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"I Can Relate": Practice and Ethical Considerations for Eating Disorder Therapists with a History of an Eating Disorder

« Je comprends très bien » : considérations sur la pratique et l'éthique des thérapeutes des troubles alimentaires ayant eux-mêmes des antécédents en ce domaine

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ABSTRACT
There is a substantial subgroup of practising psychotherapeutic professionals in the treatment of eating disorders who have a history of an eating disorder themselves. These professionals encounter unique situations in their practice inherent to their experiential knowledge. Unfortunately, the stigma surrounding experiential knowledge and eating disorders, along with discrepancies about eating disorder recovery and the course of the disorder, creates challenges for therapists with a history of an eating disorder. The psychotherapeutic profession raises complex practice and ethical issues when therapists with a history of an eating disorder treat clients with an eating disorder. Therapists with a history of an eating disorder should consider a critical evaluation of the professional and ethical aspects they encounter within their work to ensure sound practice for both clients and themselves.

RÉSUMÉ
Il existe un sous-groupe considérable de psychothérapeutes professionnels en exercice qui traitent les troubles du comportement alimentaire tout en ayant vécu eux-mêmes ce même type de troubles. Dans le cadre de leur pratique, ces professionnels doivent affronter des situations particulières en lien avec leur connaissance expérientielle. Malheureusement, ils doivent relever des défis attribuables à la stigmatisation entourant la connaissance expérientielle et les troubles de l'alimentation, ainsi qu'aux divergences en ce qui concerne le rétablissement à la suite de troubles alimentaires et l'évolution de tels troubles. La profession de psychothérapeute soulève des enjeux pratiques et éthiques complexes dans le cas où un thérapeute ayant vécu des troubles de l'alimentation traite des clients ayant le même type de troubles. Les thérapeutes ayant des antécédents de troubles alimentaires devraient envisager une évaluation critique des enjeux professionnels et éthiques auxquels ils font face dans le cadre de leur travail, afin de s'assurer que leur pratique est appropriée, aussi bien pour les clients que pour eux-mêmes.

Eating disorders are a serious mental health challenge that can affect anyone regardless of social and cultural factors (National Eating Disorders Information Center, 2019). Estimates of the lifetime prevalence of an eating disorder in the general population are 0.09% for anorexia nervosa and 1.5% for bulimia nervosa (Hudson et al., 2007). It is important to note that changes made in the Diagnostic and Statistical Manual for Mental Disorders (DSM-5) to the diagnostic criteria for eating disorders, as well as the addition of new categories of feeding and eating disorders, may alter these rates. For example, Smink et al. (2014) found when comparing the DSM-IV and the DSM-5 that the lifetime prevalence of any diagnosable eating disorder increased from 4.4% for females and 1.0% for males using DSM-IV criterion to 5.7% for females and 1.2% for males using the DSM-5 criterion.

Estimates of the lifetime prevalence of eating disorders among service providers specializing in the treatment of eating disorders ranges. In one study, Barbarich (2002) found that 12.8% of her sample had experienced anorexia nervosa, while 13.5% had experienced bulimia nervosa, with the overall lifetime prevalence of any diagnosable eating disorder at 33.2% for females and 2.3% for males. Similarly, Johnston et al. (2005) found that one out of three treatment providers in their sample identified a previous history, while Warren et al. (2013b) found that almost half of the people in their sample had experienced an eating disorder. It is difficult to attain accurate estimates of lifetime prevalence among practitioners for several reasons, including the stigma and suppression attached to eating disorders (Griffiths et al., 2015; E. P. Williams et al., 2018), one's history with mental health, and one's experiences as a practising mental health professional (Zerubavel & Wright, 2012). Nonetheless, these estimates are indicative of a substantial subgroup of practising psychotherapeutic professionals in the treatment of eating disorders who also have experiential knowledge of eating disorders.

Within this paper, the phrase *history of an eating disorder* will be used interchangeably with *experiential knowledge*. Experiential knowledge refers to the direct personal knowledge one has gained through one's experience with a mental health challenge (de Vos et al., 2016). This knowledge can be useful in helping others who are currently navigating a similar challenge.

Psychotherapy is considered an integral component of the successful treatment of those with an eating disorder (Luzier et al., 2012). Due to the complexity of eating disorders, professionals in the field often suggest that treatment providers in this area acquire specialized knowledge (M. Williams & Haverkamp, 2010). However, the psychotherapeutic profession raises complex practice and ethical issues when therapists with a history of an eating disorder treat clients with an eating disorder. Therapists with experiential knowledge of an eating disorder should consider a critical evaluation of the professional and ethical aspects they encounter within their work to ensure sound practice for both themselves and their clients.

