers to how people feel about their own body" (p. 365). They went on to report in their findings the relationship between BID and women's internalization of Western media images and messages that portray an unrealistic, thin body image. When women take the media messages too seriously and apply them to their own body image, BID may develop.

Dieting can often be a consequence of being dissatisfied with your body, and involves restrictive eating, which means trying to eat less than your body may need (Ogden, 2010). Restrictive eating may cause a person to feel out of control and either over-eat or under-eat, eventually leading to an eating disorder.

Mountford, Haase and Waller (2007) stated that one way to distinguish eating disordered women from non-eating disordered women is through their usage of body checking behaviors used to over-evaluate body weight, shape and image. Body checking is a symptom of the eating disorder and can manifest a client's thoughts and behaviors, as a way to maintain their eating disorder. An example of body checking behavior would be weighing oneself immediately after eating or purging, to make sure there has been no weight gain (Mountford, Haase & Waller).

Self-harm or self-injury is defined as an intentional act to harm one's body without the intention of dying from the behavior (Norton, 2011). One of the most common forms of self-injury is cutting (Norton), but eating disorder symptoms, such as restricting, bingeing, purging, using laxatives, diuretics or enemas can also be viewed as forms of self-injury (Costin, 2007a). In addition, Costin found that clients with eating disorders often participate in self-injurious behavior (SIB) as an additional or alternative way to cope.

In this research study, a broad definition of triggers is that they are events that happen in or around therapy that may bring up resolved or unresolved issues in the therapist's personal life, and may come about through a client's behaviors or through discussion around certain topics (Hayes et al., 1998).

Causes & Risk Factors

Eating disorders can be triggered by stressful life events such as leaving home for the first time, ending a relationship with a significant other, or being cut from a sports team. They can also be triggered by more serious physical or sexual abuse, as a way to allow the client to feel "in control" after a situation in which they did not have control (Herrin & Matsumoto, 2007). However, Barth (2008) said, "It would be a mistake to assume that all eating disorders are caused by early loss or trauma" (p. 356). There are numerous other reasons why a client may have an eating disorder.

Baker et al. (2009) reported genetics as a risk factor for eating disorders among males and females, including environmental factors, societal pressures and reproductive hormones. Herrin and Matsumoto (2007) stated that having a parent, sibling or relative with an eating disorder could be a high risk factor, as well as having high levels of neuroticism and low self-esteem.

Mayer, Muris, Meesters & Zimmermann-van Beuningen (2008) examined young females with disordered eating patterns, naming body dissatisfaction, low self-esteem, negative affect and insecure attachment as significant risk factors toward developing eating disorders. Their study of adolescent females found that high levels of eating disorder behaviors were linked to high levels of insecure attachment, depression, anxiety and low self-esteem.

Another risk factor in the development of eating disorders is poor social support (Limbert, 2010). The exact way in which social support affects eating disorder symptomology is unknown, however, Limbert found in her research that having acceptance from people in an individual's social circle could act as a safeguard to protect a person from the development of an eating disorder. Additionally, negative peer pressure

from close family and friends can also lead to a person's low self-esteem and cause them to feel like they need to be thinner than they are. Limbert (2010) found differences in the social support of anorexic and bulimic patients, noting that the families of clients with bulimia are often higher in conflict than families of clients with anorexia.

It is important to note that because eating disorders tend to be shame inducing and held private to clients, they may fail to seek help and support when needed because they want to keep the behaviors hidden from loved ones (Limbert, 2010). Family relationships are important to consider when treating a client with an eating disorder, whether they are seen as contributing to the eating disorder or as a support for the client's recovery.

Munoz, Israel and Anderson (2007) noted the role of the family as contributing to the cause and continuation of eating disorders, naming how close a family is and to what extent feelings can be expressed as factors. Their research found that the more mealtimes a family shares, the less binge eating and other eating disorder behaviors tend to occur. This can be because family mealtimes are an example of a ritual that creates stability within the family, as well a place where children learn healthy eating habits and attitudes from their parents and feel comfortable talking about their food-related problems (Munoz et al. 2007).

Barth (2009) also found that commonly, clients with eating disorders have family members who also have eating disorders or other addictions. Barnett, Buckroyd and Windle (2008) found that children of mothers with eating disorders are at a much higher risk of developing a disorder, as children tend to mimic the behaviors and attitudes of their caregivers. The authors further discussed the importance of mothers with eating

disorders to know the risks that surround their child(ren) so they may strive to promote

healthy development.

Interventions, Treatments, & Recovery

Researchers and clinicians have been trying to find effective treatments for eating

disorders for over two decades (Cooke-Cottone, Beck & Kane, 2008). Many cases of

eating disorders can be successfully treated through individually tailored combinations of

therapy and drugs, but there remains some mystery in the treatment of more severe,

chronic cases (U.S. Department of Health & Human Services, 2007). Common eating

disorder treatments generally range from Cognitive Behavioral Therapy (CBT),

Dialectical Behavioral Therapy (DBT), and family therapies. Treatment methods tend to

work differently within clients and disorder variations.

Cooke-Cottone et al. (2008) reported the most effective treatments for eating

disorders include Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy

(DBT) and the Maudsley model of family therapy, or Family-Based Therapy (FBT).

More specifically, they found that CBT interventions work better on a smaller-scale

basis, useful for treating a specific symptom rather than the entire eating disorder as a

whole (Cooke-Cottone et al.). DBT has been found useful for patients with bulimia and

binge-eating disorders (Cooke-Cottone et al.). Finally, Cooke-Cottone et al. conducted a

study on Attunement in Mind, Body and Relationship (AMBR) and found that it was

useful in treating eating disorders. AMBR is an approach which aims to integrate the core

eating disorder treatments by attuning the client's mind, body and relationship

experiences in order to reduce body dissatisfaction and eating disorder symptoms in

individual and group settings.

Family-Based Therapy (FBT) is based primarily on family involvement, and requires strong parental involvement over the course of fifteen to twenty sessions with the eating disorder client in an outpatient setting. Parents are actively involved in the client's recovery and are expected to assist in restoring the child's weight back to a healthy number, helping the child regain control over eating, and being present for open discussions about body image. This approach has been successful for treating eating disorders, especially anorexia nervosa (Bean, Louks, Kay, Cornella-Carlson & Weltzin, 2010). Benefits of FBT include an automatic support system for the client and professional training for the parents. One drawback with this approach is that it works best with intact families (both parents living at home), which is no longer the norm for American families (Bean et al., 2010). Rhodes, Baillee, Brown and Madden (2008) further defined FBT, also known as the Maudsley Method, stating that it was a way for parents to be seen as part of the solution, not the problem, and empowered them to face the disorder head-on. They also did a study on combining FBT with additional parent-to-parent consultation, and found that it was helpful for parents to confer with other parents of children with eating disorders. Munoz, Israel and Anderson (2007) also found that family stability plays a protective role in the development and maintenance of an eating disorder, and that taken into context with eating disorder treatment, family therapy can offer better outcomes for adolescents with eating disorders.

Schmidt et al. (2007) found that family-based treatments work well for adolescents with anorexia or bulimia, but reported that CBT works best for adults with bulimia. Self-guided CBT has now been discovered as an effective treatment for adults with Bulimia, as long as the client is still working with a therapist. Schmidt researched

self-guided CBT with adolescents, and found that it could be helpful as an early intervention.

In eating disorder treatment, CBT can be used for several aspects: educating the client, teaching the clients to recognize eating disorder symptoms, confronting negative self-talk and restructuring eating disorder thoughts, learning new coping skills, and preventing setbacks. It is generally used in both individual and group settings, and is effective for 40-67% of patients (Shapiro et al., 2010).

In addition, Shapiro et al. (2010) did a study on combining CBT with the use of text messaging as a form of self-monitoring and as a way for clients in group therapy to check-in on a regular basis. They claimed that the use of text messaging as a self-monitor eliminated the potential embarrassment and tediousness of keeping a journal and that the immediate feedback helped to bridge the gap between appointments. Results of the study showed that the participants who used the text messaging showed a decrease in bingeing, purging, night eating and symptoms of depression.

Cognitive behavioral therapy (CBT) has been found by Juarascio, Forman and Herbert (2010) to be the most effective treatment for eating disorders. Cognitive therapy (CT) in general has been found to be particularly successful with bulimia, used to help reduce compensatory symptoms such as purging or using laxatives. However, CT has not been significantly beneficial in treating anorexia, and can be similarly unhelpful in trying to change the strict eating pathologies in clients whose eating disorders have helped them get the closest to their ideal body weight, as they may not be interested in changing behaviors that maintain their weight loss. Murphy, Straebler, Cooper and Fairburn (2010) supported the use of CBT with eating disorders, first because of the empirical data behind

its successful history in treating bulimia and EDNOS, but also because eating disordered thoughts and behaviors are naturally cognitive.

Chen, Matthews, Allen, Kuo, and Linehan (2008) reported that cognitive-behavioral therapy was only helpful for about 50 percent of bulimia nervosa and binge-clients with eating disorders. They suspected this was because BN and BED clients do not generally respond immediately to treatment and may have co-occurring disorders, such as borderline personality disorders. They defined dialectical behavior therapy (DBT) as a "comprehensive, multimodal skills-based treatment balancing behavioral strategies with acceptance-based strategies and targeting life-threatening, therapy-interfering, and quality-of-life-interfering behaviors" (p. 505) and found in their research that it was originally created for women with borderline personality disorders. Thus, DBT may be a useful treatment intervention for clients with eating disorders with co-morbid personality or other disorders.

Ben-Porath, Wisniewski and Warren's (2009) findings were similar in that they stated because DBT focuses on regulating affect and controlling impulses, it is good for clients with eating disorders with co-morbid borderline personality disorder (BPD). In addition, they found that co-morbid BPD could be found in as high as 44% of clients diagnosed with eating disorders, so therapies that address both disorders must be sought out.

Farber (2010) found a trend in comorbidity between eating disorders and attention deficit hyperactivity disorder (ADHD), noting that the two disorders share common clinical features that make it difficult to diagnose and treat the disorders in tandem. One of the treatments used to combat ADHD is a stimulant, and because it can also be used as

energy or weight loss drug, there is potential concern for stimulant abuse and the

development or maintenance of an eating disorder. However, because a number of eating

disordered clients can have symptoms of inattention or impulsivity (mainly bulimic or

binge-eating types), taking stimulants can also work well for treating both disorders. Ma

and Lai (2009) also found additional disorders in patients with eating disorders, including

depression, anxiety and obsessive-compulsion.

In light of this, Juarascio et al. (2010) studied Acceptance and Commitment

Therapy (ACT) which "rests on the premise that a patient's reaction to a thought or

feeling is changeable, but that the internal experience itself is not" (p. 177). ACT teaches

clients with eating disorders that trying to control their distressing symptoms and

thoughts simply adds more stress to them, and encourages them to find a place of

acceptance, focusing on their important life values and gaining motivation from those.

Berman, Boutelle and Crow (2009) expanded on the goals of ACT, stating that it "seeks

to weaken the link between negative or unpleasant internal experiences or 'private

events' (whether emotions, cognitions or sensations) and subsequent maladaptive or

counterproductive behavior, without necessarily altering the private experiences

themselves" (p. 427). Though ACT is a newer therapy, studies suggest that it is helpful to

clients for a variety of concerns other than eating disorders as well.

Finally, though it is a familiar element in the different behavioral therapies,

mindfulness can be used in other psychodynamic approaches to therapy as well. Evidence

has shown that mindfulness can work well in the treatment of eating disorders, and if

taught to young girls and women, mindfulness skills may help serve as a preventative

measure (Wanden-Berghe, Sanz-Valero & Wanden-Berghe, 2010). Used in combination

with other therapies, mindfulness-based skills can help curb the urge to binge and

promote self-acceptance for clients with eating disorders (Wanden-Berghe et al., 2010).

        As far as recovery goes, Cook-Cottone et al. (2008) found in their research that

eating disorders are chronic illnesses that are difficult to treat, with anorexia nervosa

having one of the highest premature death rates of any mental illness. Ma and Lai (2009)

reported Anorexia Nervosa as a "protracted illness" whose outcome depends on the

several aspects of recovery ranging from physical weight restoration, attitudes toward

food, mental health and functionality in social settings (p. 403). Costin defined recovery

as when a person no longer uses eating disorder symptoms to cope with their problems

(2007b). Simply put, recovery time is different for each client, and variations of

treatments may need to be conducted in order to help the client to fully recover. Although

it may take years to achieve full recovery, it is possible and many clients with eating

disorders are able to reach this point (Costin, 2007b). Costin (2007a) also addressed the

use of the addiction model in eating disorder recovery. This is the idea that eating

disorders can never be fully recovered from; rather, they are addictions that can only be

controlled by abstinence and the client with the eating disorder may reach a state of

remission, but runs the risk of relapse. Costin criticized this model because she stated

clients with eating disorders cannot be abstinent from food; they have to face it every

day, and it is more beneficial for them to learn to do so in a healthy way rather than with

abstinence-based, black-and-white thinking (2007a). As an eating disorder clinician who

has recovered from a past eating disorder, Costin emphasized the importance of a

professional in the eating disorder field to examine how they view the illness, as it will

affect both their ability to treat and the outcome for the client (2007a).

