THE ETHICS EXPERIENCES OF EATING DISORDER THERAPISTS WHO HAVE A PERSONAL HISTORY OF AN EATING DISORDER: AN INTERPRETIVE DESCRIPTION

by

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Abstract

The study’s purpose was to explore and understand the professional ethics experiences of eating disorder (ED) therapists with personal ED histories, in order to generate knowledge directly applicable to maximizing such therapists’ safe and ethical practice with ED clients. Using the interpretive description qualitative approach to inquiry, data from interviews with 11 ED therapists with personal ED histories and from 2 first-person, published written accounts were analyzed inductively at manifest and latent content levels. From this emerged a description of the ethical issues and concerns reported (the ‘ethics terrain’), as well as of the interviewees’ experiences of engaging in conversation about the research topic, and their ethical self-reflections and practice changes that occurred over the course of data collection.

Additional interpretation of these descriptive findings produced patterns, concepts, and ideas contributing to a more integrative understanding of participants’ ethics experiences that enhanced the clinical applicability of the study’s findings and had direct implications for practice. Among the recommendations directed towards ED-historied therapists, professionals involved in the education and training of such therapists, and the broader EDs field that emerged from this exploratory study were that ED-historied therapists receive early and ongoing training and supervision that addresses the full range of ethical issues likely to be encountered by them when delivering therapy to ED clients, including those associated with their personal ED histories. Particular attention to therapist wellness and self-disclosure practices may be warranted, as these may be associated with early career/early-in-recovery ethical vulnerabilities that could increase risk of harm to ED clients. However, there appear to be significant risks for ED-historied therapists in disclosing their ED histories in professional environments and in discussing related ethical issues. Safe climates that foster ‘positive ethics experiences’ for such therapists may facilitate their engagement with the full range of ethical issues relevant to them so that they can maximize their safe and ethical practice with ED clients.
Preface

This research was approved by the University of British Columbia’s Behavioural Research Ethics Board (Certificate #H09-02828).
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Dedication

To Mike, my anchor and heart throughout this project. Your unquestioning patience and support, and your good humour, made its fulfillment possible.
CHAPTER 1 - Introduction

The wounded healer refers to the notion that people who have overcome a personal experience of adversity possess special skills and sensitivities to help others (e.g., White, 2000a; Wolgien & Coady, 1997). The construct has deep roots, originating in the classical Greek myths of Chiron, the master healer who is unable to heal his own wound, and Asclepius, a physician mentored by Chiron who, in recognition of his own wounds, established a sanctuary where others could be healed of theirs (Stone, 2008). In the shamanic traditions, the healer's wounds are seen as evidence of authentic healing skill (Miller, Wagner, Britton, & Gridley, 1998). In the field of psychology, the wounded healer appears in Jungian analysis as an archetype that must be activated in the analyst in order to assist the client in developing his or her effective 'inner healer' (Sedgwick, 1994).

The notion that the healer’s wound facilitates her or his empathy, understanding, and acceptance persists in many of today’s helping professions, in which practitioners' personal traumas and other difficulties are thought to foster their abilities as helpers (e.g., Bennet, 1979; Hanshew, 1998; Stone, 2008). The wounded healer concept is perhaps most overtly embraced in the drug and alcohol treatment fields, in that practitioners with addiction histories are often perceived as more credible and effective clinicians and supervisors than those without personal histories (e.g., Doyle, 2008; Lawson, 1982).

However, the healer's wounds may not always benefit others, and wounds left unacknowledged or unresolved can lead to an increased risk of harm to those whom professionals serve (e.g., Grapp, 1992; Stone, 2008). In addition, practitioners' unhealed wounds may increase their risk of experiencing vicarious traumatization in the workplace, resulting in symptoms more akin to "walking wounded" than wounded healer (Conti-O'Hare, 2002, 2004). Indeed, it may not be the wound itself but the process of recovery that contributes to healing power (de Vries & Valadez, 2005) such that practitioners “have suffered enough themselves to
understand other people’s pain, but…are no longer controlled by their own disturbance” (Park, 1992, p. 26). It is unsurprising, then, that the ethics codes of the helping professions contain multiple standards relevant to the concept of the wounded healer that are concerned with benefiting and not harming clients.

From a principle-based ethics perspective (e.g., Beauchamp & Childress, 1989; Kitchener, 1984, 2000), the meta-ethical principles relevant to the wounded healer are beneficence (doing good) and nonmaleficence (do no harm). In the ethics codes of psychology and counselling, certain standards direct clinicians to monitor personal factors that influence the potential benefits and harms of their work. For example, the Canadian Psychological Association's (CPA) Code of Ethics (2000) states that responsible caring requires psychologists to “evaluate how their own experiences, attitudes, culture, beliefs, values, context, individual differences, and stresses influence their interactions with others, and integrate this awareness into all efforts to benefit and not harm others” (Standard II.10, p. 17). Furthermore, the CPA code urges psychologists to “seek appropriate help and/or discontinue…professional activity for an appropriate period of time, if a physical or psychological condition reduces their ability to benefit and not harm others” (Standard II.11, p. 17). Moreover, psychologists must “…avoid conditions (e.g., burnout, addictions) that could result in impaired judgment and interfere with their ability to benefit and not harm others” (Standard II.12, p.17). Similarly, the American Psychological Association’s (APA) Code of Ethics (2002) states that “psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner” (Standard 2.06a, p. 5). Moreover, “when psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties” (Standard
2.06b, p.5). Standard C.2.g. in the American Counseling Association's Code of Ethics (2005) is similar to the standards cited above.

Given these unambiguous directives, it is clear that practitioners of counselling and psychotherapy are obliged to assess their 'wounds' and take appropriate actions to ensure that they do not interfere with their abilities to help and not harm their clients. Despite the guidance offered in the codes, however, research has shown that therapists are fallible in their ability to correctly identify and refrain from ethically problematic professional behaviour (e.g., Pope, Tabachnick, & Keith-Spiegel, 1987; Pope & Vetter, 1992). In addition, ethics research indicates that contextual and relational barriers are encountered by clinicians in their process of identifying, working through, and resolving ethical concerns (e.g., Prilleltensky, Rossiter, & Walsh-Bowers, 1996; Prilleltensky, Walsh-Bowers, & Rossiter, 1999).

One field of professional practice that has recently begun to grapple with the ethical dimensions of the wounded healer is the eating disorders (ED) treatment field. Evidence has emerged that a striking proportion of professionals who work in EDs treatment have personally experienced the 'wound' of an ED. In fact, the lifetime prevalence of EDs among ED treatment professionals is between 20% - 33% (Barbarich, 2002; Bloomgarden, Gerstein, & Moss, 2003; Johnson, Smethurst, & Gowers, 2005), a proportion that vastly exceeds the lifetime prevalence rates in the general population of 0.3% - 4.2% (American Psychiatric Association, 2006).

While this phenomenon may not be exclusive to the EDs treatment field, EDs are a particularly compelling exemplar to consider with respect to the wounded healer concept due to their high risk nature. EDs are complex mental health disorders associated with myriad psychological needs, potential physiological complications, and mortality rates (specifically for anorexia nervosa [AN]) that are among the highest of all mental illnesses. Furthermore, the recovery process can be years-long, complex, and characterized by relapse and ambivalence about recovery (American Psychiatric Association, 2006). The serious and potentially long-term
nature of EDs suggest that therapists or counsellors with a history of an ED are ethically obligated to carefully assess their degree or phase of recovery and to continue to evaluate their thoughts, feelings, and behaviours (e.g., regarding their body shape, weight, eating practices, self-image) as they engage in their work with ED clients.

Even for practitioners to whom the formal diagnosis of an ED no longer applies may demonstrate residual unhealthy thoughts, beliefs, attitudes, and behaviours related to eating, body weight, and body shape (e.g., Johnson et al., 2005; O’Dea, 2000; Rutz, 1993) as well as enduring personality disturbance (e.g., Klump et al., 2004). Concerns have been expressed about the extent to which therapists with ED histories may have retained some or all of these characteristics, which could be modeled inappropriately to clients either intentionally or inadvertently (Johnson et al., 2005; O’Dea, 2000; Rutz, 1993). Moreover, the often lengthy nature of recovery, coupled with data indicating that EDs typically begin during mid-/late-adolescence to early adulthood, suggests that an ED may not be completely (or, in some cases, even remotely) resolved by the time the individual enters a career in the EDs treatment field.

While the potential ethical concerns are numerous, there may also be benefits including enhanced therapeutic skills and sensitivities resulting from practitioners’ personal ED experiences (e.g., a high degree of empathy, understanding, and acceptance). These qualities may be advantageous in building a strong therapeutic alliance (Johnson et al., 2005), a critical factor in successful therapy outcome (Lambert & Barley, 2001).

The potential advantages and limitations of involving therapists with a history of an ED in EDs treatment have been voiced in the (primarily conceptual) EDs literature (e.g., Bloomgarden et al., 2003; Costin & Johnson, 2002; cf. Johnson et al., 2005). However, no research has investigated this topic with an explicitly professional ethical lens. A potential reason for this dearth of scholarship may have been the relatively recent appearance of the topic in the EDs literature (i.e., within the last 10 years). Nevertheless, this scant literature has concluded
uniformly that further research is needed to increase our understanding of therapists with ED histories, and to explore the implications of their providing EDs treatment.

Specific research recommendations have included determining the consequences of therapist self-disclosure of a past ED on the therapeutic relationship and treatment outcome (Barbarich, 2002; Bloomgarden et al., 2003), investigating the relative efficacy of recovered versus non-recovered therapists (Barbarich, 2002), and exploring what constitutes a therapist ‘recovered enough’ to practice safely with ED clients (Bloomgarden et al., 2003). Furthermore, guidelines have been called for that will help entry-level ED practitioners evaluate their readiness and suitability to work in the field (Bloomgarden et al., 2003; Johnson, 2000).