In this paper, I intend to address the complexities and ethical considerations involved in the treatment of those with an eating disorder when the psychotherapist has experiential knowledge of an eating disorder. I review the benefits and the challenges of a therapist with experiential knowledge, the impact of experiential knowledge on the person of the therapist and on clients, and the impact of disclosure of the therapist's history. I conclude with suggestions for ethical practice, limitations, and directions for future research.

Experiential Knowledge in Psychotherapy

Psychotherapists are a diverse group of professionals who are not immune to life's challenges, tribulations, and experiences of mental health issues. Those who enter the profession often cite difficult or challenging past experiences behind their desire and motivation to help others (Bowlby et al., 2015; Huynh & Rhodes, 2011). Throughout the literature, it is evident that the use of experiential knowledge in some areas of psychotherapeutic practice, specifically addictions treatment, is considered an acceptable and useful aspect of practice (Pietkiewicz & Skowrońska-Włoch, 2017; Shadley & Harvey, 2013; White & Evans, 2013; Zerubavel & Wright, 2012). Prominent people in other areas of mental health and psychotherapeutic practice such as Marsha Linehan (Carey, 2011) and Anita Sawyer (Sawyer, 2015) have shared their stories of experiential knowledge. They have done so in an attempt to increase awareness and understanding of mental health, to decrease stigma, and to create space for a conversation about psychotherapists with a history of mental health issues (Carey, 2011; Sawyer, 2015). "Interestingly, substance abuse treatment is probably the only area in mental healthcare where the experts-by-experience are accepted without any doubts" (Pietkiewicz & Skowrońska-Włoch, 2017, p. 420).

Stigma

Although the works of Linehan (Carey, 2011) and Sawyer (2015) are only a few examples of contributions to the recognition and potential benefits of experiential knowledge, there is still a stigma associated with a professional having a history with mental health issues. For example, Boyd, Graunke, et al. (2016) examined the questions that state licensing boards asked qualifying psychologists in the United States and found that several states used questions that reflected outdated and oppressive ideas about mental health and ability. For example, the authors found that several states posed questions to their applicants about their mental health challenges within a length of time, up to five years prior to the application. The broad length of time inquired about by the states seems beyond the applicant's present ability to practise competently (Boyd, Graunke, et al., 2016).

Additionally, Boyd, Graunke, et al. (2016) found that some states, based on an applicant's disclosure of a past mental health challenge, required the applicant to

provide detailed third-party proof of their present ability for competent practice. Further, the guidelines set forth by these states about persons who identify with having a history of mental health challenges impose unrealistic and unacceptable limitations and stigma on the mental health practitioner (Boyd, Graunke, et al., 2016). Strikingly, "of the approximately 170,000 psychologists in the United States, there are only approximately 20 who are publicly identified to be in treatment or recovery from mental illness, an extremely unlikely percentage" (Boyd, Graunke, et al., 2016, p. 628). This statistic suggests that there is a subgroup of professionals who are apprehensive about revealing their experiences, likely out of concern about discrimination or stigma.

Although the use of experiential knowledge is not new within other areas of psychotherapeutic practice, it has received limited consideration in the field of eating disorders. This limited interest is likely because eating disorders carry a considerable amount of misunderstanding and stigma. By exploring the direct experiences of those with an eating disorder, Griffiths et al. (2015) sought to understand better the public's opinions and perspectives about eating disorders and eating disorder recovery. Out of the 317 surveyed people with an eating disorder, a common experience for most participants was having heard the narratives that having an eating disorder is their fault and that they should easily be able to alter their disordered behaviour. Shockingly, over 70% of the participants also indicated having heard that eating disorders are not a legitimate mental health challenge. Overall, approximately 90% of the participants who had heard one or more of the above narratives noted that these narratives were harmful to them.

Similarly, other study findings suggest that persons with an eating disorder have perceived and experienced that others are unaware of and ignorant of the challenges, struggles, and realities of having an eating disorder (E. P. Williams et al., 2018). Sadly, Griffiths et al. (2015) believed that the increased levels of stigmatization that individuals who have lived experiences of an eating disorder face are linked to poorer self-worth, increased disordered behaviours, and increased secrecy and shame. Other literature confirms negative societal perceptions and stigma surrounding eating disorders in general (Blodgett Salafia et al., 2015; Dimitropoulos et al., 2016) and when compared to other mental health challenges such as depression (Roehrig & McLean, 2010) or major depressive disorder (Ebneter & Latner, 2013).

Eating disorders have a reputation for being difficult to treat, intricate, and a permanent mental health challenge (Bowlby et al., 2015; Colli et al., 2015; Johnston et al., 2005; Warren et al., 2008). Specific to the treatment of eating disorders, helping professionals cite a lack of understanding and information about eating disorders as factors fostering their discomfort in working with persons who face these challenges (Jones et al., 2013; Natenshon, 2012). Therefore, it is safe to assume that societal perceptions and misinformation regarding eating disorders increase stigma, which then perpetuates an individual's internal secrecy and shame

surrounding their experience with the disorder (Dimitropoulos et al., 2016; Griffiths et al., 2015; E. P. Williams et al., 2018; M. Williams & Haverkamp, 2015). Practising professionals with a history of an eating disorder likely carry remnants of internalized stigma resulting in the secrecy of their experiential knowledge (M. Williams & Haverkamp, 2015). As a result, the prevalence of practitioners identifying with experiential knowledge of eating disorders may become skewed and subsequently reduce the required attention to the needs of this population (i.e., supervision and guidance for ethical and effective practice).