Diversity in Eating Disorders

Although recent studies between ethnic groups have not found substantial differences in eating disorder symptoms (Gordon et al., 2010), clinicians should be aware that eating disorders are unique to the individual and that culture plays a part in how they are manifested. Gordon et al. stated that members of minority groups might be more prone to eating disorders as an attempt to cope with stressors different than that of Caucasian girls/women, including discrimination and mixed signals between their traditional culture and Western culture. Though the U.S. is populated with various minorities, Caucasians are still dominantly featured as the standard for beauty in the media (Gordon et al.). Gordon et al. (2010) defined acculturation as "a process of attitudinal and behavioral change undergone by individuals who reside in multicultural societies or who come into contact with a new culture" (p. 136). Among African American and Mexican American women, they found eating disorder symptomology to be linked with higher levels of acculturation. So, as a young girl or woman from an ethnic minority group becomes accustomed to the thin ideals of Western culture, she may be more at risk to develop an eating disorder. Costin (2007b) said, "with the exception of African American or black women, most women of color appear to have the same risk of developing eating disorders as white women," because there is evidence that African American women develop eating disorders at a lower rate than Caucasian women (p. 30).

Ma (2007) found that anorexia was an increasing mental health problem in China, including Hong Kong, Singapore and Mainland China. Ma found two possible reasons why it was happening: one was the Western acculturation in China, with thinness being seen as the ideal beauty standard. The second is that throughout Chinese history, thinness

has also been glorified and upheld as ideal. Either way, Chinese adolescents are being

told that thin is better from both cultural points of view. Ma and Lai (2009) researched

the use of family therapy with Chinese children and adolescents suffering from Anorexia

Nervosa. It is not as common in China as with Western treatment centers, but it is just as

necessary. They found that parents appreciated the family therapy because it set up a safe

environment for them to talk about the eating disorder and how the healing process works

in a culture where it is simply not discussed openly.

Therapeutic Alliance

Research has proven that the success of eating disorder treatment is based

primarily on the quality of the therapeutic relationship (McGuilley & Szablewski, 2010).

It has also been found that clinicians in the eating disorder field believe that a strong

alliance between client and clinician "results in less attrition, fewer premature treatment

terminations, and more helpful therapy" (p. 197). Bunnell (2009) echoed this sentiment,

adding that the ability to engage a client and maintain their motivation can lengthen

treatment.

A way to ensure that the therapeutic relationship is mutually well received is to

check in regularly. Norton (2010) recognized the importance of validating each other's

efforts, and that being authentic and genuine will help clients to realize that they can be

authentic and genuine as well. Not doing so may cause clients to feel hesitant about

opening up. Norton (2010) said, "the sharing of a false self by the clinician can also lead

to a false self on the part of the client" (p. 103). McGuilley and Szablewski (2010)

reiterated this concept, stating that our primary goal as clinicians is to demonstrate our

unfeigned humanity, so that the client has a chance to feel human. They also presented

several other components to having a successful therapeutic alliance, including: warmth and positive regard, active engagement, empathy and trust, endurance and tolerance, humbleness and transparency, and the ability to self-nurture (McGuilley & Szablewski).

Barth (2008) discussed attachment and affect regulation in the therapeutic relationship, stating, "…capacities for both self-reflection and mentalization grow in the presence of another who is both interested in one's experience and able to reflect back an understanding of that experience" (p. 363). Barth also found that many clients with eating disorders have difficulty with self-reflection, as well as with maintaining self-cohesion. Since eating disorders are often kept hidden from other people in the client's life, it is extremely important that the therapist stay consistent in their treatment of the client and focus first on managing the flood of feelings that come with uncovering such a disorder, rather than jumping in to stop the behaviors (Barth, 2008). Warren, Crowley, Olivardia and Schoen (2009) reported that eating disorder patients often struggle significantly in establishing trust and sharing power and control with their therapist. Therefore, it is important that therapists should approach the beginning of the relationship cautiously to build trust. However, a therapist does not have to worry about being completely flawless.

More important than perfection is empathy in the relationship between a client and clinician. If a clinician is empathic and can develop an authentic rapport, it will make way for more emotion regulation and successful treatment (Norton, 2010). Therapy, in its simplest form, is an honest conversation. If a clinician starts with that, and remains as genuine and authentic as he/she can be, trust will accrue naturally and a therapeutic alliance will be established.

Self-Disclosure

Clinicians working with clients with eating disorders must, at some point, be prepared to answer impending questions about their own body. Whether or not the clinician decides to self-disclose personal information, it is in their best interest to be able to give a thoughtful, genuinely therapeutic response (Costin, 2009). Many clinicians have mixed opinions on whether or not self-disclosure is appropriate with clients. Freud would argue that self-disclosure takes attention off of the client and thus stifles the therapeutic process (Jeffrey & Austin, 2007). Jeffrey and Austin also reported that it is naïve to think that allowing clients to know personal information about their therapist will cause them to feel less anxious and that the clients may actual develop less trust and respect as a result of clinician self-disclosure.

Though over-disclosure may have injurious results (Costin, 2009), much of the research concluded that self-disclosure has several benefits as well. Jeffrey and Austin found that self-disclosure could improve the therapeutic relationship when used carefully with appropriate timing. In addition, they described self-disclosure as the ability to "bridge the gap between patient and therapist" (2007, p. 97). Jeffrey and Austin also introduced three dimensions of self-disclosure: "…the amount of disclosure, intimacy of the information shared, and the duration of disclosure" (p. 99). When therapists are deciding whether or not to divulge personal information, they should keep these three factors in mind.

It is also important to keep population demographics in mind when considering self-disclosure. In particular, clients with eating disorders can have competitive thoughts about their therapist's body and the way it is presented (Warren et al., 2009) and may pressure the therapist to divulge private information about whether or not he/she has had

an eating disorder in the past, what kind, and how they recovered. If the therapist has not

had an eating disorder, the client may want to know their eating and exercise routines.

(Lowell & Meader, 2005). In addition, adolescents may require more clinician self-

disclosure than adult clients because of their cognitive and emotional development

(Jeffrey & Austin, 2007). A client's pressing questions may be the defensive result of

them wanting to avoid talking about themselves, or find a connection with the therapist

(Lowell & Meader). These can be difficult moments in therapy, but if a therapist has

answers prepared and is able to redirect the attention back to the client, it can be an

important learning opportunity.

Costin (2009) found that self-disclosure with clients with eating disorders can be

helpful, especially if the clinician has recovered from one as well. She also concluded

that if questions are asked and a clinician is faced with the predicament of sharing

personal information or skillfully avoiding the question, it is in the clinician's best

interest to give an "authentic, honest but non-disclosing response" (p. 189).

Countertransference

Historically, practitioners have expressed mixed opinions on the benefits and

drawbacks of transference and countertransference. Norton (2010) described Freud's

definition of transference as "the client's process of bringing past conflicts into the

present by reliving them with the therapist**"** (p. 96). Freud viewed transference as

unrelated to the current therapeutic relationship; however, modern theorists agree that it

is a "combination of both the projection of past conflicts and a piece of real life" (Norton,

p. 96). It is important for clinical social workers to understand transference as a common

occurrence in therapy, and to use it as a tool to evaluate the client's view of the

therapeutic alliance. Norton believed that, viewed in this light, transference is a normal and healthy occurrence. Understanding transference helps one to understand countertransference.

Since transference is defined as the *client's* reliving of past conflicts, countertransference is defined as the *clinician's reactions* to the client's projections (Norton, 2010). Freud again saw the negative side of these reactions when he said they were "unconscious sexual and aggressive wishes, impulses, desires, affects, and defenses that were evoked in a practitioner" (Berzoff & Kita, 2010, p. 342). He also said countertransference was hazardous and that having those thoughts meant the clinicians themselves needed therapy (Norton).

Berzoff and Kita (2010) found similar disapproving ideas of countertransference from a psychodynamic perspective when they described it as the client's problems bringing up the clinician's personal concerns, and that by pursuing his/her own therapy, the clinician could avoid the countertransference. However, countertransference can also be seen in a positive light.

Countertransference can also be used as a constructive tool that helps the clinician to see into the world of the client without necessarily using conversation. While the clients are in the midst of a difficult time of their life, their thoughts, feelings and emotions can be communicated in a way that helps the clinician to empathize fully (Berzoff & Kita, 2010). Warren et al. (2011) stated that sharing common feelings and experiences with a client can help a clinician to become better equipped to discuss and develop an appropriate plan of action for therapy, and that the overall experience of

discussing transference and/or countertransference helps the client to normalize their problem and see hope in their situation.

One of the most common examples of countertransference in working with clients with eating disorders are therapist feelings of irritation and impatience with clients who resist intervention and take a long period of time to recover (Bunnell, 2009). Some clinicians may also avoid addressing countertransference for fear of being viewed as an amateur or as lacking therapeutic skills. For therapists recovered from their own eating disorders, countertransference may cause them to think they are not done healing (Costin, 2009). It is important for a therapist to realize that countertransference is completely normal and healthy in therapy. As Berzoff and Kita (2010) said, "Where there is no countertransference, we would think, there is no real engagement or treatment" (p. 346).

Burnout & Self-Care

Empirical studies have demonstrated that mental health professionals are at a higher risk for burnout than primary care health workers and other professions, and that women are at a higher risk than men to experience compassion fatigue (Sprang, Clark, Whitt-Woosley, 2007). Berzoff and Kita (2010) defined compassion fatigue as "reactions that emerge from the therapist's overexposure to client suffering…" (p. 342), and explained that the process of being compassionate and vulnerable in order to find meaning in a therapeutic setting can prove to be very tiring. Additionally, clients with eating disorders are among the most chronically ill and difficult to treat (Warren et al., 2011). Eating disorders are seen as a form of purposeful self-harm, and can be very overwhelming to the clinician when they are not able to stop the client from doing the behaviors (Norton, 2010). Warren et al. (2009) reported that many clinicians experience

more anxiety and uneasiness when working with clients with eating disorders than with other clients.

Additionally, Warren (2011) said that clinicians and trainees working with clients with eating disorders will inevitably come across themes of beauty, body image and weight in their work, and that it will affect them in some way. In a survey of eating disorder clinicians, Warren collected the following recommendations for dealing with the feelings that may present themselves, including: engaging in self care inside and outside of work, supervision, limiting caseload, maintaining boundaries, and realizing that eating disorders are chronic and to enjoy the challenge of working with them.

Costin (2009) said that even therapists who feel they have confidence and self-worth will experience body image challenges, and will need to be prepared to address the feelings that come up and take care of themselves. Therefore, for female eating disorder clinicians, it is especially important to pay attention to their own emotions and feelings, and to utilize self-care in whatever form is most helpful to them.

McGuilley and Szablewski (2010) stated that the ability to self-nurture is equally important as having a solid knowledge base in eating disorder treatment. They found three benefits to nurturing the self, including: being able to recharge and refill, avoiding burnout, and bringing life to both a clinician's personal and professional worlds.

There is a difference between professional and personal self-care. Professional self-care includes being supervised, consulting with peers and if desired or necessary, outside therapy. Personal self-care can include a much broader range of interests, including but not limited to healthy relationships with family, friends and coworkers, and various activities and hobbies that do not involve work (McGuilley & Szablewsky).

Berzoff and Kita (2010) noted that supervision could also help with countertransference as well as serve as a form of self-care.

Therapist Body Image

Most women are affected in some way or another by society's standards for body image, whether client or clinician (Altschuler & Katz, 2010). Warren et al. (2011) reported that clients with eating disorders might have extra awareness of their clinician's body presentation, due to their own extreme body image concerns. Without proper self-care and supervision in place, social workers experiencing countertransference with their clients with eating disorders may accidentally hinder the therapeutic process with their unconscious reactions to the client's attention to their own body image (Altschular & Katz, 2010). Altschular and Katz also introduced the term "extraneous body image," which is a person's perception of the way others look and act. In other words, not only do people form body images for themselves, they also form body images for other people. As a result of this and Western culture, women are forced to place inappropriate amounts of attention on comparing their body image to others.