In 2005, Johnson and colleagues’ questionnaire study canvassed the views of clients, professionals, and caregivers regarding the potential benefits, drawbacks, and suitability of involving therapists with a history of an ED in EDs treatment. In 2003, Bloomgarden and colleagues stated that “we are at the beginning of a dialogue that is crucial to our field” (p. 167). Curiously, however, in the intervening years, scant research has been published (c.f. Rance, Moller, & Douglas, 2010) nor have guidelines emerged. Thus, given the limited attention to the topic, Johnson’s (2000) statement that the recovered ED professional is one of the “thorny issues we have avoided up to this point” (p. 3) appears to be nearly as true now as it was then.

**1.1 Research Problem**

There appear to be many gaps in the extant knowledge about ED therapists with personal ED histories, one such gap being the lack of empirically-derived information about their experiences and practices regarding professional ethics. Given the reports of the high prevalence of professionals with a personal history working in EDs treatment, a substantial proportion of the field's therapists may be grappling with the ethical dimensions of how their history interfaces with their professional work. Our scant knowledge is problematic because there are ethical issues concerning the provision of EDs treatment delivery by ED-historied therapists. These relate to
the potential help or harm of ED clients, who are an especially vulnerable group. As Prilleltensky and colleagues (1996) assert, ethically unexamined practices can perpetuate harm because unexamined expertise is inherently less sensitive to the needs and interests of all parties involved in caring relationships. Furthermore, the high prevalence of professionals with personal ED histories suggests that a large proportion of ED clients are in receipt of their services. Thus, the potential effects of this phenomenon, both positive and negative, may be wide-reaching. One appropriate and useful starting point is to acknowledge that there is negligible empirically-based information that is based on the ethical experiences and perspectives of the therapists themselves, for example regarding the ethical issues they identify and encounter.

1.2 Purpose of the Study

The purpose of the study was to explore and understand what therapists with a personal history of an ED experience in terms of professional ethics in their day-to-day work with ED clients (e.g., ethical issues identified, encountered) in order to generate knowledge that could be put to practical use in the disciplines associated with the delivery of psychotherapy and counseling to ED clients, such that the ethical practices of ED-historied therapists could be enhanced. Reflecting relevant standards in the ethics codes, particular attention was paid to whether and how therapists identified their ED histories as having professional ethical relevance.

Specifically, this knowledge can be used to assist ED therapists with personal ED histories in their ethical practices and other professional choices, as well as help their educators, trainers, supervisors, colleagues, and employers to provide appropriate support and guidance. Ultimately, the importance of investigating this topic lies in its potential to enhance ED-historied therapists’ provision of safe and ethical therapy services to ED clients.

The present study was conceived as an exploratory investigation intended to generate rich and elaborated descriptions of the experiences of professional ethics for therapists who had a personal history of an ED. It was grounded in the perspectives of professionals who worked day-
to-day in the EDs field. Given the purposes of generating knowledge for understanding and
enhancing practice, the study's purpose was considered to be practice-oriented (Haverkamp &
Young, 2007). The paradigm of science most appropriate for this exploration was the
constructivist-interpretivist paradigm (Haverkamp & Young, 2007; Ponterotto, 2005).

1.3 Research Question

The research question was: For therapists with a personal history of an ED, what are their
experiences of professional ethics in their day-to-day work with ED clients?

1.4 Assumptions

Two assumptions underlying the study’s purpose and research question were that: (1) ED
therapists with personal ED histories were the most appropriate individuals to consult in
attempting to answer the research question; and (2) these professionals would be able to describe
their experiences in an articulate manner. The philosophical assumptions guiding the study’s
design are discussed in Chapter 3 (Approach to Inquiry).

1.5 Organization of the Thesis

In the present chapter, I introduced the research topic, problem, purpose, and question. In
a departure from the traditional literature review, Chapter 2 presents what is termed the
*theoretical scaffolding* for the study. This particular approach to extant literature is consistent
with the approach to inquiry that was employed: interpretive description (Thorne, Kirkham,
MacDonald-Emes, 1997; Thorne, Kirkham, & O’Flynn-Magee, 2004; Thorne, 2008), which is
described fully in Chapter 3. The purpose of the *theoretical scaffolding* in interpretive
description is to locate the study within an empirical and theoretical landscape by establishing
the initial scholarly and intellectual positions that shaped the study’s design, as they were
conceptualized at the study’s inception. The *theoretical scaffolding* is comprised of two parts: a
literature review (a description of empirical and conceptual literature relevant to the research
question), and a *theoretical forestructure* (comprised of the theoretical perspectives perceived as
relevant at the beginning of the study, and my location as researcher including my personal worldview and theoretical influences, and other conceptual, disciplinary, and personal perspectives that informed the study).

In Chapter 3 (Approach to Inquiry), I describe interpretive description and methodological considerations, locate the approach within the constructivist-interpretivist paradigm of scientific inquiry, present the study’s design, discuss ethical issues, and detail the criteria for the trustworthiness of the study’s findings. In Chapter 4 (Results), findings are presented that answer the research question at a descriptive level. Chapter 5 (Discussion) contains a further interpretation of these findings, which transformed them into a next level of abstraction informed by the practice goals of interpretive description (e.g., Thorne, 2008). Chapter 5 also addresses the practice and research implications of the interpreted description in the form of recommendations. Finally, the delimitations and limitations of the study are described and a concluding summary is presented.
CHAPTER 2 – Theoretical Scaffolding

Consistent with the interpretive description approach to inquiry, in this chapter I present the theoretical scaffolding of the study. The theoretical scaffolding served to “prepare the ground” (Thorne, 2008, p. 53) for the investigation by positioning it within existing knowledge, and by identifying theoretical and conceptual ideas I brought to the study that influenced how it was shaped (Thorne, 2008). Although no previous studies had explored the ethics experiences of eating disorder (ED) therapists with personal ED histories, there was extant research on this population, albeit scant. Furthermore, there were certain theoretical and conceptual perspectives (e.g., regarding professional ethics) that seemed relevant to the inquiry, and with I had aligned myself.

The theoretical scaffolding has two components: (1) the literature review, a description of empirical and conceptual literature relevant to the research question that identified any conclusions reached thus far, which helped substantiate the present research question as one worth posing; and (2) the theoretical forestructure, comprised of the theoretical and conceptual perspectives I had perceived as relevant and/or had informed my thinking about the study at the time when I entered into it, as well as my location as researcher (my worldview, other personal theoretical allegiances), and other disciplinary and personal perspectives that played a significant role in shaping the study (Thorne, 2008). Reviewing and considering extant empirical and conceptual literature helped me expand my understanding of “multiple ways of viewing the phenomenon” (Morrow, 2005, p. 254).

In interpretive description, the theoretical scaffolding is not meant to be used as a predetermined, guiding structure for analysis. Rather, it represents a beginning point that can be departed from as analysis and interpretation proceed (Thorne, Kirkham, & O’Flynn-Magee, 2004).
2.1 Literature Review

The literature review describes what was known about the research problem at the time the study was proposed. In this section, the extant literature regarding ED treatment practitioners with ED histories is described in order to locate the investigation within the existing knowledge on that topic. Next, briefly presented is literature from the drug and alcohol treatment fields, in which there is a longer history of acknowledging the involvement of recovered/recovering clinicians in treatment delivery.

2.1.1 Eating Disorder Practitioners with Personal Eating Disorder Histories

The topic of ED professionals with personal ED histories emerged relatively recently in the EDs literature. When the present review was written in 2008, the total published literature included two quantitative survey studies (Barbarich, 2002; Johnson et al., 2005), two articles combining conceptual writing and the presentation of informal survey research (Costin & Johnson, 2002; Bloomgarden et al., 2003), and several conceptual and/or opinion-based pieces (e.g., Bloomgarden, 2000; Goldkopf-Woodtke, 2001; Johnson, 2000). One unpublished dissertation described the lived experience of recovered ED therapists (Bowlby, 2007). In the interim, a few more studies have been published that either focused on ED-historied ED professionals (e.g., Rance et al., 2010) or identified them as a relevant sub-group in analyses (e.g., Warren, Crowley, Olivardia, & Schoen, 2009). There appears to be a burgeoning interest in this population given many research projects currently underway (C. Costin, personal communication, June 27, 2011).

2.1.1.1 Prevalence and perceptions in quantitative descriptive research. Barbarich’s (2002) seminal, descriptive study investigated the lifetime prevalence of EDs among professionals in the field. Based on a 50.2% response rate from an initial sample of 795 international members of the Academy for Eating Disorders (AED), results indicated a lifetime prevalence of 27.3%. Calculation by gender indicated a prevalence of 33.2% for female
professionals and 2.3% for male professionals. Of the respondents who indicated they had experienced an ED, 46.8% reported having had Anorexia Nervosa (AN), 49.5% Bulimia Nervosa (BN), and 23.9% Binge Eating Disorder (BED; a subcategory of Eating Disorder Not Otherwise Specified or EDNOS). These proportions sum to greater than 100%, suggesting that some respondents had experienced more than one type of ED. In addition, 16.5% reported having experienced a sub-clinical ED. Approximately 64% of respondents who reported a history of an ED indicated that they had received treatment. Treatment types included individual therapy (55.7%), group therapy (30.2%), medication (18.9%), outpatient program (12.3%), nutrition therapy (11.3%), inpatient/residential program (10.4%), and partial hospitalization/-intensive outpatient program (6.6%) (Barbarich, 2002).

The greatest predictors of practitioner relapse were the duration of the ED, a history of binge/purge type AN, a history of more than one ED, and receipt of treatment. However, neither the length of time in recovery prior to entering the field as a clinician nor having an employer who was aware of the professional’s ED history predicted a lower rate of relapse. Unsurprisingly, the longer the duration of the ED, the greater the rate of relapse and the less the amount of time spent in recovery prior to entering the field as a professional. Twenty-two of the 27 respondents who reported experiencing a relapse while working as a professional in the field indicated that they had received treatment of some kind (whether this treatment had occurred before and/or after a relapse in the field was not specified). More than one-third (38.5%) of respondents who had experienced an ED reported that their employer was aware of their history (Barbarich, 2002). The limitations of this study included the participation of only 50% of the membership of the AED, and the use of a nonvalidated questionnaire to assess ED diagnoses retrospectively. Nevertheless, the study was groundbreaking because it was published in the *International Journal of Eating Disorders*, it was the first empirical information gleaned regarding ED-historied professionals, and it provided the first quantitative data on this
The second quantitative investigation published regarding this population was Johnson and colleagues’ (2005) survey study, which reported the opinions of ED “sufferers,” “professionals,” and “carers” on various aspects of the potential benefits, drawbacks, and suitability of ED-histoiyed therapists’ involvement in EDs treatment. The authors introduced the study by noting that the mental health of practitioners working in the helping professions is a matter of concern given that individuals with substantial mental health challenges may pose risks to themselves and others (Johnson et al., 2005).