Finding Direction

There is little direction for therapists who use experiential knowledge when counselling clients with eating disorders; thus, it would be useful to draw from other areas of psychotherapeutic practice that use experiential knowledge. Boyd, Zeiss, et al. (2016) surveyed over 75 mental health practitioners who identified a past with a mental health challenge. The mental health challenges identified by the participants included anxiety disorders, depression, bipolar disorder, and post-traumatic stress disorder. Boyd, Zeiss, et al. found that individuals in this group were not experiencing challenges or difficulty in their professional role as a result of a past mental health challenge. This finding suggests that those with experiential knowledge achieve professional successes, maintain the ability to move forward using this knowledge in a professionally appropriate way, and attain accolades and accomplishments. Similarly, Sawyer (2015), a prominent psychiatrist and author, ascribes her career success and achievements to her experiential knowledge.

To understand the transition from client to therapist, Goldberg et al. (2014) followed 12 psychotherapy students who had each experienced a mental health challenge. From their research, Goldberg et al. proposed that individuals who move from mental health client to psychotherapist advance through four stages. According to Goldberg et al., stage 1 often precedes a person's application for school. At this stage, the individual considers the roles of client and therapist and expresses a desire to use their experiential knowledge in a helpful way.

Moving into the second stage, the individual strives to develop appropriate professional role expectations, form appropriate boundaries, and recognize personal and professional limitations (Goldberg et al., 2014). The individual moves through this stage by reflecting on their experiences in the role of the client and in the role of the therapist. During this stage, the individual is likely to experience confusion and doubt about their ability to be an effective professional. Goldberg et al. (2014) noted that those who remain in this stage have an increased probability that they will experience *impairment*, a term that refers to the therapist's challenges with maintaining appropriate professional standards and boundaries (Goldberg et al., 2014).

As a person moves into the third stage, they demonstrate the ability to distinguish, acknowledge, and accept past experiences as a client along with their new

identity as a helping professional (Goldberg et al., 2014). While in this stage, the individual learns to appreciate the complexities of their transition from client to therapist. During Goldberg et al.'s (2014) fourth and final stage, the individual gains a deep understanding of their unique position in having had their experience of mental illness. Goldberg et al. found that at this stage, the therapists in their study were able to define their history as an integral aspect of their professional identity and then to develop the ability to use it as a therapeutic intervention.

Within their study, Goldberg et al. (2014) found that although each student demonstrated reflexivity and awareness of the shift from patient to therapist, not all participants advanced through all four stages. The four stages presented may pose as a model from which one can conceptualize the development of a person from a client to a therapist with experiential knowledge. Specifically, persons with a history of an eating disorder can use Goldberg et al.'s four stages as a framework from which to monitor and guide their own development from client to therapist.

Benefits and Challenges of Experiential Knowledge

Throughout the literature, several researchers have identified both benefits and challenges of experiential knowledge specific to the treatment of eating disorders. The benefits noted in the literature included the therapist having insight and insider knowledge of the disorder and recovery (de Vos et al., 2016; Johnston et al., 2005; Warren et al., 2013b), the therapist having the ability to build a strong and connected therapeutic alliance (de Vos et al., 2016), the therapist striving for increased client hope and expectancy (de Vos et al., 2016; Warren et al., 2013b), the therapist acting as a positive mentor (de Vos et al., 2016; Johnston et al., 2005), and the therapist reducing shame and stigma through increased acceptance and understanding of the client and of the disorder (de Vos et al., 2016; Johnston et al., 2005; Warren et al., 2013b).

In contrast, the challenges noted in the literature included therapists focusing on their own experience over those of the clients, therapists overextending their professional limits and boundaries (de Vos et al., 2016; Johnston et al., 2005), and increased risk, such as relapse, to the therapist (Johnston et al., 2005; Warren et al., 2013b). Nearly 95% of therapists with a history of an eating disorder acknowledged that their experiential knowledge would impact treatment at least in some way (Warren et al., 2013b).

Efficacy of Experiential Knowledge

The benefits, challenges, and overall efficacy of experiential knowledge in the treatment of eating disorders are perceived differently between clients, therapists with a history of an eating disorder, and therapists without a history of an eating disorder. Both clients and therapists with a history of an eating disorder acknowledged that therapist experiential knowledge has both benefits and challenges

(de Vos et al., 2016; Johnston et al., 2005). In fact, both groups were more positive about the benefits of experiential knowledge, with 97% of clients and 100% of therapists with a history citing benefits (de Vos et al., 2016).