Lowell and Meader (2005) said that it is not unusual for women with body image dissatisfaction to compare their bodies to other women's bodies, but that when the other woman is the therapist, it will affect treatment. Because of this, a therapist may experience negative feelings about their appearance and their body image may be altered when working with clients with eating disorders, leaving a therapist feeling distracted by his/her own self-worth and unable to provide care (Lowell & Meader). The authors suggested therapists should be aware of the feelings they may have about their own

bodies so that when countertransference issues come up, the therapist and patient can be free to have a healthy dialogue about the feelings in the room.

As a therapist with a past eating disorder, Costin (2009) found it powerful for her clients to bear witness to female therapists who are confident and comfortable in their own skin, living eating disorder free. Despite the research on clinician's experiences with eating disorder patients, limited research is available on the experiences of working with clients suffering from eating disorders after having recovered from their own. Warren et al. (2011) conducted a study on eating disorder clinicians, with only 30% of them having suffered from their own eating disorder in the past.

In summary, eating disorders are illnesses that manifest themselves in a variety of unhealthy eating patterns in both men and women. They often start out as diets, but become uncontrollable habits and can lead to severe physical and psychological consequences (Costin, 2007b). There are three different types of diagnosable eating disorders, including Anorexia Nervosa, Bulimia Nervosa, and Eating Disorders Not Otherwise Specified; these types have specific symptomatic criterion that a person must meet before being diagnosed (American Psychiatric Association, 2000). Eating disorder symptoms can be both adaptive and maladaptive (Barth, 2008). Assessing a client for an eating disorder can be done via structured or unstructured interviews, and should cover a variety of questions about the client's eating behaviors (Peterson, 2005). Gender is the biggest risk factor for eating disorders, with 5-10 million females and 1 million males suffering from disorders, with Caucasian females most likely to seek treatment (Costin, 2007b). However, eating disorders do affect other ethnic groups (Gordon et al., 2010). Treatment for eating disorders can range from CBT, DBT and FBT (Cook-Cottone et al.,

2008), text messaging (Shapiro et al., 2010), Acceptance and Commitment Therapy (Juarascio et al., 2010), and mindfulness (Wanden-Berghe et al., 2010). Recovery from eating disorders is possible, but may take years (Costin, 2007b). One of the most important elements in eating disorder treatment is the therapeutic relationship (McGuilley & Szablewski, 2010). This can be nurtured by checking in regularly with the client, being empathetic and genuine (Norton, 2010), appropriately balancing self-disclosure and countertransference, and staying on top of burnout and compassion fatigue by utilizing personal and professional self-care (McGuilley & Szablewski). Finally, clinicians should be aware of their own body image and feelings of self-worth when treating clients with eating disorders, so that they can be confident and comfortable in their own skin and be open to healthy dialogue with their client (Lowell & Meader, 2005; Costin, 2009).

Therefore, building on existing research, the purpose of this study will be to survey eating disorder clinicians, 100% of them recovered from their own eating disorders, to explore the experiences they have with countertransference, self-disclosure, body image and self-care while working with a population for which they used to be a part of. In the following section, I describe the conceptual framework that guides this research project.

Conceptual Framework

Strengths Perspective

This research project was based off of the conceptual frameworks of strength and empowerment perspectives in social work. The strengths perspective holds that all people have innate power to change themselves, and that if they focus on enhancing their strengths they will be more likely to succeed (Miley, O'Melia, & DuBois, 2007). In

addition, social workers that utilize the strengths theory automatically enhance their own work environment by creating an atmosphere that focuses on basic social work values, such as human dignity, worth and respect (Miley, O'Melia, & DuBois).

Clients with eating disorders are often self-deprecating and feel so powerless that they cannot see the strengths in themselves or their ability to overcome the eating disorder. Clients may even see their eating disorder itself as strength, and may see living without an eating disorder as a weakness. It is important to note that the strengths perspective does not completely ignore limitations, but that focusing solely on limitations and mental illness makes it difficult to discover the client's strong points (Miley, O'Melia, & DuBois, 2007). Helping clients with eating disorders to see their strengths, point out that they have the ability to grow and change, and see a future full of possibilities (Miley, O'Melia, & DuBois) is crucial to their recovery.

Empowerment

The empowerment perspective builds off of the strengths perspective in that it requires both clients and clinicians to use their strong points to increase power in their situations (Miley, O'Melia, & DuBois, 2007). Empowerment can be used in personal, interpersonal and structural ways. Personally, empowerment can inspire someone to find his or her own sense of competence and mastery in any given situation. Interpersonally, empowerment emerges from a person's own experiences to positively influence another person's life. Structurally, empowerment can increase a person's access to resources and opportunities in political and social environments (Miley, O'Melia, & DuBois). Finding power means overcoming powerlessness, oppression and victim blaming, all of which can be present in any situation (Miley, O'Melia, & DuBois).

In the context of eating disorders, clients may label themselves as powerless against the disorder, feeling oppression from society's standards and when they cannot reach those standards, blaming themselves for their perceived failures. As clinicians who have experienced their own eating disorders and are now treating clients with the same or similar disorders, they have the opportunity to use their experience as empowerment to facilitate change personally, interpersonally and structurally. Personally, they have found competence and mastery over their eating disorder. Interpersonally, they now have the ability to pass on their knowledge and recovery experience to another client with an eating disorder. Structurally, as a clinician in the eating disorder field, they have the resources to affect political and social change in the area of mental health. The researcher desired to explore what empowered clinicians did to overcome their own eating disorders, and what strengths they draw upon while treating clients with eating disorders.

Methods

Research Design

This research project's design was exploratory in nature, as there was limited research on eating disorder clinicians who had recovered from their own eating disorders and what their experiences were while working with clients with eating disorders. It was a qualitative research study, which attempted to find answers by studying individuals in their natural social environment (Berg, 2009). Qualitative research aims to uncover pertinent information that cannot be found in a number or a statistic by interviewing people directly or by reading their personal accounts (Berg). The product that this type of research leaves us with is a new understanding of a person's relational structure and worldview brings meaning into their lives (Berg). This research project was more fitting

in a qualitative format, since the questions that were asked were ones where participants'

answers could not be fully expressed through numbers or simple "yes or no" answers.

The eight questions that were asked in the interview were subjective in nature. The

researcher sought to understand the experiences of clinicians who had struggled with

their own eating disorders to find out how they recovered and what it is like to work with

clients with the same or similar struggles.

Previous research on this topic looked at eating disorder clinicians' experiences,

with only some of the clinicians having had a past eating disorder. This research project

looked only at clinicians who have had an eating disorder in the past. Upon conducting

the interviews, the researcher looked for similarities and differences within their answers

and found eight themes, including: (a) participants experiencing body image acceptance,

(b) their views on the terms 'recovered' versus 'in recovery, (c) a desire to provide hope,

(d) perceived higher levels of compassion, empathy and/or understanding, (e)

approaching self disclosure carefully, (f) the lack of countertransference around the

eating disorder, (g) agency support and use of humor and (h) the importance of self care

to avoid burnout.

Sampling

The sampling for this research project was a non-probability, convenience and

purposive sampling. It was a convenience sampling because the researcher had a

relationship with the agency and the researcher recruited from the agency (Appendix A).

It was a purposive sampling because the researcher used both hers and her supervisors'

knowledge and expertise to suggest agency locations where participants could be

recruited. It was important to the researcher that the clinicians met specific criteria,

including having worked primarily with clients with eating disorders, and by self-definition having had an eating disorder in the past. The research director of this agency gave permission for the staff to be contacted via the Internet and email to see if they would like to participate in the study on a first-come, first-served basis. Eight participants who met the criteria were accepted for interviews. The research director at the agency did not know which staff members agreed to participate in the interview, and the research paper did not connect data to specific participants.

Protection of Human Participants

Treatment providers are not generally seen as a vulnerable population, however, since these clinicians were ones who had a past eating disorder and the questions may have been sensitive in nature, participants were given a list of resources they could contact if they experienced emotional difficulties after completing the interview (Appendix E). This list of resources contained information for the agency that they worked at, as well as other agencies and hotlines in the surrounding areas. The information about the participants was kept confidential and the research director and committee members did not know which staff participated in the interviews. The participants contacted the researcher directly if they chose to participate in the interview. The interviews were audio tape-recorded, no longer than one hour long, with one demographic and seven qualitative questions asked. The researcher transcribed the data from the interviews. The interview was conducted either in the researcher's private office, the participant's private office, or an unoccupied office or conference room within the agency. In the event that a participant was from an out-of-town location, a plan to

conduct a telephone or video-chat interview was made; however, this was not needed in this research study.

The participants signed a consent form agreeing to be a part of the research, and were fully informed of any information about the research project or risks involved in participating (see Appendix C). The consent form was sent to the participants via email prior to the interview so they could review it and ask any questions they may have. A copy of the interview questions was also emailed to the participants ahead of time. The researcher asked the participants to sign a copy of the consent form at the beginning of the interview, which the researcher kept. The participants were offered a paper copy of the consent form to keep.

The participants' involvement in this research project was completely voluntary; at any time they were allowed to end the interview or choose not to answer any of the interview questions. Participants were not penalized if they chose to withdraw from the study; however, if a participant chose not to complete the interview, the researcher had the option to omit the unfinished interview and pursue an additional participant for the research project. There was no need for this option since all the participants completed the interviews. The audiotapes and any other information from the interviews were destroyed within two weeks of the completion of this research project, by May 28th, 2012. The results from the research project were made available to the agency in which the research was conducted.

Data Collection

The data was collected from eight voluntary, consenting participants through an eight-question interview that lasted no longer than one hour. The interview was made up

of one demographic and seven qualitative questions, determined by the researcher based on past research and information desired for the current research project and for future implications (see Appendix D). The interviews were audio tape-recorded and subsequently transcribed by the researcher. The audiotapes and interview notes were kept in a locked file box in the researcher's office when they were not being used. The audiotapes and any other notes and written information were destroyed within two weeks of the completion of the research project, by May 28th, 2012.

Data Analysis

The researcher transcribed the qualitative data collected from the surveys, and then codes were developed or identified in the data by the researcher. Codes were then used to identify themes and categories, and transcripts were sorted by these categories and themes to identify similarities and differences, patterns and relationships within the data. The patterns found were considered in light of previous research, and used to draw general conclusions, theories and to answer the researcher's original questions and make suggestions for future practice and research.

Strengths and Limitations

This research project offered several strengths. First, the information was based directly from eating disorder literature. Second, the idea for the project came from a meeting with an eating disorder clinician from the agency; this clinician and several others at the agency had given the researcher their consent and support for conducting this research project at their agency with their staff as participants (see Appendix A). This particular agency did a staff presentation on a similar topic, and was interested in having it replicated in other research. Third, much of the research had explored the experiences

of clinicians who had treated clients with eating disorders (Warren et al., 2011), but limited information examined clinicians who have had eating disorders themselves and were still working with the same population. This particular research project addressed the lack of literature on that topic by interviewing clinicians working at an eating disorder clinic who were recovered from their own eating disorders. Fourth, this research project was qualitative in nature and designed to provide more in-depth answers to the researcher's questions. Its purpose was to pursue an accurate and genuine understanding of what it is like for a clinician to have lived with an eating disorder in the past, and to now be working with clients with eating disorders.

This research project also had a few limitations. First, it was a small-scale project that needed to be completed in a short amount of time and relied on the first interview participants that volunteered in order to complete the research. Second, because of the time constraint, only eight participants were interviewed, as well as a limited number of questions asked. Third, the participants were all located at one eating disorder agency; no participants from other local agencies were pursued and therefore, this research only offered a small, non-diverse snapshot of the population desired. Despite these limitations, this project was important and relevant to the eating disorder field.

Findings

The researcher explored the experiences of eight eating disorder clinicians at one agency who self-identified as having had an eating disorder in the past. The following will include a description of the participants as well as the common themes and outliers found in the interview transcriptions via open coding. Themes included: (a) participants experiencing body image acceptance, (b) their views on the terms "recovered" versus "in

recovery," (c) a desire to provide hope, (d) perceived higher levels of compassion, empathy and/or understanding, (e) approaching self disclosure carefully, (f) the lack of countertransference around the eating disorder, (g) agency support and use of humor and (h) the importance of self care to avoid burnout.

In addition to themes, the research revealed several common characteristics among the participants. There were a total of eight eating disorder clinicians used in this study, with their experience at the agency ranging from six months to over ten years. All participants self-identified with having Anorexia Nervosa (AN), Bulimia Nervosa (BN), Eating Disorder Not Otherwise Specified (EDNOS) or a combination of two or more diagnoses, and all participants sought some form of treatment for their eating disorders.