The study’s sample comprised 202 adults who were members of the U.K. Eating Disorders Association. There was substantial overlap between the respondent categories of sufferer, caregiver, and professional participants. For example, one-third of the professionals reported a history of an ED, and “this was true for a number of the carers” (Johnson et al., 2005, p. 304) (number/percentage not provided). Thus, the authors divided respondents into five categories for most of the analyses: sufferers ($N = 95$, comprised of current sufferers 58.9%, and previous sufferers 51.1%); professionals ($N = 96$, comprised of those with a history of an ED 33.3%, and without a history 66.7%); and caregivers ($N = 11$, 100% without history). A second, broader classification distinguishing participants with/without histories was used for some analyses, whereby 62.9% of the total sample reported an ED history and 37.1% reported no history. A small percentage (1.5%) of professionals reported having an active ED. The total sample was comprised of 92.1% females and 7.9% males (Johnson et al., 2005).

Of the total sample, 81.7% thought it was appropriate for professionals with a history of an ED to work in the field, 2.9% felt it was not appropriate, and 14.4% were undecided. Over three-quarters (86.6%) of respondents with a personal ED history felt this was appropriate, versus 73.3% of those with no ED history (difference not significant). Among the five groups (current ED, previous ED, caregivers, professionals without a history, and professionals with a
history), professionals without a history were the least likely to endorse the appropriateness of involving professionals with a history (72% endorsed this practice). One hundred percent of the ED-historied professionals believed recovered therapist involvement to be appropriate. The other groups fell somewhere in between (83.9% of current sufferers, 81.8% of caregivers, and 79.5% of previous sufferers endorsed this idea) (Johnson et al., 2005).

Regarding the involvement in EDs treatment of professionals with active EDs, 66.8% of the total respondents felt this was inappropriate, 20.8% were undecided, and 10% felt this was appropriate. Individuals with current EDs were the least concerned, with only half of them indicating doubts about this practice. However, there was no statistically significant difference between the views of individuals with and without ED histories on this issue. Regarding professionals’ obligation to disclose their ED history, caregivers and those with EDs were more likely to favour the obligation to disclose (43%) than be against it (35%). There was the opposite trend amongst professionals (both with and without histories), who were more likely to be against this practice (46%) than for it (32%) (Johnson et al., 2005).

Regarding the therapeutic relationship, respondents from all groups felt that the strength of the therapeutic relationship between ED clients and ED-historied therapists would be equal to, or stronger than, that of ED client and non-ED-historied therapists. Professionals with a personal ED history held the most positive views on this subject. Regarding the therapist with an active ED, non-ED-historied professionals held the most negative views about the strength of the therapeutic relationship, whereas current sufferers held the most positive views. All groups perceived the professional with a current ED as being less able to offer useful “therapeutic advice” than the therapist with a history. However, recovered therapists’ quality of advice was viewed by patients and caregivers as a positive asset, while professionals held a more neutral but not negative view (Johnson et al., 2005).

Respondents offered their own examples of additional advantages and disadvantages of
involving the therapist with a history of an ED in EDs treatment. These qualitative data were
categorized into three main advantages: empathy (e.g., “more empathetic and sympathetic as
they know what the sufferer is going through…”); expertise (e.g., “hard to deceive [recovered]
therapists as they would know ‘the tricks of the trade’”); and role modeling (e.g., “proof
recovery is possible”). Empathy was the most frequently mentioned advantage. Four categories
of disadvantages were also identified: enmeshment (e.g., ‘therapist may…have problems
keeping their issues separate); therapist vulnerability (e.g., “could trigger a relapse in the
therapist”); therapist subjectivity (e.g., “therapist may lack objectivity and be unable to
recognize…routes to recovery that differ from their own experiences”); and negative traits (e.g.,
may be more judgmental, critical, impatient and overly driven – ‘I did it, why can’t you?’
). Respondents with a history of an ED were more likely to record an advantage in receiving
treatment from a previously eating-disordered therapist than those who had never experienced an
ED (statistical significance reached). Respondents with and without histories expressed similar
concerns regarding disadvantages (Johnson et al., 2005).

A limitation of this study was the lack of information provided regarding the different
professional disciplines represented in the sample. Moreover, the lack of references regarding the
“texts on psychotherapy and clinical experience” (p. 303) on which the therapeutic relationship
and advice questions were based was problematic, and 11 of the 12 relationship traits were not
described. Thus, the interpretation of the relationship qualities data was unclear. Furthermore,
the qualitative data collected on advantages and disadvantages were categorized such that it was
not possible to ascertain which groups generated what benefits and risks (i.e., who was
concerned about what). An interesting aspect of the results not discussed was the trend among
professionals with an ED history to emphasize the positive contributions of recovered therapists
on several dimensions (only exceeded by current sufferers). Finally, there was a questionable
assumption made by the authors that all individuals in their sample with a history of an ED had
received treatment, and “treatment” was not defined. This is relevant given Barbarich’s (2002) findings that just over one-third of her sample of professionals who reported an ED history had not received treatment for their ED.

2.1.1.2 Prevalence and perceptions in informal survey research. Costin and Johnson (2002) conducted an informal survey of 10 ED treatment programs in the U.S. The purpose of the survey was to ascertain these facilities’ positions on hiring recovered staff. The authors noted that there were no accepted definitions for the terms “recovery,” “recovering,” and “recovered” as applied to professionals in the EDs treatment field. Their findings revealed that 4 programs actively hired recovered staff, 5 programs did not consider recovery to be a hiring consideration, and 1 program actively avoided hiring such staff. Of the 4 programs that actively hired recovered staff, estimates of recovered staff representation among total staff ranged from 30% - 80%.

Interestingly, these programs lacked formal definitions of relapse and recovery, although recovery was typically defined loosely as normal weight and absence of bingeing and purging. In addition, no written policies or guidelines concerning the hiring or monitoring of recovered staff had been developed. However, all four sites had an informal 1-2 year recovery criterion. A major concern identified in the study was the recovered staff’s degree of comfort with their size and shape.

All interviewees referred to the American Disabilities Act, which emphasizes a neutral position regarding hiring. The authors noted that while the Act protects workers’ privacy, it may also have helped to create a “don’t ask, don’t tell” atmosphere that could inhibit professionals who are struggling with eating and body image concerns from seeking help. All program representatives interviewed were interested in receiving guidelines from the professional organizations of the EDs field. The main limitations of this study included its informal nature, the small sample size (10 representatives, 1 from each centre), and the lack of description of the interview protocol.
Bloomgarden and colleagues (2003) described their experiences of disclosing their personal ED histories first to one another and, subsequently, to their co-workers at an in-service workshop they developed. Prior to delivering the workshop, they disseminated a questionnaire to the centre’s staff. Survey results indicated that 24% of staff (no sample size reported) had experienced a “bona fide” ED, with an average time period since recovery of 12 years. Seven percent described having experienced “eating problems,” and 13% reported having a family member who had struggled with an ED. The authors perceived that, as a result of the workshop they delivered, the atmosphere in the facility shifted towards more openness and discussion (e.g., about self-disclosure and countertransference issues) and resulted in more thoughtful ethical decision-making concerning professionals’ recovery. They recommended that several issues pertaining to the recovered ED therapist be investigated, including the professional culture in treatment settings, the issue of self-disclosing an ED to clients, and the ethics of what constitutes a “recovered enough” therapist.

2.1.1.3 Professional opinions. In addition to reporting the results of their interviews with representatives from 10 ED treatment facilities, Costin and Johnson (2002) provided their professional opinions on the perceived advantages of employing recovered staff in EDs treatment. These included the representation of hope, the ability to offer understanding and provide motivation, and that recovered professionals exude confidence in understanding and dealing directly with patients’ ED symptoms. Moreover, recovered professionals were perceived to understand deeply the profound struggle inherent in recovery from an ED, which could engender trust in clients. In addition, recovered professionals were perceived by the authors as having greater license to challenge clients on the self-pity, subtle self-centeredness, and one-upmanship that can be associated with an ED. Moreover, they were perceived as being effective in reminding the team that symptom improvement (e.g., weight gain) should not be forgotten in resolving the underlying dynamics of the ED. Finally, clients’ shame about their own ED was
perceived to be lessened when recovered staff were seen to be valued in the treatment setting.

The disadvantages of having recovered staff involved in EDs treatment were identified as risk of relapse, countertransference vulnerabilities, and a sense of over-responsibility for client recovery. Relapse was judged to be highly correlated with the clinician’s level of training and length of time since recovery (Costin & Johnson, 2002), the latter factor interesting given Barbarich’s (2002) finding that that length of time since recovery prior to entering the field as a clinician did not predict relapse.

Costin (Costin & Johnson, 2002), program director at Monte Nido residential treatment centre in the U.S., stated that the recovered staff at her treatment centre comprised 75% of the total team (85% if only therapists, dieticians, and support counsellors were counted). She indicated that no staff relapses had occurred at her facility, although 2 individuals had left due to feeling triggered. Costin indicated her preference to hire self-described “recovered” rather than “recovering” staff due to the greater degree of resolution implied in the former. Johnson (in Costin & Johnson, 2002), then program director at Laureate, a U.S. inpatient ED treatment centre, reported having hired 11 recovered staff over the years. He indicated that they had made positive contributions to the program, and stated: “the benefits have outweighed the costs” (p. 295). However, he noted that 3 of these individuals had felt vulnerable to ED symptoms at various points, one had experienced a moderate relapse, and one had had a severe relapse requiring hospitalization. Increased supervision and open discussion of issues and difficulties were reported to have helped these staff members manage their difficulties.