In contrast, therapists without a history of an eating disorder were found to differ in this outlook. Just over 10% of this group considered experiential knowledge to have no benefits, approximately 26% felt that those with a history were not suited to practise in the field of eating disorders, and a majority of the respondents expressed increased pessimism toward therapists with a history (Johnston et al., 2005). This finding is in stark contrast to Pietkiewicz and Skowrońska-Włoch (2017), who in their study of substance abuse therapists with and without experiential knowledge found that both groups perceived experiential knowledge in a much more positive and advantageous light.

Lack of Recognition

The lack of recognition of the benefits of experiential knowledge in the field of eating disorders could indicate that practitioners without a history of an eating disorder may be demonstrating and perpetuating the stigma and the shame associated with eating disorders (Johnston et al., 2005). Consequently, therapists without a history of an eating disorder may understate the benefits of experiential knowledge and focus more on the challenges, resulting in the notion that experiential knowledge equates to increased ethical risk and incompetence.

Interestingly, when exploring the challenges of experiential knowledge, persons with and without a history of an eating disorder identified them equally (Johnston et al., 2005). This finding suggests that therapists with a history have demonstrated an ability to reflect on and to accept potential challenges. Moreover, this could suggest that therapists with a history can identify objectively and consider the challenges associated with experiential knowledge just as much as someone without a history.

Impact of Experiential Knowledge on the Person of the Therapist

The previously identified challenges of experiential knowledge in the field of eating disorders indicated concern related to risks for the therapist's well-being. The therapist relapsing, being emotionally triggered, or becoming overly immersed in their work and the lives of their clients are some of the concerns that have been identified within the literature (Johnston et al., 2005; Warren et al., 2013b). These concerns are thought to increase for a therapist with a history of an eating disorder if they are early in their own recovery (Bardone-Cone et al., 2010; Costin, 2018b). In addition, the current inconsistency and confusion surrounding the meaning of recovery from an eating disorder intensifies these concerns (Noordenbos, 2011a). The question then becomes as follows: how can one know when it is appropriate

to move from client to therapist without a clear idea of what recovery from an eating disorder means?

Recovery

There is no consensus in the literature regarding a standard definition of recovery from an eating disorder; however, some researchers have attempted to clarify and to solidify this challenge. Bardone-Cone et al. (2010) developed a definition of recovery with marked differences between what they considered "full" versus "partial" recovery. According to Bardone-Cone et al., the following three fundamental aspects mark *partial recovery*: the DSM-5 diagnostic criteria are no longer relevant to the individual, the individual has refrained from eating disorder behaviours for three months, and the individual's weight is at a healthy norm. *Full recovery* parallels these aspects with one addition: the individual no longer adheres to disordered or abnormal narratives (Bardone-Cone et al., 2010).

Similarly, Costin (2018b) identified differences between a person "in recovery" or "recovering" and "recovered," which equate to Bardone-Cone et al.'s (2010) definitions of partial and full recovery, respectively. In addition, Costin drew awareness to the unclear definitions and confused perceptions associated with the current terminology used. Costin maintained that the terms "in recovery" and "recovering" perpetuate the idea that eating disorders are constant, making a full recovery seem impossible.

Costin (2018a), who is a well-known figure in the eating disorder community, advocated for the use of experiential knowledge in the treatment of eating disorders. Costin (2018b) believed that a therapist must identify as sustaining full recovery for a minimum of two years before working as an eating disorder therapist. Interestingly, in a study conducted by Bowlby et al. (2015), they found that their sample of therapists with a history of an eating disorder preferred an identity of in recovery and recovering and were uncomfortable identifying as recovered. Therefore, personal preference and meaning attached to various terms create further difficulty in reaching consensus on recovery. This confusion surrounding the definition of recovery makes it more difficult for a therapist with experiential knowledge to know when it is appropriate to enter the field as a practising professional.

Moreover, Costin (2018b) pointed out that many people presume an erroneous belief that an eating disorder will be a constant challenge for someone. While many people with histories of an eating disorder might feel uncomfortable stating that they are recovered, Costin encouraged the use of the term "for now" to dispel these erroneous beliefs. In support, Bardone-Cone et al. (2010) found not only that full recovery is possible but also that individuals who met all four aspects of a full recovery were identical to study participants without an eating disorder. Bardone-Cone et al. (2010) reported "that prior findings [which suggested] that residual symptoms often persist in those recovered from an eating disorder may

[actually] be an artifact of an incomplete definition of recovery" (p. 9). Consequently, there is a high demand from practitioners in the field who are seeking a definition of recovery that goes beyond weight and behaviours to include the cognitive aspects of recovery and a possibility of freedom from the disorder (Bardone-Cone et al., 2010; Bowlby et al., 2015; Noordenbos, 2011a, 2011b).