Body Image Acceptance

After telling the story of their past eating disorders and being asked to describe their current feelings about body image, a common theme among the participants was an overall feeling of body image acceptance. Not love or hate, but more of a respect for the body that they were given, appreciating it for what it is and can do, rather than how it looks. Most of the participants admitted to still having "bad body image days" but that those "bad days" were no longer ones to be fixated on or obsessed about. One participant emphasized a new respect for her body:

> You know there are areas of my body I'd want to change if I could, but do I really
>
> need to or want to or obsess about it anymore? I don't. There isn't like that, I used
>
> to when I was younger, you know kind of fixate on areas of my body that I
>
> wanted to change in some way or whatever. I don't do that anymore. And I also
>
> have a different experience of my body that I didn't have back then, it was much

more objectifying when I was younger, and now at this stage of my life there's so much more respect for it.

Another participant described the body acceptance process as taking several years:

I was at a place where I loved my body, well not love, but I didn't have any problems with it. I would say probably the first two years of sustained recovery from the Anorexia, I just thought "I will never like my body. I just have to acknowledge that I'm never going to see myself the way others see me, and I've just got to deal with it." Over time, that just started to change and I'd say it was roughly two years where it just took that long without having any eating disorder symptoms and just having more time in recovery and I really started to appreciate my body for what it does, and really did not have body image issues.

Four of the participants emphasized age and health as factors that played into learning to accept their body:

I think that's sort of forever a work in progress. It's not bad to lose a little weight for health reasons. I've been told that it would probably help with my blood pressure, although I haven't checked it in awhile.

That ebbs and flows, but I feel really comfortable with my body and where it's at. Knowing that it will probably ebb and flow throughout life with changes. It certainly changes – I don't have the same body now that I did in my early twenties now that I'm older. I feel pretty comfortable with it.

Mostly I want to be strong as I get older…it's not so much about body or size, it's more related to aging and the changes of aging. You gotta be strong and healthy for longevity.

Ten years ago, if I would have known at this age that this is what I'd look like, I think I would have been scared. Honestly! But I like myself. I feel stronger than I've ever been. I can do more. I think better. I physically can do more. So that's really helpful. I think there are times when I miss the thinness, and I think I just might struggle with that on and off for the rest of my life, but I'm not in a place of hate about it.

The participants reported realizing that they needed to find a respect for what their bodies had gone through, and an appreciation for what their bodies are physically able to do. They also recognized that body image is something that will constantly be changing throughout their life and as they begin to age.

"Recovered" Versus "In Recovery"

Participants were asked to weigh in on whether or not they referred to themselves as "in recovery" from their eating disorder or simply being "recovered" from it. Some of the participants were able to answer confidently, while others struggled with going back and forth between the two terms. In addition, several of the participants demonstrated an awareness of the possibility of relapsing and described urges or fleeting thoughts they still experience. One participant strongly stated feeling recovered, and found humor in the thought of ever going back to it:

I would definitely say I'm recovered. I could never go back to doing any of that

stuff again, 'cause it just doesn't sync with me anymore, my sense of self. I feel

like I'm so much more aware through my own therapy and things of what's going

on internally, and then the solutions that come to mind aren't eating disordered

anymore…it's almost laughable in a way when those urges come up at this point,

because it doesn't feel like a viable option, it seems like "oh that would be silly."

Another participant felt confident in using the term "recovered" due to the amount of

time that had passed since the eating disorder. In addition, the participant compared

eating disorder recovery to that of chemical dependency. However, the participant agreed

that relapse is still possible:

I look at myself as being recovered because I haven't been active in symptoms for

a long time. To me it was almost like a stage in my life, and now it's many years

later. At this stage in my life it doesn't feel like that is so central. So those are two

primary reasons that I look at myself as being recovered. And I know there is a lot

of contention in the field about that. If you look at the chemical dependency field

a lot of people refer to themselves as in recovery, always working on sobriety.

And I think there is that risk there that once you've had an eating disorder and

you've struggled with that, it could happen again, especially during stressful

events or significant life stressors. So I think that there is that possibility. But I

don't see myself as really in that recovery process anymore.

Still, several of the participants did not have a strong bias towards one term or the other.

One participant who was in treatment for several years did not see any difference

between the two: "Sometimes I say I'm recovered, and sometimes I say I'm in recovery.

And before they meant two very different things to me, but now they don't mean, they're not sort of different to me anymore." Similarly, another participant stated: "I don't have any strong feelings one way or the other. I think I'd say I am recovered because it's not an issue for me. That may change but for now that's how I view it." One participant described a sense of acceptance for always being "in recovery" due to a family preoccupation with weight and image:

> I guess I'd say I'm in recovery. I'm not sure that with the family I have I'll ever get out of having the automatic response to have my body or to question my body. So to me, it's about how I learn to respond to that initial thought. It's sort of like a tic, like I wish it wasn't part of me. It just happens. So how do I roll with it? How do I turn it into a signal that emotionally I'm not okay?

Another participant described the automatic thoughts that come up with access to a scale:

> "There it is. There's one of those scales. Oh, I'm just gonna go tap it and see how it is—this is a fancy one! Oh look what it says on it!" And then it brings back, like, "well if you go stand on that, are you ready for whatever it might tell you?" and I thought "Yeah, okay, we'll see what happens." There's something that happens when I experience stepping on it and being able to compare how it used to be to how it is now and I still feel free.

In addition, a theme among three of the participants was having stronger urges and lower body image around pregnancy. One participant stated, "Sometimes I would say those urges come in and I would say when they did was after each of my babies and weight gain. So I'd have those thoughts and I wouldn't even say urges at this point, because I

didn't really go with it." Yet another participant described feeling "recovered" and then changing to "in recovery" once she got pregnant. She stated:

> I thought that when I was pregnant, it wouldn't bring up any body images for me at all. Because I get that I'm growing a human being and that takes some space, so my body has to expand. So I was surprised that it has impacted my body image the way it has.

Another participant described feeling surprised, uncomfortable and anxious around the pregnancy weight gain:

> I found myself weighing myself every other day, and it was kind of weird seeing the number go up and up and up. I was kind of surprised by my internal reaction to that…kind of uncomfortable and anxious. It was surprising. It wasn't to the point of needing to do anything about it afterwards. But the difference is rationalizing—it's pregnancy, it's okay. I needed to practice what I preach. I didn't think it was going to be an issue, but it was hard.

Though many of the participants appeared to be undecided about whether the correct term for them was "recovered" or "in recovery," all participants expressed openness to using both terms in their overall recovery. They understood that although they may have a passing thought or a brief urge to go back to an eating disorder symptom they used in the past, they now have better coping mechanisms and an awareness of how to get past those thoughts or urges in a healthy way. The participants also demonstrated an awareness of the fact that as a person who used to have one, there is always a possibility that it could come back and that they should remain vigilant about their self care.

Desire to Provide Hope

The majority of the participants expressed a strong desire to provide hope to their clients, stemming from their past experience with an eating disorder. Three of the participants talked about hope as being the reason why they chose to enter this profession. One of the participants stated, "That's what sparked my interest. Having suffered through this and realizing how awful it was – I wanted to help other people. To help them find hope – that's where it sparked." Similarly, another participant stated, "I wanted other people not to have to experience forever what I was experiencing and to be able to offer some hope, not necessarily directly through my experience, but in other ways." Yet another participant described excitement in healing, wanting to tell others about it:

> First phase was giving myself permission to eat whatever I wanted, whenever I wanted, and then it evolved to just a real balance and just got freed. And then I was like, "I want to turn people on to this!" and gradually started to integrate it into my professional world and training.

In addition, four participants expressed that their clients tend to find hope in the self-disclosure of their past eating disorders. One participant talked about hope in terms of the initial match of client to therapist: "I think they're thinking most often a match with a therapist and wanting somebody either who hasn't struggled so that they're very neutral or somebody that has, so that they can relate and provide them hope, that kind of thing." Another participant commented on the fragility of the issue in terms of self-disclosure:

> It's sort of a delicate issue. I think the things clients like about self-disclosure is that it imparts hope in some ways, so that they can also make the changes that they need to make. It can maybe help them to feel and be willing to take more

responsibility for themselves when they feel more hopeful. It's easier to have

hope.

Two other participants found that disclosing their past eating disorder helped their clients

to see that full recovery is possible. One participant stated:

The three people I can think of that I shared with said they found it helpful to

know that recovery is possible; that they can pursue a career as a therapist or

pursue a career as a dietitian and be successful, even though they have this

experience.

The other participant had a similar experience, but again emphasized being careful with

disclosing:

So I've learned over time to really just pay attention to the appropriateness, and

what's my motivation for sharing about myself here. And often it comes with to

give hope that it's possible to fully recovery, particularly if it's someone that's

very similar to my story.

Though many of the participants came into the profession wanting to provide hope for

others struggling with eating disorders, they all agreed that when it comes to the self-

disclosure of their own eating disorder, it is important to pay attention to the needs of the

client and to keep the focus of the session on the client – not the therapist. During the

interviews, it was apparent to the researcher that the clinicians had their own individual

ways of approaching self-disclosure about their past eating disorder. However, most

clinicians agreed that it should not be rushed into and that exploration into why the client

would like to know is a contributing factor to whether or not it is shared.

Perceived Higher Levels of Compassion, Empathy and Understanding

Though the participants did not distinguish themselves as better clinicians than those who do not have an eating disorder history, many reported feeling as though they had higher levels of compassion, empathy and/or understanding because of their own personal experience with an eating disorder. One participant simply stated, "Yes, that's the root!" when asked about higher levels of compassion and empathy. Another participant agreed:

> Absolutely. I do find that there are times where I might get a little frustrated with particularly people who are chronic, people who have struggled for decades and have been in treatment for years and years. But there is always empathy and understanding.

Another participant commented that not only does a past with an eating disorder give her more understanding, but it also helps when talking to the parents of adolescent clients, even if being recovered is not disclosed outright:

> I know how hard that is and how scary it is…just the idea that to go have a sandwich is not that easy. It can be extremely fearful. I don't think you necessarily need to have an eating disorder to be a good clinician, to help people with this but I think it does maybe. Particularly when I talk to parents to try to get them to understand it really is hard to just go eat a dessert. Even if I don't disclose that I've had an eating disorder, it seems like some clients actually wonder about that. They've said it seems like you do really understand what I'm talking about. That kind of gets conveyed, so yes, I feel like I do.

Three participants pointed out that their colleagues without eating disorders have a great

deal of compassion and empathy too, but that they still felt they had a deeper

understanding of the disorders. One participant stated:

> I definitely think that other people who work here who've never had an eating
>
> disorder still have a lot of compassion and empathy for their clients, but I do
>
> sometimes think that like, "yeah, but you don't know that hell, you don't
>
> personally know the hell of what that is like and what it's like to cling to
>
> something that is so painful and torturous and yet you cling to it and don't know
>
> how to let it go." So there's empathy and compassion and understanding on a
>
> cognitive level but I do sometimes feel like I have a different understanding like,
>
> in my heart, as corny as that sounds, but that I just get it on a different level.

Another participant agreed, but emphasized equality between colleagues:

> Sure, I think our non-eating disorder colleagues are pretty compassionate too. I
>
> wouldn't want to say I have more compassion than they do. It's certainly
>
> heightened for me the issues of people with eating disorders. It's given me
>
> some...I think it's helped with compassion. But I don't think I'm more
>
> compassionate than other people or more sensitive to the issues.

Still another participant spoke to a better understanding of the fear and anxiety a client

might be experiencing:

> It's hard to say if I have more compassion than someone else, but I think I do
>
> have a ton of empathy and understanding for what it's like to be in those
>
> situations where you don't want to tell your parents but you're just saying what
>
> you need to say to get by and get out the door…I feel like I do have a more

intimate understanding of what's maybe going on in that person's head, and that

feeling of fear and panic that "I really can't do this."

The participants interviewed conveyed a deeper understanding of the negative

emotions felt by their clients going through an eating disorder, including fear, panic, and

anxiety. They reported that being recovered from an eating disorder does not necessarily

make them a better clinician, but it does give them a more intimate connection into the

root of their clients' mental illness since they have been in similar situations. They also

reported being able to convey hope to their clients (and their clients' parents) because of

their deeper understanding.

Approaching Self-Disclosure Carefully

Despite the fact that all of the participants experienced having an eating disorder in

the past, does not mean they necessarily want or need to disclose that information to their

clients. All of the participants stressed the importance of being careful around self-

disclosure of their eating disorder in terms of timing, rapport with the client, and amount

of information shared. One participant had no qualms about self-disclosing, noting that

those who do not should evaluate their reasons behind it:

> I'm disclosing it because I think being unwilling to disclose it sounds somewhat
>
> like you are ashamed of having an eating disorder, which would not be a very
>
> therapeutic attitude to have. I think it's important to sort out what your own
>
> feelings are about the eating disorder and where you are with it.