2.1.1.4 Unpublished qualitative research. Bowlby’s (2007) unpublished dissertation reported the results of a phenomenological study exploring the lived experience of 13 recovered ED therapists. Aspects of this lived experience included the challenges and benefits of participating in the therapy process, the impact of therapists’ personal history on their decision to enter the EDs treatment field, and the potential impact of clinical work on their recovery. Under
two overarching themes (participant as former client, and participant as therapist in the EDs field), several sub-themes were reported. Sub-categories under the first theme included the nature of EDs (tools for coping, and debilitating and dangerous illnesses), recovery (non-linear process, multi-faceted, understanding and valuing the self, de-identification with illness, purpose and meaning in life, and developing meaningful relationships), and change factors for recovery (support, self-expectation, and “closing the door”). Under the second overarching theme were sub-categories regarding treatment process (treatment frame, empathy and understanding, grace/patience, hope for recovery, and leverage), countertransference and difficulties within treatment (physical danger, family of origin issues, and struggling professionals), and self-disclosure (complexity and intended purpose) (Bowlby, 2007).

The implications drawn from the results included that recovered ED therapists have valuable perspectives to offer regarding treatment and recovery because they possess two intersecting perspectives: client and clinician. Furthermore, the reduction of stigma with respect to mental illness and professionalism was recommended, so that practitioners might learn more from one another. Other recommendations included exploring the potential contributions of recovered therapists to the EDs treatment field, and considering how recovered and non-recovered ED professionals can work together and learn from one another in order to benefit clients. It was suggested that recovered professionals may be able to provide insights into the nature and course of EDs, and that non-recovered professionals may be better equipped to help recovered professionals “observe blind spots and clouded expectations” (Bowlby, 2007, p. 136).

Research recommendations included comparing recovered and non-recovered therapists on several dimensions (e.g., ideas about recovery, treatment strategies and difficulties, the role of the therapist, and the use of self-disclosure) in order to test assumptions regarding each group’s views on their role. Two additional research areas were suggested: (1) ascertaining whether a career in EDs treatment permits continued connection to the ED without having to “stay sick,”
and (2) exploring the relationships between a clinician’s past ED diagnoses, personality characteristics, and use of self-disclosure.

The study’s sub-theme of struggling professionals seemed particularly relevant to the impetus for the present study. Bowlby’s participants reported it challenging to witness others in the EDs treatment field who did not appear to be recovered (e.g., “sometimes they look worse than their clients” [p. 120]). They worried about eliciting a negative response from struggling professionals when addressing their concerns about appearance and/or behaviours directly with them, and felt uncomfortable questioning their colleagues’ competence. There was a perceived lack of guidance in terms of professional guidelines or protocols that would regulate and define appropriate levels of recovery for treatment professionals. However, the idea of the ED treatment field monitoring professionals’ weight or making judgments about it was also a concern.

The issue of struggling professionals was described by one of the participants as “scary” and “a shame” (p. 120), and another participant framed it as an issue of personal and professional integrity in that clients seeking help are being cheated by therapists who cannot claim recovery themselves. The desire of recovered therapists to be authentic and honest about their histories was expressed, in order to facilitate effective collaboration with non-ED-historied colleagues, benefit clients, and challenge stereotypes surrounding recovered clinicians. Bowlby (2007) summarized the issue of struggling ED treatment professionals as a “taboo” (p. 121) in the field, and noted that that addressing this taboo topic with colleagues appeared to be “a sensitive issue” (p. 121). The study’s limitations included that the self-selection of participants excluded perspectives of recovered therapists who did not wish to disclose their history; and that the retrospective accounts collected might have overrepresented optimistic perspectives rather than accurately representing the more difficult aspects of navigating career vis a vis mental health functioning.
2.1.1.5 **Published personal accounts.** Written accounts from the first-person perspectives of ED-historied therapists were also identified in the EDs scholarly literature. Given the interpretive description approach’s flexibility in including collateral data sources, two of these accounts (Bloomgarden, 2000; Goldkopf-Woodtke, 2001) were incorporated into the dataset of the present study (discussed further in Chapter 3). Briefly, however, as the director of an ED clinic, Bloomgarden (2000) wrote of her decision-making process about whether to disclose her history of an ED to adolescents in an outpatient ED therapy group. Goldkopf-Woodtke (2001) described elements necessary in her recovery process from AN, and how these informed her work as a clinician.

2.1.1.6 **Summary.** Empirical studies on ED-historied therapists were found to be scant, and there existed limited conceptual literature. Key aspects of the available knowledge that informed the present investigation included that a relatively significant proportion (approximately one-third) of professionals working in the field appeared to have a personal ED history, and that stakeholders in EDs treatment (caregivers, those who experience[d] EDs, and professionals in the field) seemed to believe that there were potential benefits as well as risks of harm posed by the involvement of such individuals in EDs treatment. While the ethical dimensions (e.g., benefits, risks) of ED-historied therapists’ involvement in EDs treatment were clearly implied in this literature, an explicitly professional ethical lens had not been employed.

There were clues in the extant literature that these ethical dimensions might be of interest in terms of applied practice in EDs treatment. As examples, improving ethical decision-making (Bloomgarden et al. 2003), assisting ED-historied therapists in managing ethical and clinical difficulties that arise (Costin & Johnson, 2002), and increasing collaboration and mutual learning amongst colleagues (Bowlby, 2007) were implied to enhance safe and ethical services to ED clients. While guidelines regarding ED-historied professionals have been called for (Bloomgarden et al., 2003; Bowlby, 2007; Costin & Johnson, 2002; Johnson, 2000), it remains
to be seen how such guidelines might be developed without at least an initial understanding of
the professional ethical dimension of these topics.

In the next section of the literature review, in order to provide more context regarding
psychotherapy practitioner mental health, I offer a brief synopsis of research literature on
practitioners who have experienced other mental health concerns (specifically depression and
substance misuse). These concerns are also relatively common comorbidities with EDs. The
addictions treatment field appears to most openly acknowledge therapist-client issue overlap.

2.1.2 Practitioners with Personal Experiences of Other Mental Health Concerns

Gilroy and colleagues have noted (2002) that mental health practitioners have been
widely documented as experiencing personal mental health issues such as substance use/abuse,
anxiety, and depression, as well as problems in relationships (Deutsch, 1985; Mahoney, 1997;
Norcross, 1990; Wood, Klein, Cross, Lammers, & Elliot, 1985). In fact, mental health
practitioners are considered to be at even greater risk for experiencing mental health difficulties
than the general population (Sherman, 1996). Depression and substance misuse amongst mental
health practitioners are discussed briefly below.

Lifetime prevalence of some form of depression among mental health care providers has
been reported to be up to 76% (Gilroy, Carroll, & Murra, 2001; Pope & Tabachnick, 1994).
Relevant to ethics, active depression can impair professional functioning (e.g., Sherman, 1996)
and practitioners have been documented as reluctant to access personal therapy (e.g., Barnett &
Hillard, 2001). However, the research has also indicated that, similar to the EDs literature, a
personal experience of depression is perceived subjectively by practitioners as having a positive
influence on therapy (e.g., in terms of increased empathy, patience, and attunement with
depressed clients; increased appreciation for clients’ experiences of therapy; and the provision of
more informed psychoeducation and diagnoses) (Gilroy et al., 2001). Gilroy and colleagues
stated that professional self-care and guidelines to help practitioners implement it are a “moral
imperative” for helping prevent practitioner depression, as is personal psychotherapy. They argue that if self-care were emphasized throughout professional training and incorporated into professional culture, negative stigma about mental illnesses among practitioners regarding clinicians with mental illnesses (and therefore a barrier to help-seeking behaviour) might be reduced (see also Barnett, Baker, Elman, & Schoener, 2007; O’Connor, 2001).

Regarding the addictions field, the emergence of the Alcoholics Anonymous (AA) philosophy and approach to addressing problem drinking began to permeate professional treatment settings after World War II (e.g., Lemanski, 2001). In the 1970s, the idea of the drug or alcohol counsellor emerged out of this context, which was modeled on other established mental health worker roles (e.g., psychologist, social worker). This emergence prompted relevant education, training, certification, and licensing. According to White (2006), a personal history of problem drinking became de-emphasized at this point. However, there remains widespread, acknowledged inclusion of ‘recovered’/‘recovering’ individuals in contemporary addictions treatment (White, 2000b), although the potential for practitioner relapse has been identified as an ongoing concern (Bissell & Royce, 1994).

Considering this long history, there is remarkably scant research on the ethical implications of involving these clinicians in addictions treatment, with much of it outdated. One recent addition was Hecksher’s (2007) study of former substance users, which revealed perceived ethical challenges regarding self-disclosure, objectivity and therapist agenda, risk of relapse, and dual relationships. Several older studies indicated that practitioners with substance misuse histories do not provide more effective therapy (e.g., Aiken, LoSciuto, Ausetts, & Brown, 1984; Brown & Thompson, 1976).

Other ethical issues are suggested by literature indicating that recovered/recovering addictions practitioners may have less education (e.g., Stöffelmayr, Mavis, Sherry, & Chiu, 1999) and may be resistant to new learning and over-committed to the 12-step approach (e.g.,
Humphreys, Noke, & Moos, 1996; Siassi, Angle, & Alston, 1977). However, benefits such as credibility and role modeling have also been identified (e.g., Bell, 1973). Research on client perceptions of recovered/recovering addictions clinicians has been mixed, with some studies suggesting the perceived provision of more helpful guidance, development of superior therapy relationships, and perceptiveness of problem behaviours (e.g., Aiken & LoSciuto, 1985; Ball, Graff, & Sheehan, 1974; Lawson, 1982). Other studies found no differences in, as examples, perceived performance and empathy (e.g., Brown & Thompson, 1976; Kirk, Best, & Irwin, 1986).

### 2.1.2.1 Summary.

The literature directly above was presented in order to further situate the present study. Conceptual literature and research findings seemed to suggest that it is not unusual for practitioners who have past and/or current personal mental health concerns to be involved in mental health treatment delivery, including situations in which therapist-client histories are similar (e.g., as in the case of a proportion of addictions practitioners). Furthermore, several ethical implications of practitioners compromised by mental health problems, and of practitioners who share mental health histories with their clients, have been identified. These bodies of literature provide additional support for empirically exploring and understanding ED-histoved therapists’ ethics experiences, for the purposes of enhancing clinical practice.