Reflection on Recovery Status

Therapists with a history of an eating disorder must reflect on their recovery status as this can impact directly their ability to treat those with an eating disorder. If a therapist has not been recovered long enough or if they are recovered only partially, the risk of relapse may become greater (Bardone-Cone et al., 2010; Costin, 2018b). Unfortunately, the study of relapse rates among practitioners with a history of an eating disorder is limited. A study conducted by Barbarich (2002) found the relapse rate of therapists with experiential knowledge working with eating disorders to be around 28%. In contrast, Costin (2018b) reported that in the 30 years she has worked with recovered therapists, only one practitioner has experienced a relapse. The significant difference between these two findings may be because Costin upholds specific guidelines and supports for the recovered practitioners that she works with. The therapists that Costin referred to in her assertion have received direct supervision and support related to their experiential knowledge and have been recovered for a set amount of time. It is unclear if this was the same for the practitioners in Barbarich's study (Costin, 2018b; Costin & Spotts-De Lazzer, 2016).

Therapists who are not fully recovered when practising as an eating disorder therapist increase their risk of providing unethical care to their clients. Several authors within the literature have indicated that ethical mistakes and challenges are more likely to occur when a therapist with experiential knowledge is new to the field or has recently recovered (Costin & Spotts-De Lazzer, 2017; Shadley & Harvey, 2013; M. Williams & Haverkamp, 2015; Zerubavel & Wright, 2012). For instance, in an interview study conducted by M. Williams and Haverkamp (2015), therapists with experiential knowledge reported having experienced a higher occurrence of ethical mistakes upon entry into the field. One of the study participants noted that as a novice therapist she disclosed information about her personal experience with an eating disorder, which led to the client leaving treatment. The participants in M. Williams and Haverkamp's study also cited partial or recent recovery as impacting their ability to use their experiential knowledge effectively and appropriately. These findings suggest that persons who are still navigating their recovery, combined with being a novice professional, have an increased vulnerability to ethical mistakes. It is also likely that these therapists have not advanced through all four of the stages, as proposed by Goldberg et al. (2014), which may leave the individual vulnerable to impairment.

Burnout and Counter-Transference

In general, mental health professionals perceive people with an eating disorder as a difficult population to work with and to treat (Bowlby et al., 2015; Colli et al., 2015; Johnston et al., 2005; Warren et al., 2009). Because of the difficulties, researchers have asserted that practitioners treating persons living with an eating disorder tend to experience high levels of burnout (Warren et al., 2012) and negative counter-transference (Satir et al., 2009). *Burnout* is when a therapist experiences "high levels of emotional exhaustion, depersonalization, and ineffectiveness at work" (Warren et al., 2012, p. 176), whereas *counter-transference* is the therapist's response or reaction to the client based on the therapist's emotions, values, or experiences (Baldwin, 2013; Satir et al., 2009). In contrast, several researchers have not found evidence to support the assertion that treatment providers experience those living with an eating disorder as difficult to treat (Satir et al., 2009; Warren et al., 2013a). The discrepancy in findings may be varied because Satir et al.'s (2009) and Warren et al.'s (2013a) study samples contained high percentages of therapists with protective factors, such as more professional experience and a history of an eating disorder.

The potential stresses of working with persons living with an eating disorder, such as high mortality rates (Warren et al., 2013a), can leave professionals feeling inept, ill-prepared, discouraged, and concerned (Colli et al., 2015; Thompson-Brenner et al., 2012). Similarly, Warren et al. (2008) explored the direct experiences of practitioners who work in the field of eating disorders and the impact of those experiences. Participants of Warren et al.'s (2008) study reported that about one out of every four clients had remarked on their appearance verbally. Additionally, over 80% of the participants stated that they sensed their clients had assessed the therapist's appearance mentally. Participants also reported that their work with the eating disorder population had impacted their perceptions of food, their appearance, and the appearance of others. Overall, a large portion of Warren et al.'s participants noted that their work in the field of eating disorders had increased their worry about their personal appearance. Moreover, a small portion of the sample reported that they had been partaking in disordered eating behaviours as a direct result of working in the eating disorder field. Clearly, to varying degrees, therapists working with persons living with an eating disorder may be impacted negatively by the work.

One would assume that the likelihood of experiencing comments about one's appearance, compounded with the impact this work can have on a practitioner, would increase the risks of burnout and negative counter-transference to the practitioner with experiential knowledge. However, some researchers have found the opposite: that having a history of an eating disorder can be a protective factor against burnout and negative counter-transference (Warren et al., 2013a). The therapist's internal knowledge and experience of the disorder, as well as an

increased understanding of what it is like to be in the client's position, may be the reason for this finding (Satir, 2013; Warren et al., 2013a).