Another participant spoke to the uniqueness of the field and of the agency, noting that

many clinicians are automatically asked if they had a past eating disorder and need to be

prepared with an answer:

> Well I think that probably for most who enter the field, it sort of comes at you
>
> before you even really know what your response is going to be. I'm cautious but I
>
> also don't feel rigid about sharing. I really try to use the lens of "why do I want to
>
> share this?" I try to think about that, and sometimes I talk about it with the client.

One participant emphasized that with self-disclosure, "less is more" and that "some

clients feel like they need to know that information in order to work with somebody."

When a client does come in with questions about the clinician's past, many of the

participants talked about exploring the client's reasoning behind wanting to know. In

addition, having already established a strong rapport with the client added to making the

participants more likely to disclose. Five of the participants shared on this:

> I can only think of about half a dozen times or less that I've self-disclosed about
>
> my eating disorder with clients…it would have been in a more longer-term
>
> relationship with a client where they would ask that. Then we would sort of talk
>
> about why they were asking the question and process that.

> It's very case-by-case. I don't usually do it right away at the beginning, you
>
> know, I kind of wait to get a feel for that relationship because sometimes I feel
>
> like if some clients have access to stuff, I'm not as inclined to share as much
>
> because even with their boundaries it can get kind of funny…it can potentially
>
> cause more harm.

Sometimes people will ask, and it depends upon the person, but more often I don't

disclose in an intake. I don't have the rapport established; I don't know exactly

what the intention of the question is even though I'll explore it with them to figure

that out.

And so as I've worked, the clients I've worked with longer, those are the clients

that I have ended up disclosing to, more recently I think because we have a strong

rapport, a strong relationship and I can be more certain that, well you can never be

100% certain, but I can be really sure that it's going to be helpful for them to hear.

Very judiciously and carefully. Sometimes where I feel I goof is when in my

eagerness to support the client, sometimes I will disclose right at the

beginning…and then I feel a disconnect happen…rather than this wanting to align

and create an empathic connection.

Having a strong relationship with the client, limiting what is disclosed and processing

with the client about why they want to know that information about their clinician were

all common themes among the participants in terms of self-disclosure of their past eating

disorder. However, the participants also agreed that any form of self-disclosure should be

carefully considered before being shared in any therapeutic setting, not just within the

eating disorder field.

Lack of Countertransference around Eating Disorder

Participants were asked about their experiences with countertransference and triggers in session with their clients, particularly around their past eating disorders. Though most of the participants stated that they had not experienced any countertransference directly related to their eating disorder, they did speak to experiencing some around other aspects of their lives. However, one participant did experience some triggers around a past eating disorder symptom:

> I have experienced some triggers. Not so much around restriction or bingeing/purging or anything like that. Sometimes around exercise though. Because that was part of my anorexia—over-exercising. And I've always enjoyed exercise and exercise has been an important part of my recovery, like doing it in a very appropriate way. So I did sometimes find that when clients would talk about their exercise routines, I would have thoughts of like "I really should be exercising more."

Three participants reported experiencing some countertransference around interpersonal or family dynamics in their lives:

> I want to say I don't think I've ever been triggered in session…not in terms of an eating disorder, but it might be like some family dynamics. Like if the parents aren't very supportive, I might be kind of reactive internally. My parents were so reactive; I would feel so bad because that is how their parents should be acting. Maybe some countertransference of frustration – "If I can do this I know that you can too." Like when people are saying, "this is just too hard, I just can't do it," since I know how hard it is and I did it, I do know.

Interestingly I think what comes up less is about the eating disorder behaviors and more about how I live my life now. So if it's something regarding parenting that comes up, something in someone's marital relationship, those might be things that I have more countertransference about. Rather than eating disorder symptoms and wanting to be thin again.

Maybe countertransference, but not necessarily with the eating disorder I wouldn't think. Not with eating disorder symptoms. I might have countertransference issues if somebody was struggling with some other interpersonal issue or maybe was having some other stress in their life. Really the eating disorder was such a drag that it just doesn't look attractive to me really at all.

Finally, two participants did not report feeling any countertransference or triggers related to their eating disorders. One stated, "I don't know if I've experienced countertransference specifically related to the eating disorder. I know I have in other aspects." The other stated:

I feel so removed from it that I have never experienced that. And I was concerned about that coming in here, initially like "okay, I'll just give it a try and see if anything gets triggered for me, and if so I'll bring it up in supervision and sort of go from there." I think actually it's the opposite effect for me, because I think it continuously reminds me why not to go there and why it doesn't work and how it's used for people so it keeps me really aware and directed on the path to recovery and staying with that.

Once again, the participants demonstrated an awareness of knowing that countertransference and triggers in session are always a possibility, whether it is about the eating disorder or not. They expressed that they must do their best to stay aware of it and continually utilize personal and professional self-care in order to best serve the client.

Agency Support and Use of Humor

Varied responses were found when participants were asked to talk about the support within the agency offered to clinicians with past eating disorders and comfort level in talking about their eating disorders among staff. An additional question was asked about the use of humor within the agency setting as a coping mechanism and whether or not the clinicians are ever bothered by it. For clinicians who experienced countertransference or triggers, half of the participants reported feeling satisfied with staff and agency support. One participant stated:

> I do feel they would be supportive…I would be very surprised if they weren't supportive of that. I feel very confident that I could go to my direct supervisor and say "this is what I'm struggling with" and it wouldn't be held against me; other places I've worked it potentially could. This to me feels like a very safe environment.

Another participant stated that even though she did not anticipate having a "textbook relapse," she would definitely feel comfortable approaching staff about it if she did. Another participant spoke to the fact that staff eating disorders do not really come up in conversation:

> I don't think I've done a whole lot of talking about it. I mean it comes up here and there, but it's more like, "I guess in my experiences, blah-blah-blah." It just

doesn't need to be a part of the conversation often times. If I noticed though that it

started coming up for me again, I think I would definitely talk to, I can think of

who I would speak to, a couple of people came to mind that might be able to

provide some support.

Agreeing that many of the staff do not appear to talk about their past eating disorders on a regular basis, one participant said, "I think we offer great support for people who want it. I think it's trickier for people who are struggling that don't want to let other people in." When participants do decide to disclose their eating disorder to other staff members, many were more inclined to do so on a one-on-one basis instead of in larger groups. One participant said, "I feel comfortable talking about it more one-on-one…I'd say I have two staff here that I feel I can talk openly about it with." Another participant said, "I'm comfortable talking about it one-on-one. I'm not a stand up on a mound and preach about it. I just don't like talking about it in big groups of people. I don't talk about it in group therapy either; it's something that really doesn't come up as an issue in those places."

Yet another participant stated, "I'm very comfortable talking about it, especially now that we are bigger. I don't bring it up all the time – it's not like it makes me a better therapist, it's just one aspect of me. I certainly don't hide it." One participant agreed and emphasized the importance of being open with fellow staff members:

I would think that people should be comfortable with the fact that they had an

eating disorder. I imagine that there are all different levels of comfort that people

might have, but I think if you are ashamed with having an eating disorder, if that

is a motivation that people would have to keep a secret, then that seems like there

might be some more work to do before you'd be involved in this field. We're in

mental health, and transparency is really important I would think.

One participant called attention to the importance of creating boundaries—both with

clients and with fellow staff members—and agreed that the agency provides a safe

environment:

I think part of my recovery journey has been about boundaries. So I feel like

that's part of my work here too, is what kind of boundaries do I have with

different people. So there's some things I'm comfortable with the whole agency

knowing I'm in recovery…and there are some people I'm closer to that know

more. I feel like it's a really safe place to talk about that stuff.

However, four of the participants expressed some discomfort with sharing and worried

about being judged by other staff members for self-disclosing. One participant said,

"Sometimes I feel like I might be judged for sharing about myself and self-disclosing that

way, so that's created another learning piece for me to pay attention to. Particularly in

group co-facilitation but also just in the day to day." One participant admitted to

withholding the eating disorder in the initial interview:

To be honest, I think they asked me if I had an eating disorder when I

interviewed, and I think I said no. As I started working here, I was like, maybe I

should be honest about that. So definitely when I first started my career here, no, I

was not comfortable—I thought I would be judged or there would be some

reaction or expectation of me. But then once I started talking about it I felt more

comfortable. I don't talk about it a lot with staff—if someone asks me I'll answer

honestly.

Another participant disclosed the eating disorder in the interview, but stayed quiet about it right after:

> It's interesting because in the interview I opened up about it, but after that I closed up. I think that was partially that reaction of just wanting to keep some things private and holding out until I felt comfortable with certain staff members to open up those experiences. But I now I feel much more open about it, so if it comes up in conversation it's right there, like a consult group or as I was in supervision.

Finally, one participant stated that they struggle with determining when it is appropriate to share with other clients, and that their insecurity about staff judgment feeds into the struggle:

> I'm finding myself being more concerned with what that staff person's going to think of my self-disclosure, cause I'm fairly confident that the times that I have those kind of pulls to self-disclose, it will be helpful for that client. So I'm not as concerned that they're going to have a negative reaction to it, or if they do have a negative reaction that we won't be able to work through that. I find myself just being a lot more concerned like if that staff person's gonna think it's appropriate or not.

In terms of the use of humor in the workplace, most of the participants did not appear to be bothered by or take offense to it being used by a fellow staff member who had not suffered from an eating disorder in the past. The participants all agreed that humor could be a healthy release for clinicians. One participant said, "It doesn't bother me. I think it can be a way to lighten up the mood and help people talk about their own struggle." Another participant stated:

I've never really thought about that. It doesn't bother me; I do the same thing. I

feel like we all kind of make light of it. I think that we make jokes so that we can

continue to stay in this field. It is a stress-reliever. I'm sure my old therapist did

the same thing. It's okay to have that comic release…I just hope other people are

okay with it too.

One participant used humor a lot initially in the field, but does not need to anymore

because of a higher comfort level within the agency and more respect for clients:

Yeah, so I used humor initially, to sort of get through the activation that I

experienced, especially with certain clients that I just felt like were going

nowhere. I think that for me personally, it had much more to do with feeling like I

didn't have direction with them and not necessarily feeling like I understood to a

deeper degree where it originated with them. And I do a lot more of that with my

work now, so that I just don't feel like I need to use the humor anymore. I can't

even think of a time recently when I have. I think I just see them with so much

respect.

A few participants were able to communicate which type of humor they find

uncomfortable to hear in the workplace:

I think I do fine with the humor, I do get that we need to laugh about things. Kind

of like gallows humor. I think I have a harder time when people talk about them

being manipulative, or they're lying. That kind of language, when it's not using

humor. That language gets to me more because I think about the things that I did,

that I lied about, and I'm not a manipulative person. And it would have broken

my heart to think that somebody on my treatment team was calling me manipulative. That kind of stuff gets to me more, but the humor is okay.

I haven't noticed it so much with talking about eating disorders, but I don't like it when talking about clients or joking about a behavior choice they make or a lifestyle choice or another symptom they are experiencing…it makes me uncomfortable when it's joked about because it feels like there's a judgment in there. I don't know if it's for me personally – if I were the client, I wouldn't want to be talked about that way.

Well I think if it's humor that seems to sort of attack the character of the person who's struggling, I don't like that. But I can say that in my years of working here, I have never witnessed someone speak ill of a client.

Finally, one participant described a reaction to hearing other staff joke about eating disorders: "I do hear it, and I lean in towards compassion, particularly with staff who are new to working in the field and don't have a story of their own." Overall, the participants reported feeling comfortable and supported within the agency. Some participants reported being more open with other staff about their eating disorder and with the use of humor, while other participants described feeling uncomfortable with inappropriate use of humor and with sharing about their eating disorders, especially in larger groups.

Importance of Self Care to Avoid Burnout

The final topics explored in the experiences of eating disorder clinicians were that of personal and professional self-care and the risk of burnout within the field. A

secondary theme that came out as a result of this question was that of exhaustion and

frustration among participants when talking to friends or family about eating disorders

outside of the workplace. In terms of self-care and concern about burnout, there were a

lot of similarities between participant responses as to what they do to take care of

themselves. One participant stated:

> I've thought about being burned out, or at times have felt that way. For me, self-
> care is one of those primary things. Once I had my children, I needed to cut back,
> so I decreased my hours and it's been perfect. More generally, like on a day-to-
> day basis, I use a lot of meditation throughout my day. Otherwise I make sure I
> have self-time when I am at home. I think just making sure my supports are up
> outside of here has been really important, but then also making sure I have people
> I can consult with here. And continuing to seek training outside of here.

Another participant listed self-care techniques and admitted to being willing to leave the

position if it got too difficult:

> Yes, I pay attention, because I have gotten crispy around the edges. And so, I
> have my tribe I go to for support, both within the program and outside, and I just
> take care of myself. Try to go to work on time, leave on time, not take the stories
> home. I've got a pretty consistent morning meditation/relaxation process that I do.
> So that's the essence. Being transparent, talking about what comes up…I'm really
> willing to walk away from this whole gig if it gets too stressful.