Given that the extant EDs literature had not made the link explicit between professional ethics and practitioners’ ED histories, the following sections provide foundational information about professional ethics. That is, the following sections provide an overview of several perspectives on professional ethics that were identified as conceptual and theoretical foundations for this study, at the time of its inception. In addition, other literature that was speculated to be relevant (on stigma and shame regarding mental health) is described. As per the interpretive description approach to inquiry, this material forms part of the second component of the study’s theoretical scaffolding: the theoretical forestructure. The theoretical forestructure also includes a
description of my location as a researcher (regarding discipline, personal worldview and theoretical influences, and personal experiences).

2.2 Theoretical Forestructure

In the second component of the theoretical scaffolding, the theoretical forestructure, I describe conceptual and theoretical perspectives on ethics I perceived as relevant to the inquiry at the time it was proposed, as well as my location as researcher (my worldview, personal theoretical allegiances), and other disciplinary and personal perspectives that informed the study. Specifically, below, I describe portions of the ethics codes I viewed as particularly relevant to the investigation; survey several theoretical perspectives on ethics (principle, virtue, and feminist) and a conceptual framework for applied ethics advanced by psychologist Prilleltensky and colleagues (1996); and my personal worldview, theoretical influences (i.e., pragmatism), stance as a counseling psychologist researcher and practitioner, and pertinent life experiences. The intent of outlining these positionings at the study’s onset was: (1) to scaffold the study comprehensively such that theoretical, disciplinary, and personal perspectives I brought to it at its inception were made evident; and (2) to convey an integrity of purpose by acknowledging the influences that played a role in shaping the design and outcome of the study (rather than neutralizing them, which applies more to post-positivist research) (Thorne, 2008).

2.2.1 Professional Ethics

According to Huber and Baruth (1987), “ethics is concerned with the conduct of human beings as they make moral decisions” (p. 3). From a professional health and mental health care perspective, ethics can be thought of as “the application of theoretical ethics to moral problems which arise in health care settings” (Browne & Sweeney, 2003, p. 3). Society has granted professions such as psychology the ability to self-regulate and define their scope of practice. Accordingly, society has required that the professions develop codes of ethics to which their members agree to be held accountable (Pope & Vasquez, 2001); therefore, the codes are the
lyncpin of professional ethics. The ethics codes are based on foundational ethical principles that, in turn, have been drawn from broader ethical theories. Kitchener (1984, 2000) argues that, of these three levels of “tools” that can be employed in ethical decision-making (codes, principles, theories), the ethics codes represent the minimum directives for professional behaviour.

When I proposed the study, I viewed as particularly relevant to the investigation certain directives in the ethics codes of psychology (and of other disciplines relevant to the provision of psychotherapy) that practitioners should maximize benefit and avoid harm to clients by cultivating self-knowledge and evaluating multiple aspects of their practices (including their fitness to practice, and degree of impairment). Therefore, specific standards in the ethics codes of psychology and counselling pertaining to these obligations are described below.

2.2.1.1 Standards in the ethics codes. The ethics codes of psychology are clear that psychologists must monitor personal factors that influence the quality and safety of their service delivery. The Canadian Psychological Association’s (CPA) Code of Ethics (2000) is perhaps the most direct about evaluating the impact of any personal experience, stating that responsible caring requires psychologists to: “evaluate how their own experiences, attitudes, culture, beliefs, values, context, individual differences, and stresses influence their interactions with others, and integrate this awareness into all efforts to benefit and not harm others” (Standard II.10, p. 17).

Professional impairment is also addressed, in that psychologists are urged to “seek appropriate help and/or discontinue…professional activity for an appropriate period of time, if a physical or psychological condition reduces their ability to benefit and not harm others” (Standard II.11, p. 17). Finally, psychologists must “avoid conditions (e.g., burnout, addictions) that could result in impaired judgment and interfere with their ability to benefit and not harm others” (Standard II.12, p.17).

The American Psychological Association’s (APA) Code of Ethics (2002) has a more
strictly ‘current impairment’ focus regarding personal experiences, stating that that “psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner” (Standard 2.06a, p. 5). In addition, “when psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties” (Standard 2.06b, p.5).

When therapists become ill or develop some other personal problem or encumbrance (such as an emotional or mental state that negatively affects functioning) that renders them incapable of maintaining acceptable practice standards, they are thought to have become impaired (Orr, 1997). Concerns about the professional fitness of professionals with a history of an ED have been voiced strongly in the UK. The Clothier Report (Clothier, Macdonald, & Shaw, 1994) singled out EDs as better guides than psychological testing to assess for nurse training suitability, and recommended that persons with ED histories be barred from the nursing profession. A subsequent report recommended that these guidelines apply to all health care professions in the U.K. (Bullock, 1997). A North American stance on this issue has not been articulated.

The standards in the codes described above suggested that a past or active ED (and potentially any serious lingering effects of a past ED) could represent a “personal problem,” “experience,” “condition,” stressor, and/or an area of potential impairment about which the therapist, according to the codes, should develop self-knowledge and an understanding of its impact on their delivery of psychotherapy services to ED clients. The codes also oblige ED-historied therapists, when necessary, to consult, seek help, and/or suspend professional activities, in order to maximize benefit and minimize harms to their ED clients.
Moving beyond the codes, the concept of emotional competence seemed helpful in illuminating the notion of self-knowledge. According to Pope and Vasquez (2001), emotional competence necessitates that practitioners acquire self-knowledge, and practice self-acceptance, self-monitoring, and self-questioning in the face of their inherent fallibility as human beings. Practitioner fallibility was clearly illustrated in a national survey of therapists in which more than 60% of respondents reported having experienced an episode of clinical depression, and 29% reported having had suicidal feelings (Pope & Tabachnick, 1994). The delivery of therapy can elicit strong emotional reactions in therapists, and unhelpful or harmful therapy can occur when therapists are unprepared for the emotional stresses and strains associated with the work. Some therapists may need to access personal therapy in order to maintain or restore their emotional competence (Pope & Vasquez, 2001).

Further to emotional competence, Haas and Malouf (1995) argued that in situations where the client’s problem is too close to the clinician’s personal experience for the clinician to avoid countertransference (as may be the case for some ED therapists with personal ED histories), the clinician should seek consultation and/or supervision, or refer the client elsewhere. They recommended that therapists judge their emotional competence by asking themselves whether they are emotionally able to help a particular client, and whether they could justify their decision to work with the client to a group of peers. In these authors’ view, any clinical activity one is tempted to hide or would be ashamed to admit to a group of peers is probably not a responsible action (Haas & Malouf, 1995).

These types of questions could serve as useful litmus tests for ED-historied therapists in making decisions to work with ED clients. However, in my view, they may not be enough in cases where the therapist lacks self-awareness about the degree of her/his current ED pathology, body image disturbance, etc. Furthermore, there could be ED-historied therapists who do not feel comfortable justifying a particular clinical decision to peers (i.e., if that decision was somehow
related her/his own history of an ED, such as self-disclosing that history) in workplace atmospheres characterized by interpersonal mistrust.

Emotional competence and self-awareness, and the ability to ask oneself questions about one’s emotions, might be important components of a process of self-evaluation, decision-making, and taking appropriate actions concerning one’s professional fitness. However, research has indicated that individuals with active EDs demonstrate less ability to identify and describe their own feelings than controls (e.g., Bydlowski et al., 2005; Legenbauer, Vocks, & Rüddel, 2008). Moreover, individuals with EDs have been shown to favour disadvantageous choices in decision-making tasks (e.g., choosing immediate gains in spite of higher future losses) (e.g., Brand, Franke-Sievert, Jacoby, Markowitsch, & Tuschen-Caffier, 2007). The degree to which these behaviours persist after recovery is not clear, although one study indicated that individuals with AN continued to demonstrate impaired choices after physical health/nutrition had been restored (Cavedini et al., 2004). The results of these studies suggested that therapists with active EDs might demonstrate skills deficits in the areas of emotional competence and decision-making, thus potentially making self-evaluation, decision-making, and taking appropriate actions concerning professional fitness more difficult.

To summarize, in this section, I described specific standards in the ethics codes relevant to psychotherapy pertaining to ED-historied therapists’ ethical obligations to evaluate the impact of their experiences on clients and monitor their fitness to practice, such that they maximize benefit and minimize harm to their clients. Conceptual and empirical research literature was presented briefly in order to highlight aspects of recovered therapist self-knowledge/awareness and decision-making related to these obligations. However, the ethics codes have been described as inherently limited, due to the inclusion of cautious and ambiguous language, failure to address some ethical questions, and lack of direction for prioritizing conflicting standards (e.g., Daniluk & Haverkamp, 1993; Kitchener, 2000; Welfel, 2002). These types of limitations led Kitchener
(1984, 2000) to argue that the codes should constitute only one component of moral reasoning in psychology. She posited that employing the foundational ethical principles underlying the codes can provide additional insight into ethical issues and dilemmas.

The following section describes the principle ethics perspective, in which I am highly versed and employ routinely in my own clinical and teaching work. Thus, principle ethics is included here in order to augment the theoretical and conceptual bases of the theoretical forestructure, as well acknowledge one of my theoretical allegiances.

2.2.1.2 Principle ethics. Kitchener (2000) posited two levels of moral reasoning: the immediate, intuitive level (pre-reflective, ‘gut’ feeling), and the critical-evaluative level (employing the ethics codes, ethical principles, and ethical theories). Kitchener suggested that psychologists move away from a more rule-bound conception of ethics towards a stance focused on identifying the foundational ethical (or meta-ethical) principles, which can be fruitfully applied to even the most difficult ethical dilemmas (Kitchener, 1984, 2000). The meta-ethical principles permit practitioners to frame ethical problems in a common vocabulary and to think carefully about issues that may not be addressed directly in the ethics codes. Drawn from biomedical ethics, the five principles undergirding the practice of psychology are derived from a “common morality” applicable to all health care practice (Beauchamp & Childress, 1994, p. 102). These are autonomy (the individual’s freedom of action and choice), nonmaleficence (avoiding harm), beneficence (doing good), justice (fairness, treat like cases alike), and fidelity (faithfulness, promise keeping, truthfulness) (Kitchener, 2000).