Self-Disclosure

Self-disclosure is a psychotherapeutic technique that entails revealing one's thoughts, reflections, personal aspects/experiences, or a combination of these within a therapeutic or professional context (de Vos et al., 2016; Kramer, 2013). This technique remains a complicated choice as it requires careful thought and attention to purpose and intent (Costin & Spotts-De Lazzer, 2017; Fishman, 2015; Kramer, 2013; Simonds & Spokes, 2017). In the field of eating disorders, there are additional factors for a therapist with experiential knowledge to consider when contemplating self-disclosure. For example, considerations include differences in having versus using experiential knowledge within therapy (de Vos et al., 2016), depth and specificities of the disclosure to clients (de Vos et al., 2016; Jacobs & Nye, 2010), and how one's outward appearance can be a form of disclosure (Fishman, 2015; Jacobs & Nye, 2010). Moreover, considerations of a therapist's disclosure of their history with an eating disorder will vary according to the audience.

Clients

The literature offers practitioners only very general guidelines and suggestions for navigating self-disclosure ethically and safely. In particular, the purpose and the intent of the counsellor's use of self-disclosure are central to the potential effectiveness of this technique (de Vos et al., 2016; Costin & Spotts-De Lazzer, 2017; Kramer, 2013). Beyond this consideration, there are no standard guidelines for practitioners with experiential knowledge of eating disorders trying to navigate self-disclosure to a client.

In an attempt to fill this gap, Costin and Spotts-De Lazzer (2017) suggested guidelines specific to the disclosure of one's history with an eating disorder. These included using disclosures that involve motivators for change and recovery, emphasizing what being recovered is like, and expressing an understanding of the fears and difficulties involved with recovery. The authors also suggested that therapists with a history of an eating disorder avoid specific details regarding their past disordered behaviours, the intensity of their illness, and weight information (Costin & Spotts-De Lazzer, 2017). Additionally, Costin and Spotts-De Lazzer included recommendations for the therapists, such as considering challenges that may arise in therapeutic work, keeping professional boundaries, knowing and recognizing personal triggers, and meaning-making.

When a therapist with experiential knowledge uses self-disclosure with a client, the client may experience a positive turning point in the therapeutic work as it provides hope that survival from the disorder is possible and tangible (de Vos

et al., 2016; Costin & Spotts-De Lazzer, 2017). In fact, Simonds and Spokes (2017) found that the use of self-disclosure in the treatment of eating disorders is generally useful and helpful to clients. Still, caution must be exercised when using this technique as unhelpful, ill-timed, and ill-purposed disclosures can rupture the alliance or create ethical challenges (M. Williams & Haverkamp, 2015).

Colleagues/Employers

Disclosure of one's history with an eating disorder carries risks such as stigma from peers and employers and increases the vulnerability to one's privacy (Jacobs & Nye, 2010; M. Williams & Haverkamp, 2015). Specific to eating disorders, the therapist's physical appearance and eating behaviours, such as weight loss or food choices, can become sources of concern (Jacobs & Nye, 2010; M. Williams & Haverkamp, 2015). Sadly, the literature reports that a therapist with a history of mental illness is more likely to be subjected to preconceived notions of impairment and vulnerability (Boyd, Graunke, et al., 2016). Therefore, choosing to disclose one's history with an eating disorder to colleagues and employers can be difficult.

As found in Canadian ethical codes for psychotherapists and psychologists, professional members are expected to uphold ethical codes and all standards (Canadian Counselling and Psychotherapy Association [CCPA], 2007; Canadian Psychological Association [CPA], 2017). Incorporated into these ethical codes and standards is the expectation that members will address their colleagues' incompetence, impairment, or unethical behaviour appropriately (CCPA, 2007; CPA, 2017; Jacobs & Nye, 2010). For example, the CPA (2017) ethical code expects each member to

> bring concerns about possible unethical actions by a psychologist directly to the psychologist when the action appears to be primarily a lack of sensitivity, knowledge, or experience [and to] bring concerns about possible unethical actions of a more serious nature (e.g., actions that have caused or could cause serious harm; actions that are considered misconduct in the jurisdiction) to the person(s) or body(ies) best suited to investigating the situation and to stopping or offsetting the harm. (pp. 6–7)

Therefore, when paired with the conflation between impairment and mental health issues by colleagues who do not have experiential knowledge of eating disorders, the result can be layers of stigma, misunderstanding, and unnecessary reporting (Jacobs & Nye, 2010; M. Williams & Haverkamp, 2015).

Interestingly, Costin (2018b) reported that she has always chosen to disclose her history with an eating disorder to clients, colleagues, and supervisors. Costin stated that full disclosure of her experiential knowledge is an essential aspect of her authenticity as a practitioner and of her successful treatment of clients.

Unfortunately, Costin's disclosure has not been without backlash and negative attitudes from other professionals (Costin & Spotts-De Lazzer, 2017).