Three participants emphasized the need to find balance both at home and at work:

The question I ask myself a lot is am I in balance? Balance across the board:

balance in social time, balance in my schedule at work…and then just balancing

out personal life with professional life. When I go home, I pretty much cut it off.

I think if I'm not in balance that might be a reason that I would burn out. So I

have to pay attention to that, how I'm taking care of myself…. I also remind

myself that I'm doing something meaningful and something important and this is

a big contribution to the eating disorder community.

I have thought about becoming burned out, but I think with enough balance, and

especially being a therapist and seeing enough of a variety of presentations, or

different types of cases. I also think vacation is huge. Knowing myself and when I

need a break…regularly exercising, practicing yoga, or going for a run; also

socializing with friends that don't do this work.

When it came to frustrations with family and friends, many participants agreed that when

they leave the work place, they do not want to talk about eating disorders, body image,

diets, or weight when they are with friends or family. However, some participants found

that they cannot avoid it altogether, and have come up with ways to handle it. Four

participants commented on this:

When I do talk with any friends who have body image concerns, like I want to be

supportive and helpful towards them, but I've noticed that since I've been

working here, my response is usually "there's this really good book that you could

read about that" like I just don't have any energy to help you with this. I wish I

did, but I don't. I just…I don't wanna hear it. I hear it 40 hours a week, I don't

wanna hear it! Most of the time, I have a lot of patience for my clients who talk

about it. But by the end of the day, or by the time the weekend comes, it's like, I

don't wanna hear it from my friends and other people in my life.

Whenever I said what I did, people would tell me about the latest diet they're

doing or ask me for advice, or tell me that they're counting carbs or trying to lose

weight. It was pervasive and really annoying. I did a lot of listening and

nodding…but it's pretty pervasive in our culture.

It's really interesting, not many people do. … I can pretty much let that roll off

my back when people say, "oh I need to go on a diet on Monday because I ate too

much over the holidays." I can let that go. There are times when I'll respond to it

with something very brief. Sometimes I just ignore it. And usually that diffuses

the situation and then you move onto another conversation.

I find I have to really work hard to step out…I get sort of fed up. I think I'm

pretty good about saying what I think to my friends and family, so if they're

saying something that feels really off-base and it's bothering me, I might just say

something. But yeah, definitely makes me anxious when people start to talk about

it outside of here.

In terms of becoming burned out within the field, some participants were not

concerned about this happening. One participant stated, "I don't ever worry about

becoming burned out since I've been in it for so long…maybe it's because I've peaked in

terms of amount of clinical hours. Now I'm doing more varied kinds of things." Another

participant described the "lighter atmosphere" at the agency and that the agency provided

a lot of "flexibility" in terms of vacation time, which helped in practicing self-care and

avoiding burnout. Yet another participant stated, "having very clear and transparent

boundaries with my clients and sticking to a 45 minute session gives me time to reflect on

what I'm doing with the client and the care that I'm offering." One participant mentioned

the intensity of the work in this field:

> Yes, very much so. When I spoke of the intensity of the work, I think we provide
>
> and demand a very high level of care for our clients and the disorder necessitates
>
> that and it's a severe disorder—has the highest mortality rate, right? So we have
>
> to be on top of it. And I think we're gonna learn how to make ourselves more
>
> resilient. But you know I think being young in my profession, I'm just getting a
>
> sense of how do you do this work long term. So yeah, I think about it.

A variety of self care methods are utilized among the participants, including but not

limited to: physical activity, social support, individual therapy, getting enough sleep and

nutrition, not bringing work home, balancing the workload, and talking about other topics

outside of work. Seven out of eight participants said they worried about burnout, but felt

that the agency provided enough vacation time and support to take care of their staff.

The participants were asked to share as much or as little as they wanted about

their experience with an eating disorder, and how they felt about working in an eating

disorder clinic. The eight main themes that emerged from coding the interviews were all

reflected in some way in the literature review, except for humor used among staff and frustrations with family and friends.

Discussion

The following research questions were examined in this project: (1) what are the experiences of clinicians who treat clients with eating disorders after having recovered from their own? (2) How much self-disclosure is appropriate in the therapeutic relationship? And finally, (3) what type of accountability or support is in place for the clinician to be prepared for triggers or other emotions that may come up in sessions to prevent relapse? The interpretation from this research project was that clinicians' past eating disorders affected their practice in both similar and different ways, that self-disclosure is approached carefully, and that the agency in which the clinicians are employed provides a safe, flexible and respectful environment in which the clinicians are able to practice personal and professional self-care in order to avoid burnout in the field.

Specific themes found within this research project included, (a) body image acceptance, (b) views on the terms "recovered" versus "in recovery," (c) a desire to provide hope, (d) perceived higher levels of compassion, empathy and/or understanding, (e) approaching self disclosure carefully, (f) the lack of countertransference around the eating disorder, (g) agency support and use of humor and (h) the importance of self care to avoid burnout. The literature review highlighted previous studies on eating disorder types, symptoms and assessment, client population, onset and duration of eating disorders, causes and risk factors, interventions, treatment and recovery. In addition, previous studies on the therapeutic alliance, use of self-disclosure, countertransference and clinician self-care and burnout were explored.

Body Image

The previous studies and this research project exposed similar findings within the areas of body image, recovery, the therapeutic alliance, use of self-disclosure, countertransference and clinician self-care and burnout. In terms of body image, the previous studies revealed that it is not unusual for a clinician in the eating disorder field to experience negative feelings about their appearance while working with clients with eating disorders, and that it may cause them to become distracted by their own feelings of self-worth (Lowell & Meader, 2005). The research also suggested that therapists should be aware of the feelings they may have about their own bodies so that when those feelings, triggers or countertransference comes up, they are fully equipped to deal with them and be able to process them with the client and/or colleagues (Lowell & Meader). The current research reflected similarities with the previous research (Warren et al., 2011) in that many of the participants reported still having some feelings of negative body image at times. However, the participants in this research study revealed that they had come to a place where they found appreciation for their bodies and that they realized body image is something that will be changing throughout their lives and that they were able to respect their bodies' needs in the process.

"Recovered" Versus "In Recovery"

In terms of recovery, previous research suggested differing views on the usage of "recovered" versus "in recovery." Costin (2007a) criticized the addiction model in eating disorder recovery, stating that it gives the idea that eating disorders can never be fully recovered from and that they are addictions controlled by abstinence that run the risk of relapse. Costin believed that steering away from that model would be more beneficial to

the client since they cannot be completely abstinent from food and that they need to learn to embrace their bodies and appreciate food for what it is meant to be. In addition, Costin emphasized the importance of eating disorder clinicians to be aware of their beliefs on this subject, as it will affect their ability to treat their clients. The participants in this research had mixed opinions on the terminology, but they all expressed openness to using both terms in their overall recovery process. Some of the participants insisted on using the term in the past tense, noting the amount of time that had passed since the eating disorder and the fact that they did not experience any triggers or anticipate any type of relapse. Other participants were aware that triggers and relapses are still possible, and that they must remain vigilant with their self-care.

Desire to Provide Hope and Perceived Higher Levels of Compassion

Along the recovery process, many participants in this research expressed a desire to provide hope and inspiration to their clients, as well a perception that they hold higher levels of compassion, empathy and/or understanding when it comes to working with clients with eating disorders. Though the participants did not distinguish themselves as better clinicians than those who do not have an eating disorder history, they conveyed having a more intimate connection into the root of their clients' mental illness since they had been through a similar situation. Previous research emphasized that eating disorder clients often struggle significantly with establishing trust and sharing power and control with their therapist; therefore, clinicians should approach the beginning of the relationship cautiously to build trust (Warren, Crowley, Olivardia & Schoen, 2009). In addition, Costin (2009) found it powerful for her clients to bear witness to female

therapists who are confident and comfortable in their own skin, living eating disorder free.

Self-Disclosure

Participants in this research similarly reported that self-disclosing about their past eating disorder should be approached carefully, as it could be helpful to the client in the right situation. Timing, rapport with the client, amount of information shared, and motivation behind sharing were all aspects of self-disclosure the participants felt needed to be explored before disclosing. Some of the participants felt it was appropriate to share past experiences with the clients, while other participants shied away from doing so in order to avoid steering the focus away from the client. All participants felt it was important to be honest with the client, whether or not they choose to disclose that information. Costin (2009) agreed with this, stating that the clinician should focus on giving a thoughtful, genuinely therapeutic response regardless of whether a disclosure is made. Other previous research presented mixed opinions on self-disclosure within a therapeutic setting. For example, Jeffrey and Austin (2007) frowned upon automatic self-disclosure, stating that it would be naïve of clinicians to think that their disclosures would lead to less anxiety in therapeutic relationships; in fact, it may cause less trust and respect. Costin (2009) weighed in on the subject as well, stating her belief that self-disclosure from a clinician in recovery from an eating disorder can be helpful for a client currently suffering from one. The participants in this research presented as genuinely wanting to use their experiences to help others with eating disorders.

Countertransference

Previous research also presented controversy around the benefits and drawbacks of transference and countertransference in the therapeutic setting. For example, Freud viewed transference as unrelated to the current therapeutic relationship; however, modern theorists argued that it is both the past and present being projected into the current relationship (Norton, 2010). Bunnell (2009) found that clinicians working with clients with eating disorders commonly had countertransference feelings of irritation and impatience due to treatment resistance and longevity. In addition, Costin (2009) found some clinicians to avoid addressing countertransference in fear of being viewed as less experienced; and for those who had a past eating disorder, countertransference could be viewed as the clinician not being completely healed. In this research, almost all the participants denied experiencing countertransference specifically tied to their past eating disorder; instead they described experiencing it occasionally around other aspects of their lives, such as parenting, interpersonal relationships, and/or marital problems. One participant did experience some countertransference around exercise, but described being successfully able to process it with colleagues and family members. Most participants demonstrated an awareness of knowing that countertransference, triggers and relapse are always a possibility, but stated they continue to be aware of it and use self-care techniques regularly.

Self-Care and Risk of Burnout

Finally, many similarities were found between previous research and this research on the importance of self-care, self-care techniques and the risk of burnout within the field. Previous research found that in general, mental health professionals are at a greater risk for burnout than in other professions, and that women are at an even higher risk than

men (Sprang, Clark, & Whitt-Woosley, 2007). Additionally, Warren (2009) reported that clinicians in the eating disorder field experience more anxiety and uneasiness than with other clients, and that their field of choice inevitably brings up themes of beauty, body image and weight in their work that may affect their practice in a negative way. Warren listed several self-care recommendations for dealing with the feelings that may present themselves, including: engaging in self care inside and outside of work, supervision, limiting caseload, maintaining boundaries, and realizing that eating disorders are chronic and to enjoy the challenge of working with them. McGuilley & Szablewsky (2010) also talked about the difference between personal and professional self-care, noting consultation and healthy relationships as most important. Participants in this research described utilizing several of the same personal and professional self-care techniques, including but not limited to the following: creating boundaries with clients and staff, decreasing hours, meditation, social support, using vacation time, supervision, exercise, and not taking work home. Most of the participants shared that they worried about becoming burned out, but all of the participants had specific ways in which they would practice self-care to avoid burnout and were confident that the agency would support them fully.

Use of Humor and Feelings of Frustration

Two themes found in the current research that were not present in the previous literature were the use of humor among staff and feelings of frustration with family and friends. With the humor, most of the participants agreed that it was a healthy release and a positive way of dealing with difficult clients, as long as it remained appropriate. In terms of frustration with family and friends, many participants described exhaustion with

talking about topics around eating disorders, dieting or weight outside of the workplace. Participants shared that even when their family or friends continued to talk about it or ask for advice, they found they would need to give a brief answer then politely change the subject, or ignore it completely.

Strengths and Limitations

This research project offered several strengths. First, the information was based directly from eating disorder literature. Second, the idea for the project came from a meeting with an eating disorder clinician from the agency; this clinician and several others at the agency had given the researcher their consent and support for conducting this research project at their agency with their staff as participants (see Appendix A). This particular agency did a staff presentation on a similar topic, and was interested in having it replicated in other research. Third, the previous research had explored the experiences of clinicians who had treated clients with eating disorders (Warren et al., 2011), but limited information examined clinicians who have had eating disorders themselves and were still working with the same population. This particular research project addressed the lack of literature on that topic by interviewing clinicians working at an eating disorder clinic who were recovered from their own eating disorders. Fourth, this research project was qualitative in nature and designed to provide more in-depth answers to the researcher's questions. Its purpose was to pursue an accurate and genuine understanding of what it is like for a clinician to be recovered from a past eating disorder and to now be working with clients with eating disorders.