Nonmaleficence and beneficence are traced to utilitarian/consequentialist conceptions of ethics, which are concerned with bringing about the best balance of benefit over harm, for the most number of people. In contrast, the principles of autonomy and justice have their roots in deontology, which takes into account the rightness, wrongness, and obligatory nature of our actions, whatever the consequences (e.g., lying to and killing others is wrong, no matter what the
circumstances) (Browne & Sweeney, 2003). The principle of fidelity is critical in psychology because honesty and promise-keeping are central to engendering trust, and form the core of the fiduciary relationship between the helping professional and the client (Kitchener, 2000).

The meta-ethical principles are considered *prima facie*. That is, the practitioner has an equal obligation to each principle, but a more pressing principle can be prioritized over another if there is a sound rationale. Therefore, good reasons must be identified to balance or overturn any principle. Decisions made by practitioners must ultimately be “ethically defensible given the circumstance, and provide the best possible balance of ethical harms and benefits while protecting individual rights” (Kitchener, 2000, p. 41). While the principles represent core ethical norms in health and mental health care, they are seen to conflict in the case of ethical dilemmas. In the case of ethical dilemmas, ethical theories may be consulted, and reasoned judgments must be used to ascertain where primary obligations lie. The process of reasoned judgment is best undertaken using established models of ethical decision-making, such as the one included in the CPA (2000) ethics code, or other models developed for health and mental health care practice (e.g., McDonald, 2004).

When I speculated about the relationship of the meta-ethical principles to ED-historied therapists’ ethics experiences in delivering EDs treatment, the principles of nonmaleficence and beneficence seemed to relate to the potential benefits and risks of harm to clients of involving such professionals in ED treatment. For example, recovered therapists’ embodiment that recovery is possible may increase clients’ hopes and expectations of recovery (and expectancy effects in general are linked to improved therapy outcome [Lambert & Barley, 2001]). Conversely, if the recovered therapist is unable to admit eating problems despite appearing emaciated, this could negatively affect the therapeutic relationship perhaps in terms of therapist credibility, or it could engender subtle or overt competition between client and therapist that may be overlooked in the therapy. Such relational factors may introduce harm and/or reduce the
overall success of therapy. This is an important consideration given that the therapeutic relationship is thought to account for 7% - 17% of the variance in therapy outcome (Beutler et al., 2004).

The principles of autonomy, fidelity, and justice also seemed important to consider in light of ED-historied therapists’ ethics experiences. Clients’ informed consent seemed relevant, given research indicating that some caregivers and individuals with EDs believe that ED therapists should disclose their histories to clients (Johnson et al., 2005). Regarding fidelity, therapists who provide services to clients with EDs are, in effect, promising to help them, and any therapist factors jeopardizing this promise could erode this duty. The principle of justice can be linked to the fair treatment of individuals with EDs, for example, perhaps to professional practices (e.g., diagnostic labeling used pejoratively) that mirror any negative societal attitudes towards EDs.

To summarize, an overview of the principle approach to ethics was presented, followed by examples illustrating how the meta-ethical principles might apply to ED-historied therapists’ ethics experiences in providing ED treatment. The principle ethics approach has been critiqued on several grounds, including an overemphasis on the universality of the principles and the exclusion of individual, cultural, systemic variables; an inability to eliminate practitioners’ idiosyncratic privileging of certain principles; and their having been developed without incorporating the perspectives of non-dominant societal groups such as women and people of colour. Alternative conceptions of ethics that have attempted to address some of these limitations are virtue ethics and feminist ethics (Brabeck & Ting, 2000; Jordan & Meara, 1990). At the time of the proposal writing, I did not count virtue ethics as among my theoretical influences; however, the contextual and relational aspects of feminist ethics were certainly such an influence. Nevertheless, I believed that acknowledging both perspectives was important for demonstrating adequate theoretical breadth within the present study’s theoretical forestructure.
2.2.1.3 **Virtue ethics.** The root of the word “ethics” is the Greek word “ethos,” meaning “character.” A virtue ethics perspective in psychology emphasizes historical virtues of character (e.g., Platonic, Hegelian), which are thought to provide the basis for professional judgment. Whereas principle ethics focuses on what practitioners ought to do (behaviour), virtue ethics focuses on who practitioners are (disposition). Virtues identified as having importance in psychological practice include prudence, discretion, perseverance, genuineness, courage, integrity, humility, hope, public spiritedness, and benevolence. Psychology scholars have argued that, by endorsing specific virtues, a discipline can address idiosyncrasies in ethical decision-making and define the overall character of the discipline’s practice (Jordan & Meara, 1990).

Proponents of virtue ethics argue that practitioners who possess these virtues may be able to identify their biases more easily, guard more carefully against imposing their values on clients, and be more vigilant in separating personal and cultural preferences from psychological and therapeutic phenomena (Jordan & Meara, 1990). Beauchamp and Childress (1994) argued that for every virtue (e.g., benevolence), there is a corresponding principle (e.g., beneficence) that can be invoked. However, May (1984) disagreed, suggesting that virtues represent professional ideals that extend beyond the boundaries of rules or principles, and that their pursuit is not ethically optional – rather, they are intrinsic to what it means to be a professional.

A virtue ethics approach accepts the meta-ethical principles as useful for organizing competing claims and identifying alternative options. However, virtue ethics proponents have criticized principle ethics for seeming to represent only one virtue: conscientiousness (i.e., regarding decision-making). In addition, principle ethics are seen as reducing ethics into abstract, intellectual puzzles in which individual players and human suffering are pushed into the background. Finally, principle ethics have been critiqued for permitting practitioners’ to weight principles based on their preference for a utilitarian versus deontological stance, and allowing ethical decision-making to fall back on personal biases and previous experiences (Jordan &
At the outset of the study, I speculated that a virtue ethics perspective could facilitate an understanding of who ED-historied therapists were as people and professionals as they go about their practice with ED clients (i.e., who they want to be in their work, what characterological qualities they bring to bear in ethical decision making, how they label their approach to professionalism, why they privilege certain ethical positions, etc.). For example, a recovered ED therapist participant in Bowlby’s (2007) study referred to the importance of maintaining integrity and honesty in examining how her history had influenced her practice. Furthermore, virtue ethics might illuminate how recovered therapists weigh the virtues of genuineness and prudence in providing EDs treatment, for example during the informed consent process with clients. That is, the genuineness virtue invoked alone might direct recovered therapists to disclose their history. Activating the virtue of prudence might direct recovered therapists to ensure they understand the potential consequences of such disclosures on a client, based on the client’s presentation, history, and other variables.

Several limitations of virtue ethics have been identified. For example, there is confusion about its role in ethical discourse: should it be the primary approach, is it complementary to principle ethics, or is it fundamentally different from principle ethics in terms of conceptualizing what it means to think and act ethically? Second, practitioners have little guidance for choosing from among a very long list of virtues. Third, the process of defining appropriate professional virtues within a discipline is unclear (Jordan & Meara, 1990). Fourth, it is uncertain whether the elements of virtuous character can be developed in professionals, or whether they are more akin to stable traits. Finally, the virtue ethics approach has also been critiqued on the bases of its being too individually focused, and its reliance on male conceptions of what is considered virtuous. An overview of feminist ethics perspectives, which have attempted to address these concerns, is presented below.
2.2.1.4 Feminist ethics. Feminist ethics perspectives in psychology emerged within the last 35-40 years, offering another alternative lens for examining ethics in psychological practice. They were developed in response to perceptions that moral philosophy had been a primarily male endeavor. Thus, prevailing understandings of women and their experiences (including their ethical decision-making processes) were critiqued for having been developed in a patriarchal society that privileged male insights, beliefs, and experiences (Brabeck & Ting, 2000). Therefore, traditional ethical perspectives were considered incomplete, oppressive, and unrepresentative of women’s experiences.

Feminist ethics approaches have critiqued both principle ethics and virtue ethics for their too-individualistic focus. For example, a feminist ethics position is that ethical actions must be understood as occurring within relational and socio-political contexts, and that a purely individual focus cannot adequately correct structural wrongdoings. Furthermore, the principles in principle ethics were conceived as “universal,” and virtue ethics focused on individual character as conceptualized by males. In response, feminist ethics attended to context and incorporated women’s and other marginalized peoples’ perspectives into moral philosophy. In addition, feminist ethics critiqued societal forces oppressing non-dominant groups, and incorporated a social justice agenda whereby equity for people within structures (e.g., organizations, systems) was sought and/or structural changes were made. However, feminist ethics perspectives share some aspects traditional ethical perspectives, including examining the nature of actions (required, forbidden, permitted), consequences of actions (good, bad, neutral), and motives behind actions (self- or other-directed, or both) (Brabeck & Ting, 2000).

Brabeck and Ting (2000) described five themes in feminist ethics scholarship. The first theme was that women and their experiences have moral significance. For example, Nel Noddings (1984) introduced the “ethic of care” theory, which pertains to a responsibility to (and for) others that is grounded in women’s relationships. The ethic of care is considered to be
broader than the principle of beneficence. Carol Gilligan (1982) examined the moral reasoning of women, and revealed differences between the “feminine voice” and the “male identity.” She reasoned that the feminine voice developed as a result of women being encouraged to define their identity through relationships of intimacy and care. Thus, the feminine voice has worth based on women’s ability to care for and protect others. In contrast, she argued that the male identity is defined by separation and the more abstract ethic of justice. Noddings’ and Gilligan’s work has been described as a relational approach to ethics. The relational approach critiques the idea that moral reasoning is the pinnacle of human thought and it challenges the notion of individualistic moral choice. The relational approach also emphasizes empathy, nurturing, and caring. While relational feminists celebrate women’s values, relationships, and unique moral perspectives, they also value males’ perspectives, relationships, and attributes (Brabeck & Ting, 2000; Gilligan, 2002).