Given the potential risks of self-disclosure to colleagues, therapists with a history of an eating disorder tend to safeguard themselves from the potential backlash and the negative responses of others. Rance et al. (2010) interviewed 12 therapists who identified as having a history with an eating disorder. They found that all study participants exaggerated "normality" to manage and protect themselves from the negative attitudes they believed others had of them. *Normality* meant that an individual stressed full, unwavering recovery from an eating disorder and that the person had no challenges with food, body image, or weight (Rance et al., 2010).

Moreover, the participants seemed to use normality as a defence against having to address any internal thoughts, feelings, or challenges still associated with their history of an eating disorder (Rance et al., 2010). In other words, it prevented the participants from analyzing or reflecting critically on how their history impacts the self or their therapeutic work. In turn, the use of normality deprived the study participants of an opportunity to engage in meaningful dialogue with clients, colleagues, and supervisors (Rance et al., 2010).

Supervisors

The disclosure of one's experiential knowledge of an eating disorder to supervisors can benefit the therapist in the way of receiving appropriate supervision in navigating unique challenges and issues that may arise (Jacobs & Nye, 2010; Warren et al., 2013b; M. Williams & Haverkamp, 2015). Also, it can provide a chance to elevate the person to a place where they can advocate on behalf of the eating disorder community to reduce stigma and improve therapeutic care for others (Boyd, Zeiss, et al., 2016; Sawyer, 2015).

At the same time, the choice not to disclose one's history to supervisors can carry ethical implications and practice challenges. By not disclosing one's experiential knowledge, a therapist may miss opportunities to receive appropriate supervision and support (Jacobs & Nye, 2010; M. Williams & Haverkamp, 2015). Missed supervision opportunities can result in the practitioner having to navigate uniquely challenging professional situations without guidance (Jacobs & Nye, 2010; Satir, 2013; M. Williams & Haverkamp, 2015), thus increasing the potential for ethical mistakes. Furthermore, fears surrounding increased stigma and questions of fitness to practice, make it more difficult for a therapist with experiential knowledge to be honest when facing challenges or needing support related to their eating disorder history (Rance et al., 2010; Zerubavel & Wright, 2012).

Overall, "there appears to be implicit agreement within psychology that it is risky to disclose woundedness—those who disclose risk stigma, judgment, or overt hostility from other professionals" (Zerubavel & Wright, 2012, p. 488). The therapist with lived experience is put into a difficult space of having to balance

self-disclosure with the ethical risks to clients and the risks to one's personal and professional self. Given the narratives within the counselling community, many practitioners with experiential knowledge may simply avoid disclosure to clients, colleagues, and supervisors.

Guidance for Therapists With Experiential Knowledge

Until the field of eating disorders identifies practice standards and guidelines regarding experiential knowledge, it is the responsibility of the therapist with a history of an eating disorder to ensure safe and ethical practice for themselves and for their clients (Costin & Spotts-De Lazzer, 2016; M. Williams & Haverkamp, 2010, 2015). Without specifically tailored competencies, guidelines, and standards of practice in the treatment of eating disorders, practitioners are left to do this with little guidance (M. Williams & Haverkamp, 2010). Attempting to bridge this gap, M. Williams and Haverkamp (2010) tasked a select group of professionals with expertise in the treatment of eating disorders to identify core competencies for practitioners treating eating disorders. Interestingly, the group of professionals provided consensus on over 200 competencies while still perceiving the therapist having a history with an eating disorder as a point of contention. Nevertheless, the literature offers suggestions for what therapists with experiential knowledge in the treatment of eating disorders can do to promote safe and ethical practice for themselves and for their clients.

First, therapists should maintain good self-awareness. Therapists with experiential knowledge should recognize the impact that their experiences have on themselves as a professional and on their therapeutic work with clients (de Vos et al., 2016; Fishman, 2015; Warren et al., 2008; Warren et al., 2013b). Upholding ethical codes and standards (CCPA, 2017; CPA, 2017) along with Costin and Spotts-De Lazzer's (2017) proposed guidelines specific to therapists with a history may help advance and direct the practitioner in how to use their knowledge appropriately. Combining ethical direction with an in-depth awareness of one's experiential knowledge is relative to the therapist advancing to the fourth and final stage of Goldberg et al.'s (2014) model. Making it to the fourth stage demonstrates that the therapist can use their experiential knowledge effectively in a way that is ethical and safe for themselves and for their clients (Goldberg et al., 2014). The therapist moves to a place of deep self-awareness and acceptance of one's personal history, along with an understanding of how it impacts self, clients, and the profession (Goldberg et al., 2014).

Second, therapists should ensure that they are accessing appropriate supervision, training, and support (de Vos et al., 2016; Costin & Spotts-De Lazzer, 2016; Warren et al., 2012; Warren et al., 2013b). Connection can help the therapist with experiential knowledge feel less isolated and less alone while receiving the support they need to practise ethically (M. Williams & Haverkamp, 2015).