This research project also had a few limitations. First, it was a small-scale project that needed to be completed in a short amount of time and relied on the first interview

participants that volunteered in order to complete the research. Second, because of the time constraint, only eight participants were interviewed, as well as a limited number of questions asked. Third, the participants were all located at one eating disorder agency; no participants from other local agencies were pursued and therefore, this research only offered a small, non-diverse snapshot of the population desired. Fourth, there was a selection bias to the sample: participants who volunteered for the research were ones who felt comfortable being interviewed and spoke to the experiences of recovered clinicians. In order for all recovered clinicians to be represented, future research could include an anonymous survey option for those who do not feel comfortable interviewing. Future research could also include a larger-scale study that does not have a time limit, includes more diverse participants from multiple agencies and asks more specific questions about their experiences in the workplace.

Despite these limitations, this project was important and relevant to the eating disorder field. Although the study is small in nature, the information obtained from the study was useful to the eating disorder field.

Practice, Research and Policy Implications

The findings from this research project provided several implications for future practice, research and policy. In terms of practice implications, a strong emphasis on clinician self-care needs to be present within eating disorder agencies to insure that the best services are being provided to the client. Previous research showed that clients with eating disorders can be some of the most difficult to treat and that the clinicians working with them are at risk for having their own body image being personally affected (Warren et al., 2011; Altschuler & Katz, 2010; Lowell & Meader, 2005; Costin, 2009). It appears

that clinicians who are able to genuinely model healthy body image to their clients,

whether they have a personal history with an eating disorder or not, will be the most

effective in a therapeutic setting. Agencies must also adequately support their clinicians

by providing enough vacation time, consultation, ongoing training, and promoting self-

care. Some of the participants in this research study expressed concern over feeling

uncomfortable with sharing about their eating disorders with other staff members in fear

of being judged. This need could be met within the agency by offering extra supervision,

support groups or staff retreats for all clinicians, and by promoting a respectful, open

environment. In addition, ongoing attention to, training and education on the mission of

the agency would be helpful to all clinicians to determine the eating disorder culture they

are entering into.

In terms of research implications, the experiences and needs of clinicians working

in the eating disorder field should be studied at a greater depth and with a larger sample

size—both with clinicians who have and have not recovered from an eating disorder.

Future research could focus on the experiences of recovered clinicians who are or have

been pregnant, the differences between male and female clinician experiences, and the

variations within age groups and years of experience. In addition, interviewing clients on

their experiences with clinicians who have and have not had an eating disorder in the past

would provide further information for treatment practices. Continued study in this area

would contribute to the limited research knowledge on experiences of clinicians working

in the eating disorder field. The current research study found that participants were

overall satisfied with the agency support, however further studies on what specifically the

agency is doing to support the clinicians compared to other agencies would also contribute to the limited research.

In terms of policy implications, future agencies and programs could benefit from the importance of listening to the voices of recovered clinicians in order to gain perspective and understanding on the best treatment for clients with eating disorders. Additionally, the findings from this research imply that recovered clinicians do not necessarily need special attention; rather, all clinicians within the eating disorder field should be offered the same amount of support in order to be well-equipped for working with their clients. If a clinician needs or wants extra, individualized support, agencies would benefit from making this easily accessible to their clinicians, in order to prevent burnout and promote a comfortable working environment.

Conclusion

The literature review supported some of this research study's current findings in the areas of body image, the therapeutic relationship and clinician self-care. This qualitative research study was based off of the conceptual frameworks of strength and empowerment perspectives in social work. The research study's design was exploratory in nature and used a non-probability, convenience and purposive sampling to investigate the experiences of clinicians working in an eating disorder clinic who are in recovery from eating disorders themselves. Data was analyzed using open coding and then developed into themes.

Major themes revealed in the findings were: (a) participants experiencing body image acceptance, (b) their views on the terms "recovered" versus "in recovery," (c) a desire to provide hope, (d) perceived higher levels of compassion, empathy and/or

understanding, (e) approaching self disclosure carefully, (f) the lack of

countertransference around the eating disorder, (g) agency support and use of humor and

(h) the importance of self care to avoid burnout. Though not all the themes revealed in

the study were fully supported by the previous research in the literature review, some of

the findings contributed new knowledge to the research base and to the field of social

work. As a result of this qualitative study design, conceptual framework and findings, the

current research offers ideas for improving practice and furthering research in the eating

disorder field regarding the experiences of clinicians in recovery from their own eating

disorders.

References

Altschuler, J. & Katz, A. D. (2011). Keeping your eye on the process: Body image, older

women and countertransference. *Journal of Gerontological Social Work, 53*(3),

200-214. doi:10.1080/01634370903507589

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental

Disorders,* Fourth Edition, Text Revision. Washington, DC: American Psychiatric

Association.

Baker, J. H., Maes, H. H., Lissner, L., Aggen, S. H., Lichtenstein, P., & Kendler, K. S.

(2009). Genetic risk factors for disordered eating in adolescent males and females.

Journal of Abnormal Psychology, 118(3), 576-586. doi:10.1037/a0016314

Bardone-Cone, A. M., Harney, M. B., Maldonado, C. R., Lawson, M. A., Robinson, D.

P., Smith, R., Tosh, A. (2010). Defining recovery from an eating disorder:

Conceptualization, validation, and examination of psychosocial functioning and

psychiatric comorbidity. *Behavior Research and Therapy, 48,* 194-202.

doi:10.1016/j.brat.2009.11.001

Barnett, S., Buckroyd, J. & Windle, K. (2008). Eating disorders: Breaking the

intergenerational cycle through group therapy—the effects of the group

experience. In Buckroyd, J. & Rother, S. (Eds.). *Psychological responses to

eating disorders and obesity: Recent and innovative work. (pp. 55-71).* England:

John Wiley & Sons, Ltd.

Barth, F. D. (2008). Hidden eating disorders: Attachment and affect regulation in the

therapeutic relationship. *Clinical Social Work Journal, 36*, 355-365.

doi:10.1007/s10615-008-0164-2

Bean, P., Louks, H., Kay, B., Cornella-Carlson, T., & Weltzin, T. (2010). Clinical

observations of the impact of Maudsley therapy in improving eating disorder

symptoms, weight and depression in adolescents receiving treatment for anorexia

nervosa. *Journal of Groups in Addiction and Recovery, 5,* 70-82.

doi:10.1080/15560350903550142

Ben-Porath, D. D., Wisniewski, L., & Warren, M. (2009). Differential treatment response

for eating disordered patients with and without a comorbid borderline personality

diagnosis using a dialectical behavior therapy (DBT)-informed approach. *Eating

Disorders, 17,* 225-241. doi:10.1080/10640260902848576

Berman, M. I., Boutelle, K. N., & Crow, S. J. (2009). A case series investigating

acceptance and commitment therapy as a treatment for previously treated,

unremitted patients with anorexia nervosa. *European Eating Disorders Review,

17,* 426-434. doi:10.1002/erv.962

Berzoff, J. & Kita, E. (2010). Compassion fatigue and countertransference: Two different

concepts. *Clinical Social Work Journal, 38,* 341-349. doi:10.1007/s10615-010-

0271-8

Berg, B. L. (2009). *Qualitative research methods for the social sciences.* (7th Ed.).

Boston: Allyn & Bacon.

Bunnell, D. (2009). Countertransference in the psychotherapy of patients with eating

disorders. In Maine, M., Davis, W. N., & Shure, J. (Eds.), *Effective Clinical

Practice in the Treatment of Eating Disorders: The Heart of the Matter* (pp. 79-

93). New York: Taylor & Francis Group, LLC.

Chen, E. Y., Matthews, L., Allen, C., Kuo, J. R., & Linehan, M. M. (2008). Dialectical behavior therapy for clients with binge-eating disorder or bulimia nervosa and borderline personality disorder. *International Journal of Eating Disorders, 41*(6), 505-512. doi:10.1002/eat.20522

Cheng, H. L. & Mallinckrodt, B. (2009). Parental bonds, anxious attachment, media internalization, and body image dissatisfaction: Exploring a mediation model. *Journal of Counseling Psychology, 56*(3), 365-375. doi:10.1037/a0015067

Cook-Cottone, C., Beck, M., & Kane, L. (2008). Manualized-group treatment of eating disorders: Attunement in mind, body, and relationship (AMBR). *The Journal for Specialists in Group Work, 33*(1), 61-83. doi:10.108/01933920701798570

Costin, C. (2007a). *The eating disorder sourcebook: A comprehensive guide to the causes, treatments and prevention of eating disorders.* (3rd Ed.). New York: McGraw-Hill.

Costin, C. (2007b). *100 questions & answers about eating disorders.* Sudbury, MA: Jones and Bartlett Publishers.

Costin, C. (2009). The embodied therapist: Perspectives on treatment, personal growth, and supervision related to body image. In Maine, M., Davis, W. N., & Shure, J. (Eds.), *Effective Clinical Practice in the Treatment of Eating Disorders: The Heart of the Matter* (pp.179-192). New York: Taylor & Francis Group, LLC.

Darcy, A. M., Katz, S., Fitzpatrick, K. K., Forsberg, S., Utzinger, L., & Lock, J. (2010). All better? How former anorexia nervosa patients define recovery and engaged in treatment. *European Eating Disorders Review, 18,* 260-270. doi:10.1002/erv.1020

Farber, S. K. (2010). The last word: The comorbidity of eating disorders and attention-

deficit hyperactivity disorder. *Eating Disorders, 18,* 81-89.

doi:10.1080/10640260903439623

Gordon, K. H., Castro, Y., Sitnikov, L., & Holm-Denoma, J. (2010). Cultural body shape

ideals and eating disorder symptoms among White, Latina and Black college

women. *Cultural Diversity and Ethnic Minority Psychology, 16*(2), 135-143. doi:

10.1037/a0018671

Hayes, J. A., McCracken, J. E., McClanahan, M. K., Hill, C. E., Harp, J. S., & Carozzoni,

P. (1998). Therapist perspectives on countertransference: Qualitative data in

search of a theory. *Journal of Counseling Psychology, 45*(4), 468-482.

doi:10.1037/0022-0167.45.4.468

Herrin, M. & Matsumoto, N. (2007). *The parent's guide to eating disorders: Supporting

self-esteem, healthy eating, & positive body image at home.* (2nd Ed.). Carlsbad,

CA: Gurze Books.

Jeffrey, A. & Austin, T. (2007). Perspectives and practices of clinician self-disclosure to

clients: A pilot comparison study of two disciplines. *The American Journal of

Family Therapy, 35*(2), 95-108. doi:10.1080/01926180600814528

Juarascio, A. S., Forman, E. M., & Herbert, J. D. (2010). Acceptance and commitment

therapy versus cognitive therapy for the treatment of comorbid eating pathology.

Behavior Modification, 34(2), 175-190. doi:10.1177/0145445510363472

Limbert, C. (2010). Perceptions of social support and eating disorder characteristics.

Healthcare for Women International, 31, 170-178.

doi:10.1080/07399330902893846

Lowell, M. A. & Meader, L. L. (2005). My body, your body: Speaking the unspoken

between the thin therapist and the eating-disordered patient. *Clinical Social Work

Journal, 33*(3), 241-257. doi:10.1007/s10615-005-4941-x

Ma, J. L. C. (2007). Meanings of eating disorders discerned from family treatment and its

implications for family education: The case of Shenzhen. *Child and Family Social

Work, 12*, 409-416. doi:10.1111/j.1365-2206.2007.00496.x

Ma, J. L. C. & Lai, K. (2009). Applicability of family therapy for Chinese children and

adolescents suffering from anorexia nervosa in a Chinese context: A preliminary

study. *Social Work in Mental Health, 7*(4), 402-423.

doi:10.1080/15332980802237750

Mayer, B., Muris, P., Meesters, C., Zimmermann-van Beuningen, R. (2008). Brief report:

Direct and indirect relations of risk factors with eating behavior problems in late

adolescent females. *Journal of Adolescence, 32*, 741-745.

doi:10.1016/j.adolescence.2008.12.002

McGilley, B. H. & Szablewski, J. K. (2010). Recipe for recovery: Necessary ingredients

for the client's and clinician's success. In Maine, M., McGuilley, B. H., and

Bunnell, D. W. (Eds.), *Treatment of Eating Disorders: Bridging the Research-

Practice Gap* (pp. 197-213). Amsterdam: Academic Press.

Miley, K. K., O'Melia, M., & DuBois, B. (2007). *Generalist social work practice: An

empowering approach. (5th Ed.).* Boston: Pearson Education, Inc.