The second theme in feminist ethics is that attentiveness and subjective knowledge illuminate moral issues. For example, Frye (1983) argued that because we can construct people through our perceptions of them, attentiveness can be understood as a moral and agentic act. She encouraged loving attention to others, and equal care in attending to ourselves. The third theme in feminist ethics is that feminist critiques must challenge all discrimination. That is, gender oppression is only one form of oppression, and attention must be paid to women of colour, lesbians, poor women, women with disabilities, or any woman who lives outside of dominant western cultures (e.g., hooks, 1993). Different standpoints and contexts must be entered into, and related oppressions challenged (Brabeck & Ting, 2000).

The fourth theme is the analysis of power, wherein everyone is urged to be responsible for critiquing their own position(s) in power hierarchies, and how power affects their perspectives and moral sensitivities in all their practices. Therefore, all ethical acts must be understood in terms of power dynamics and hierarchies, and as occurring within societal and
political contexts. The assertion of an absolute, objective reality is challenged, as power is thought to determine peoples’ realities. The fifth theme in feminist ethics is that action and social justice are required. For example, achieving equity for women and other marginalized groups within various structures (or changing the structures themselves) is considered a crucial task (Brabeck & Ting, 2000).

When I proposed the present study, I speculated that feminist ethics perspectives might help illuminate several aspects of ED-historied therapists’ ethics experiences. First, given that females with EDs vastly outnumber males in every study (Striegel-Moore & Bulik, 2007) and the large proportion of female versus male ED practitioner respondents in the survey research described in the literature review, the majority of ED-historied ED therapists were likely female. This called attention to the utility of women’s perspectives in understanding the phenomenon under investigation. Second, I wondered whether the characteristics of different EDs treatment contexts (and the relationships and power dynamics therein) were likely to play a role in ED-historied therapists’ ethics experiences. As examples, were there allegiances and cliques within programs, what were they based on, and how did ED-historied therapists fit into these social-professional dynamics? Furthermore, feminist ethics perspectives drew my attention to how the ethic of care might be enacted in any/all levels of the ED treatment setting (e.g., care for clients, care among colleagues, care between hierarchies such as between administrators and clinicians). Moreover, I speculated that feminist ethics approaches might help illuminate moral issues by attending to clinicians’ subjective knowledge, and their attention to others and themselves. Finally, I wondered whether the social justice aspect of feminist ethics might be helpful in understanding how recovered therapists did/did not view themselves as having ethical agency in their work contexts.

2.2.1.5 Participatory framework for applied ethics. Informed heavily by feminist ethics, but also grounded and critical theories, contextual approaches, and discourse models of
ethics (Rossiter, Prilleltensky, & Walsh-Bowers, 2000), Prilleltensky and colleagues’ (1996) participatory framework for applied ethics represented one of my key conceptual and theoretical allegiances at the study’s outset. It extends beyond principle, virtue, and feminist ethics perspectives in its explicit post-modern turn of describing applied ethics as essentially a socially constructed process. The framework was presented as “an emerging conceptual model of applied ethics,” developed with the explicit aim of “promoting ethical discourse in mental health practice” (Prilleltensky et al., 1996, p. 287). The authors engaged in an iterative process of conceptualizing the framework and going out into the field to conduct research in organizations (Prilleltensky et al., 1996; Prilleltensky, Walsh-Bowers, & Rossiter, 1999; Prilleltensky, Valdés, Rossiter, & Walsh-Bowers, 2002; Rossiter, Walsh-Bowers, & Prilleltensky, 1996; Valdés, Prilleltensky, Walsh-Bowers, & Rossiter, 2002; Walsh-Bowers, Prilleltensky, & Rossiter, 1996).

The ‘grounded’ aspect of Prilleltensky et al.’s framework referred to theory building grounded in the lived experiences of professionals rather than reflecting only aspirational statements or simplified vignettes. Critical theory was incorporated by these authors into their framework so as to acknowledge the power dynamics inherent in social behaviour (e.g., status, prestige, privilege, social relations) among professionals, who are often portrayed as being selfless and uninterested in power (Morrow, 1994). Their framework appeared to have had social justice aims in mind, including balancing power imbalances amongst professionals, and helping psychologists recognize how clients are affected by power differentials, ethical decision-making processes, and narrow notions of what constitutes harm. The framework was informed by feminist theory such that local knowledge and context are emphasized in ethical decision-making (Bowden, 1997), and that the inherently relational nature of mental health care is clearly understood (Prilleltensky et al., 1996). It should be noted that the critical theory component of this framework was not used as a guide for the eventual analysis and interpretation of the data in the present study.
The authors contrasted the framework with the more traditional framework (which they termed *restrictive*) on five dimensions. These dimensions were: (1) power and control, (2) decision-making process, (3) scope, (4) relevance, and (5) conceptions of harm. In essence, the authors argued that the restrictive model promoted a power imbalance between professionals and clients, was rule driven and mechanistic, narrowly defined what constituted an ethical issue, was minimally relevant to daily practice, and viewed harm as the problematic behaviour of a few “bad apples” in the profession. These characteristics were contrasted with the participatory model, which the authors envisioned could help equalize power between helper and helpee, balance attention to rules with subjective processes, consider both individual and social ethics, be maximally relevant to daily practice, and consider harm to be a latent potential in all professionals (Prilleltensky et al., 1999).

The authors’ central critique of the restrictive model was that it offered a “fragmented and isolated view of the moral agent” (Prilleltensky et al., 1999, p. 316). Instead, their framework emphasized that professionals co-constructed the social context in which they worked and, as such, their conceptions of ethics took place within an “evolving web of social relations” (p. 317). For example, power relations were hypothesized to affect how professionals perceived ethical issues (e.g., if they felt disempowered or threatened, they might find themselves prioritizing their own needs over their clients’) (Prilleltensky et al., 1999). Thus, the framework shifted ethics towards a more post-modern perspective focusing on the socially embedded nature of morality (Jennings, 1991).

Another noteworthy aspect of the framework was that it identified ethically unexamined practices as leading to harm because unexamined expertise was inherently less sensitive to the needs and interests of all parties involved in caring relationships. The discourse ethics aspect of the framework was believed to provide a solution to the problem of unexamined practice/expertise by reframing ethics as a public process of consensus building (versus ethics as
rules by experts) (Prilleltensky et al. 1996). In the authors’ view, frameworks for applied ethics must be developed based on the “lived experience of workers” (Prilleltensky et al., 1999, p. 316) so as to ensure they are not removed from practice. Therefore, they argued, ethics as a whole must include workers’ perspectives that are considered within the contexts in which the ethical issues and dilemmas they encounter arise. Finally, Prilleltensky and colleagues’ framework called for the active participation of clients in ethical discourse on helping relationships. The authors posited that client involvement in this discourse reminds practitioners that clients’ welfare is central to the helping professions and, therefore, that ethical discourse should be central to daily practice.

When I began to consider the research question and design of the present study, Prilleltensky and colleagues’ participatory framework informed my decision to elicit perspectives on the research topic from workers themselves (i.e., ED-historied ED therapists) regarding their day-to-day practice. The framework also suggested a broadened conception of harm, from a narrow focus on obvious harms perpetrated by potentially impaired recovered therapists to harms that could result from a variety of treatment practices and environments. For example, according to the framework, documented negative attitudes expressed about EDs by clinicians in treatment settings (e.g., a belief that recovery is impossible) and about the individuals who experience EDs (e.g., stubborn, manipulative, boring, blameworthy) (e.g., Williams & Leichner, 2006) would be considered worthy of ethical attention and remediation. In turn, this suggested that the ethics experiences of ED-historied ED therapists could include aspects of the professional culture of EDs treatment (Bloomgarden et al., 2003; Prilleltensky et al., 1996). Furthermore, Prilleltensky and colleagues’ research suggested that any potential feelings of isolation and insecurity among ED-historied therapists might inhibit their ability to resolve ethical issues and concerns they encountered.
2.2.1.6 Summary. To summarize, above were presented a number of perspectives on professional ethics identified at the study’s outset as having potential relevance to the ethics experiences of ED therapists with personal ED histories (standards in the codes; principle, virtue, and feminist ethics; participatory framework for applied ethics). Furthermore, I positioned myself as primarily theoretically aligned with principle ethics. However, upon entering the study, my thinking was also informed by aspects of feminist and post-modern conceptions of ethics, particularly Prilleltensky and colleagues (1996) framework for applied ethics.

In the next section of the theoretical forestructure, I present a brief overview of extant theories and research on stigma and shame as related to mental health in general and to EDs specifically. I have included this literature because it had informed my thinking when I conceived of the project regarding factors potentially influencing ED-historied therapists’ ethics experiences.

2.2.2 Stigma and Shame in Eating Disorders

Stigma involves using negative schemas as generalizations that are discriminatory in tone. These schemas are then “manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance” (U.S. Department of Health and Human Services, 1999, p. 6). Research indicates that mental illnesses are generally stigmatized by the public (e.g., Crisp et al., 2000), including EDs (e.g., Crisp, 2005; Stewart, Keel, & Schiavo, 2006). Also indicated is that individuals with mental health concerns experience diminished self-esteem or self-worth and may then label themselves as socially unacceptable, a process known as self-stigma. This, in turn, can pose barriers to help-seeking behaviour (e.g., Vogel, Wade, & Haake, 2006). The experience of being stigmatized can lead to feelings of shame and decreased self-esteem (Corrigan, 1998).

There is also research suggesting that mental health professionals’ stigmatizing attitudes about mental illness do not differ substantially from attitudes in the general public (Schulze,
Behaviours and attitudes that perpetuate stigma amongst mental health clinicians include the pejorative use of diagnostic labels and pessimistic outcome beliefs (e.g., Beales, 2001). Although this is an emerging area, most investigators have recommended that professionals stimulate their self-awareness regarding their beliefs and attitudes, and identify any associated detrimental clinical consequences (Schulze, 2007).