Although a history with an eating disorder has been identified as a potentially protective factor against burnout (Warren et al., 2013a), this does not mean that therapists with a history are immune to these challenges. Appropriate supervision, training, and support can protect the therapist further from experiencing negative impacts, such as burnout and counter-transference, from their work (Warren et al., 2013b; M. Williams & Haverkamp, 2015). However, accessing these supports may be easier said than done as per the previous discussion surrounding the risks of self-disclosure to colleagues and supervisors.

Third, therapists with a history of an eating disorder should complete their own work about challenges related to a personal eating disorder (Warren et al., 2008; Warren et al., 2012; M. Williams & Haverkamp, 2015). Attending personal therapy may help the therapist increase their self-awareness as a professional with experiential knowledge and understand their personal recovery better (Satir, 2013; Warren et al., 2008). This can help ensure that they work through any personal challenges that may arise from the work they do.

Fourth, after therapists have reached the fourth stage of Goldberg et al.'s (2014) model, therapists should use their professional status to advocate for others (Sawyer, 2015). Therapists can help shift the narrative and perception of eating disorders by addressing and challenging stigma (Sawyer, 2015). This can help draw awareness to bias and to negative perceptions surrounding eating disorders and experiential knowledge while calling on our peers to educate themselves, challenge their stigmatizing ideas of eating disorders, and act as our allies.

Limitations and Directions for Future Research

It would be interesting to investigate further the unique ethical and practice challenges faced by therapists with a history of an eating disorder. This may help the field move toward developing field-specific suggestions, standards, and guidelines. It may also increase access to appropriate support and training for all practitioners, including those with and without a history of an eating disorder. More specifically, researchers could study comparisons between the experiences of eating disorder clinicians with and without a history of an eating disorder in the treatment of eating disorders. They may also want to investigate the ethical challenges that therapists with a history may face specific to interactions with colleagues, supervisors, and clients or regarding recovery status. Further, researchers should explore the internal and external stigma one experiences with a dual identity as a person recovered from an eating disorder and as an eating disorder professional with experiential knowledge. It may also be interesting for future researchers to study the application of Goldberg et al.'s (2014) stages of development from a client to a therapist with a focus on those with a history of an eating disorder. In addition, the field of eating disorders would do well to amalgamate definitions of recovery and to create a standardization of terminology.

Moreover, my focus was limited to a discussion on how therapists with a history of an eating disorder can navigate experiential knowledge. It would be beneficial for future researchers to expand this discussion to include the roles of supervisors and colleagues in both supporting and learning from fellow professionals who have experiential knowledge in the treatment of eating disorders. Further, it would be interesting to compare experiential knowledge in eating disorder treatment to other areas of psychotherapeutic practice.

The challenges and concepts I spoke to in this paper are significant areas where further dialogue and research need to occur to move the field forward. Therapists with a history of an eating disorder make up a large subsection of eating disorder clinicians (Barbarich, 2002; Johnston et al., 2005; Warren et al., 2013b). Therefore, future research should work to understand better the unique challenges and positions these therapists find themselves in.

Conclusion

Is it realistic to assume that anyone, including psychotherapists, can separate themselves enough from their personal experiences to a point where they do not use these experiences to frame their ideas, thoughts, beliefs, and perceptions? Past experiences are a part of who a person is and will manifest in how they see the world (Bowlby et al., 2015). This reality means the psychotherapeutic profession would do better to support and help professionals with experiential knowledge in the field of eating disorders learn how to use their experiences safely and ethically (de Vos et al., 2016).

It is evident that therapists in the field of eating disorders who have experiential knowledge encounter stigma and misunderstandings of ability and competence related to their experience (Jacobs & Nye, 2010; Johnston et al., 2005; M. Williams & Haverkamp, 2015). These perspectives create challenges and barriers for therapists with experiential knowledge in attaining appropriate support and guidance in their professional work (Jacobs & Nye, 2010; M. Williams & Haverkamp, 2015). Ultimately, the barriers and challenges experienced may limit or hinder the therapist's ability to practise safely and ethically. For now, until the field moves forward with standards and guidelines for therapists with experiential knowledge, therapists with a history of an eating disorder are left to do this for themselves. Therefore, therapists with experiential knowledge need to examine critically and reflect on the benefits and challenges of their history, their personal recovery status, and self-disclosure. Moreover, they need to recognize and to consider the effects their experiential knowledge have on themselves, on their clients, and on the professional care they provide.

We must also keep in mind that a history of an eating disorder does not mean that a person will be an impaired professional, will be incompetent, or will engage in unethical behaviours (Barbarich, 2002). This aspect of the professional is just

one aspect. "It must be emphasized that a history of an eating disorder is only one among many personal and technical factors that determine the suitability and competence of the individual clinician" (Barbarich, 2002, p. 312).

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