Mountford, V., Haase, A.M., Waller, G. (2007). Is body checking in the eating disorders

more closely related to diagnosis or to symptom presentation? *Behavior Research

and Therapy, 45,* 2704-2711. doi:10.1016/j.brat.2007.07.008

Munoz, D. J., Israel, A. C. & Anderson, D. A. (2007). The relationship of family stability and family mealtime frequency with bulimia symptomology. *Eating Disorders, 15,* 261-271. doi:10.1080/10640260701323516

Murphy, R., Straebler, S., Cooper, Z., & Fairburn, C. G. (2010). Cognitive behavioral therapy for eating disorders. *The Psychiatry Clinics of North America, 33*(3), 611-627. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/20599136

Norton, C. L. (2010). Developing empathy: A case study exploring transference and countertransference with adolescent females who self-injure. *Journal of Social Work Practice, 25*(1), 95-107. doi:10.1080/02650530903525991

Ogden, J. (2010). *The psychology of eating: From healthy to disordered behavior. (2nd Ed).* United Kingdom: Wiley-Blackwell.

Peterson, C. B. (2005). Conducting the diagnostic interview. In Mitchel, J. E. & Peterson, C. B. (Eds.). *Assessment of eating disorders.* (pp. 32-58). New York: Guilford Press.

Rhodes, P., Baillee, A., Brown J., & Madden, S. (2008). Can parent-to-parent consultation improve the effectiveness of the Maudsley model of family-based treatment for anorexia nervosa? A randomized control trial. *Journal of Family Therapy, 30,* 96-108. Retrieved from:
http://www.ncbi.nlm.nih.gov/pubmed/19302516

Schmidt, U., Lee, S., Beecham, J., Perkins, S., Treasure, J., Yi, I., . . . & Eisler, I. (2007). A randomized controlled trial of family therapy and cognitive behavior therapy guided self-care for adolescents with bulimia nervosa and related disorders. *American Journal of Psychiatry, 164*(4), 591-598. doi:10.1176/appi.ajp.164.4.591

Shapiro, J., Bauer, S., Andrews, E., Pisetsky, E., Bulik-Sullivan, B., Hamer, R. M., and

Bulik, C. (2010). Mobile therapy: Use of text messaging in the treatment of

bulimia nervosa. *International Journal of Eating Disorders, 43*(6), 513-519.

doi:10.1002/eat.20744

Sprang, G., Clark, J. J., & Whitt-Woosley, A. (2007). Compassion fatigue, compassion

satisfaction, and burnout: Factors impacting a professional's quality of life.

Journal of Loss and Trauma, 12, 259-280. doi:10.1080/1532502070128093

U.S. Department of Health and Human Services, National Institutes of Health, National

Institute of Mental Health. (2007). *Eating Disorders* (NIH Publication No. 07-

4901).

Wanden-Berghe, R. G., Sanz-Valero, J., & Wanden-Berghe, C. (2010). The application

of mindfulness to eating disorders treatment: A systematic review. *Eating

Disorders, 19*(1), 34-48. doi:10.1080/10640266.2011.533604

Warren, C. S., Crowley, M. E., Olivardia, R., & Schoen, A. (2011). Treating patients with

eating disorders: An examination of treatment providers' experiences. *Eating

Disorders: The Journal of Treatment & Prevention, 17*(1), 27-45.

doi:10.1080/10640260802570098

APPENDIX A

Letter of Cooperation for Research Project

Institutional Review Board
St. Catherine University
St. Paul Campus
2004 Randolph Avenue
St. Paul, MN 55105

RE: Qualitative research project on the experiences of clinicians treating eating disorder clients while in recovery from their own

Lead Investigator: Melissa A. Young
                          Student
                          St. Catherine University and the University of St. Thomas
                          School of Social Work; Joint Program

Student Advisor and Chair of Research Project:
                          Dr. Catherine Marrs Fuchsel, PhD., LICSW
                          Assistant Professor
                          St. Catherine University and the University of St. Thomas
                          School of Social Work; Joint Program

To whom it may concern:

        We have agreed to assist Melissa A. Young in recruiting participants for her research project. Ms. Young's research project will be qualitative in nature, as she interviews staff from the agency in recovery from their own eating disorders about their experiences treating clients with eating disorders. The questions in the interviews will address topics such as countertransference, triggers, relapse prevention, self-disclosure, supervision, body image, self-esteem, etc. We will allow Ms. Young to post her request for participants on the agency's staff-shared website, which will reach staff from all agency sites, until she is able to recruit 8-10 participants. We will allow her to coordinate with the participants the best time to conduct the interviews, and she will be expected to do so in a closed office that is safe to participants.

        Ms. Young will make it clear to potential participants that their participation is completely voluntary, that they do not have to answer any question that they do not feel comfortable answering, and that all information will remain confidential. These interviews will be audio taped; no other person will have access to these audiotapes except Ms. Young. She will also be transcribing the interviews, and no one other than Ms. Young or her research chair, Dr. Catherine Marrs Fuchsel, will have access to these

transcripts. Both the audiotapes and transcriptions will be destroyed after the completion of this research project.

In addition, the participants will be given Ms. Young's and Dr. Marrs Fuchsel's names and phone numbers in order for the participants to inquire about the study and for Ms. Young or Dr. Marrs Fuchsel to answer any questions about the process. Again, Ms. Young will make it clear to participants that their involvement in the study is completely voluntary and that their refusal to be interviewed will in no way affect their relationship with Ms. Young or the agency. Ms. Young will share the findings of this research project with the agency.

If you have any questions, please feel free to contact me.

Sincerely,

_____   _____

Signature and Title   Date

_____   _____

Print Name   Date

APPENDIX B

PARTICIPANT RECRUITMENT FLYER

Subject Line: Staff Research Participants Needed!

<u>Eating Disorder Clinician Study</u>

Recruiting Participants for a Research Study!

Do you meet the following criteria?

- **Eating Disorder Clinician**
- **Have not worked directly with me at the agency**
- **Have had an eating disorder in the past**

If so, I would like to interview you for my clinical research paper!
I am currently completing my Master's in Clinical Social Work at the University of St. Thomas/St. Catherine University under the supervision of my advisor, Dr. Catherine Marrs Fuchsel, PhD., LICSW. The purpose of this research study is to examine the experiences of eating disorder clinicians who are recovered from their own eating disorders. Interviews will consist of eight questions and last no longer than one hour. Interview question topics include but are not limited to: countertransference, triggers, relapse prevention, self-care, self-disclosure, supervision, body image, and self-esteem.
I will come to your office for the interview, and your participation in the study will remain anonymous. If you are located in out of town, the interview can be conducted via phone or Skype. All interviews must take place on or before February 1, 2012.
Participants of the study will be helping a graduate student complete her degree, and will receive a $5.00 gift card to a local coffee shop!

If you are interested in participating or would like to find out more about this study, please call or email me at:

XXX-XXX-XXXX
xxx@stthomas.edu

If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through St. Catherine University at
(651) 690-7739

APPENDIX C

CONSENT FORM

Experiences of Eating Disorder Clinicians

RESEARCH INFORMATION AND CONSENT FORM

Introduction:
You are invited to participate in a research study investigating the experiences of eating disorder clinicians who are recovered from a past eating disorder. This study is being conducted by Melissa Young, student in the Master's in Clinical Social Work Program at the University of St. Thomas/St. Catherine University under the supervision of Dr. Catherine Marrs Fuchsel, PhD., LICSW. You were selected as a possible participant in this research because you are a clinician at an eating disorder clinic who has had a past eating disorder and have not worked directly with the researcher in any capacity. Please read this form and ask questions before you decide whether to participate in the study.

Background Information:
The purpose of this study is to explore the experiences of clinicians who are recovered from their own eating disorder while working primarily with clients with eating disorders. Themes of countertransference, triggers, relapse, supervision, self-care, self-disclosure, self-esteem and body image will emerge in the interviews. Approximately 8-10 people are expected to participate in this research.

Procedures:
If you decide to participate, you will be asked to 1) let the researcher know where and when you would like the interview to be conducted, 2) sign this consent form at the beginning of the interview, and 3) answer 1 demographic and 7 qualitative interview questions. The interview will take approximately one hour.

Risks and Benefits:
The study has minimal risks. The questions will be sensitive in nature as they ask about your past eating disorder and what your clinical practice means to you in terms of your recovery. If you experience significant emotional distress during the interview, you or the researcher may withdraw from the study at any time and the researcher will provide you with a list of resources to contact if you choose to do so. If you choose to withdraw from the study, the researcher will have the option to omit the unfinished interview and pursue an additional participant for the research project. At that point, the audiotape from the interview will be destroyed immediately. It should be noted that the researcher will not acknowledge or disclose to anyone your participation in the study.

There are no direct benefits to participating in this study, except for the benefit that you will be a part of contributing to the limited research on the topic of eating disorder clinicians' experiences who have recovered from their own eating disorders.

Compensation:
If you participate, you will receive a $5.00 gift card to a local coffee shop, which you will receive immediately after completing the interview. If the participant lives out of town and the interview is conducted via telephone or Skype, the gift card will be mailed subsequently following the interview.

Confidentiality:
Any information obtained in connection with this research study that could identify you will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented. No one at the agency will know that you participated in the study, other than the researcher.

I will keep the research results in a password protected computer and a locked file cabinet in my office at the agency and only I will have access to the records while I work on this project. I will be finished analyzing the data by May 28th, 2012 at the latest. I will then destroy all original reports and identifying information that can be linked back to you. The data will be used for the purposes of writing and presenting my clinical research paper.

Voluntary nature of the study:
Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with this agency, St. Catherine University or the University of St. Thomas in any way. You may refuse to answer any questions asked in the interview. If you choose not to answer the questions and to withdraw from the study, the researcher will have the option to omit the unfinished interview and pursue an additional participant for the research project.

New Information:
If during course of this research study I learn about new findings that might influence your willingness to continue participating in the study, I will inform you of these findings.

Contacts and questions:
If you have any questions please feel free to contact me, Melissa Young, at XXX-XXX-XXXX. You may ask questions now, or if you have any additional questions later, the faculty advisor, Dr. Catherine Marrs Fuchsel, PhD., LICSW, at 651-690-6146 will answer any question you may have. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact John Schmitt, PhD, Chair of St. Catherine University Institutional Review Board, at (651) 690-7739.

You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time and no further data will be collected.

_____

I consent to participate in the study and I agree to be audio taped.

_____
Signature of Participant   Date

_____
Signature of Parent, Legal Guardian, or Witness   Date
(if applicable, otherwise delete this line)

_____
Signature of Researcher   Date

APPENDIX D

INTERVIEW QUESTIONS

1. What is your role at the agency and how many years have been there?

2. What is your personal experience with an eating disorder?
[Follow up questions: What does recovery mean to you? How did your experience lead you to pursue a career as an eating disorder clinician? Do you find you have more compassion, empathy, and understanding for your clients because you experienced an eating disorder yourself?]

3. Tell me about your use of self-disclosure in sessions with clients. How do you determine whether, how and when to disclose your past eating disorder to a client?

4. What are your experiences with countertransference in your sessions? How were they addressed?
[Follow up questions: Have you ever experienced triggers in session? If so, how did you respond?]

5. How would you describe your current feelings about your body image?

6. Have you ever had to seek support for your eating disorder while working at this agency? If so, did you continue to or cease working with your clients in order to focus on your own recovery?

7. As someone who has had an eating disorder, what is your experience with the other staff at this agency?
[Follow up questions: Do you feel comfortable talking about your past eating disorder with other clinicians at this agency? How do you handle it when fellow clinicians use humor to cope with the difficulties of dealing with clients with eating disorders? What type of consultation is offered at your agency to help support you as a recovered clinician? Do you feel adequately supported?]

8. As an eating disorder clinician, how do you practice personal and professional self-care?
[Follow up question: Do you ever worry about becoming "burned out" within the eating disorder field?]

APPENDIX E

CRISIS NUMBERS

1. The Emily Program
Deb Schermann, Clinical Director
651-645-5323
www.emilyprogram.com

2. Park Nicollet Melrose Institute
3525 Monterey Drive
St. Louis Park, MN 55416
952-993-6200
1-800-862-7412

3. Ceridian Crisis Response
1-800-366-1192

4. Minneapolis/St. Paul 24-Hour Crisis Counseling
Crisis Connection
612-379-6363

5. Duluth 24-Hour Crisis Line
Miller-Dwan Medical Center
218-723-0099
1-800-720-3334

6. Seattle, WA 24-Hour Crisis Line
866-427-4747
206-461-3219

7. THE JOY PROJECT
PO Box 16488
St Paul, MN 55116
director@joyproject.org

8. EATING DISORDERS ANONYMOUS
edastpaul@gmail.com
eda.minnesota@hotmail.com

9. THE WATER'S EDGE COUNSELING AND HEALING CENTER
1755 Southcross Dr. West
Burnsville, MN 55306
(952) 898-5020