Regarding individuals with EDs, feelings of shame may be experienced regarding eating and body image (e.g., Burney & Irwin, 2000; Swan & Andrews, 2003). Other research has indicated that body shame in EDs results from measuring oneself unfavourably against sociocultural standards of beauty (e.g., Moradi et al., 2005). In addition, certain relational contexts have been found to increase individuals’ efforts to conceal, and inhibit admission of, an ED (Vandereycken & Van Humbeeck, 2008).

Negative attitude towards individuals with EDs have been found amongst ED professionals (e.g., Beumont & Vandereycken, 1998; Burket & Schramm, 1995; Piran & Jasper, 1993; Williams & Leichner, 2006), which may perpetuate stigma regarding EDs. Clinicians’ reactions to ED clients have included feelings of demoralization, boredom, anger, helplessness, mistrust, and the desire to solve the problem or rescue the client (e.g., American Psychiatric Association, 2006; Beumont & Vandereycken, 1998). As a result, negative attitudes about these clients may develop and be conveyed inappropriately in treatment and training environments. For example, a study of 225 Canadian psychiatry residents revealed that 28.0% of respondents had encountered (or possessed themselves) during their training negative attitudes towards ED patients. Patients were described as difficult, frustrating and/or exhausting to work with, were judged or blamed for their ED (e.g., the disorder is voluntary or “all in their heads”), and were labelled “boring,” “crazy,” “controlling,” and “manipulative” (Williams & Leichner, 2006, p. 330). Negative clinician reactions such as these have been described as one of the most critical
factors contributing to iatrogenesis (an inadvertent adverse effect resulting from treatment) in therapy for EDs (Garner, 1985).

When I conceived of the present study, this literature had suggested to me that, since those who experience EDs have been labelled negatively and stigmatized, and if they experience personal shame about their disorders, professionals with personal ED histories might keep quiet about those histories. Thus, ethical discourse related to professionals’ ED histories might not occur, or might “go underground” due to professionals’ sense that it was unsafe to have open conversations on the subject. For example, how free might both ED-historied and non-ED-historied therapists feel to safely, openly, and productively consult about their feelings of genuine frustration and helplessness in the face of a client’s ambivalence about change? How might a more constrained conversational space affect how the relapse of an ED-historied colleague is addressed? How might these situations affect client care? I speculated that harder-to-detect forms of harm (e.g., subtle devaluing of individuals with ED histories) could undermine clients, in addition to the more blatant types of harm such as therapist impairment (e.g., Prilleltensky et al., 1996).

2.2.2.1 Summary. Above, I have laid out the first portion of the theoretical forestructure of the study by providing an overview of a variety of ethics perspectives, within which I made clear my influences when I entered the study. Also briefly described were conceptual and empirical perspectives regarding stigma and shame as related to mental health and EDs that influenced my thinking about the study. In the next sections, I present my location as a researcher, which also influenced how the study was shaped.

2.3 Location of Researcher

As per interpretive description, in order to more comprehensively acknowledge “the researcher as instrument” (Thorne, 2008, p. 64), in the next sections I provide additional information about my location as a researcher. This includes a description of my disciplinary
location, my worldview and additional personal theoretical influences, and my personal perspectives and experiences that played a significant role in shaping the study.

2.3.1 Trainee in Counselling Psychology

A Canadian definition of counselling psychology was recently ratified by the Canadian Psychological Association (CPA, 2009). Consistent with this definition, my several years of training within this applied discipline prompted me to adopt strengths-based, relational, developmental, and wellness perspectives in my clinical work and research. Moreover, it influenced me to attend to social contexts, cultures, and diversity. As a counselling psychologist-in-training, I have worked clinically to help others reduce their distress, facilitate their well-being, and maximize their effective functioning, and I have viewed mental health as an often complex combination of biological-psychological-social interactions. Research and practice in counselling psychology are considered “mutually informative,” and may adopt emic (individual) or etic (universal) perspectives on human behaviour. In counselling psychology, research methods from diverse epistemological perspectives can be considered.

Because counselling psychology is an applied discipline, in my view, some of the research emerging from it should be able to inform counselling practice as expediently, usefully, and responsibly as possible. For me, this meant being able to consider research questions that emerge from observations about clinical practice (rather than theory), and being able to readily apply the knowledge generated from these questions to practice. From my perspective, research that identifies common patterns in human experiencing is critical; but the nature of counselling psychology practice is such that the application of that knowledge needs to occur in an individualized, collaborative, and client-centred manner.

Counselling psychologists are beginning to work more frequently in interdisciplinary settings (e.g., Alcorn & McPhearson, 1997), including eating disorders treatment (e.g., Hotelling, 2001). The assumptions, values, and biases of other disciplines (e.g., medicine, psychiatry,
clinical psychology) more traditionally involved therein may have informed consensus for practice in a manner that is unquestioned (Muscat, 2010). Thus, there may be different and potentially valuable perspectives offered by counselling psychology research that could enhance practice in EDs treatment settings. As examples, these perspectives might emphasize positive growth and strengths-based approaches to understanding and helping ED clients, and including focus on social, vocational, educational, health-related, and organizational concerns (APA, 2007). Furthermore, counselling psychology has made unique and substantive scholarly contributions in the area of professional ethics, and to research on therapy process and outcome as well as the relational aspects of human experience, including the therapeutic alliance.

In my view, this disciplinary training shaped the present study in several ways, including that I made efforts to attend to positive and strengths-based, as well as problematic, aspects of participants’ ethics experiences; I sought and took into account contextual information; and attended to (and ultimately conceptualized as findings) the interpersonal processes occurring during data collection. Furthermore, I sought an approach to inquiry that could help me answer questions about the clinical ethical practices of ED therapists with personal ED histories, that I hoped would produce knowledge easily transferable to enhancing such practitioners’ ethical practices.

2.3.2 Personal Worldview and Theoretical Influences

At the time the study was proposed, I aligned myself philosophically with the post-positivist paradigm of science. I believed in a “real reality out there” that was observable and independent of human consciousness, but perceived imperfectly due to our biological limitations as a species as well as innumerable other variables including our level of development, culture, gender, family of origin experiences, genetic makeup, socioeconomic and health status, and worldview. However, I believed these imperfect, subjective perceptions to be nonetheless useful and meaningful as one way to understand human experiencing.
Epistemologically, I believed that knowledge ranges from less to more socially constructed, depending on the research methods used and their underlying assumptions. Thus, I accepted the notion that qualitative research data would be co-constructed between myself and the participants, necessitating methodological efforts to engage as a researcher in reflexivity. Axiologically, I considered myself a pragmatist in that it was important to me that the products of my research be of the most immediate, practical value possible to the EDs field such that they improve services for clients with EDs. Pragmatism is a school of philosophy stressing the relevance of practical application, and holds as primary values improving peoples’ situations and finding solutions to problems that work (e.g., Martin, 2002; Patton, 1990). For pragmatists, the ‘ultimate truth’ about objects is impossible to ascertain, and therefore the use of objects is considered to be of greater practical value (Benzies & Allen, 2001).

2.3.3 Personal Experiences

I selected the research question as a result of my longstanding research and clinical interests in the topic of EDs, and my more recent interests in the therapeutic relationship and professional ethics. One finding in my master’s thesis indicated to me that the issue of the involvement of ED-historied therapists in EDs treatment might be controversial and worth exploring further. However, I trace my interests even further back to my own experience, from my late teens to mid-20s, of having had an ED. After identifying myself as “recovered,” I worked at non-profit ED advocacy organizations, and as a result felt comfortable being “out” as someone who had struggled with an ED. However, when I later began my professional training as a counsellor, and particularly within the EDs treatment context, I began to feel more self-conscious about my ED history. Early in my graduate training, as a novice counsellor in an EDs treatment program, I disclosed my personal experience to selected supervisors believing that this was in the ultimate interest of accountability and client safety. The response to my disclosures was warm and supportive. On a very few occasions in this setting, I also disclosed my history to
clients. The supervision I received concerning these disclosures was both supportive and challenging, and took into account the characteristics of the client, the context (e.g., group or individual counselling), and my rationale for having disclosed.

I attended staff meetings in which the issue of recovered and non-recovered therapists’ countertransferential reactions to clients with EDs surfaced. In my view, conversation was constrained, and I participated in more open, follow-up conversations between smaller groups of professionals behind closed doors. At one point, a self-described recovered therapist was brought in to do a professional development talk on the topic. I perceived the atmosphere at the workshop to be palpably intense. No professional in the room other than the speaker identified openly as having an ED history; perhaps no one except myself had a history. In hindsight, I wondered whether there might have been others in the room, given reported prevalence rates in the field (e.g., Barbarich, 2002). I felt somewhat “othered” by these discussions, and somewhat ashamed of my history, and, as a result, opted from then on to remain silent about my personal ED experience.

My sense of disequilibrium about my role as a mental health worker in the EDs field, given my personal ED history, lessened markedly over the years as my confidence in my professional competence to work with ED clients rose and as I clarified my professional stance(s) towards disclosing my ED experience to my colleagues, supervisors, and clients. Nevertheless, I remained interested in how my own ED history might be impacting clients, and conceptualized this as, foremost, an ethical issue. However, at the outset of the present study, I did not hold the assumption that the involvement of ED-historied therapists in EDs treatment was either wholly beneficial or harmful (rather, I imagined there might be potentially helpful and harmful aspects), nor did I seek to legitimize their/our work in the field. In sum, then, these personal experiences were pivotal in my identifying and pursuing the research topic.
2.3.4 Summary

In the sections above, I provided information about my location as a researcher that included my disciplinary orientation, my worldview and valuing of pragmatism, and my personal experiences that played a significant role in shaping the study.

2.4 Chapter Summary

In this chapter, as per the interpretive description approach, I presented the theoretical scaffolding of the study, comprised of a literature review summarizing what was known regarding the topic of the present investigation, and the theoretical forestructure, which identified theoretical and conceptual ideas I perceived as relevant, and that were influences I brought into the study. These included scholarship concerning professional ethics and issues of shame/stigma, but also my disciplinary framework as a counselling psychology trainee, my worldview, my allegiance to pragmatism, and my personal experiences, all of which influenced how the study was shaped (Thorne, 2008).

In my view, the scaffolding provided additional support to the research question (“For therapists with a personal history of an ED, what are their experiences of professional ethics in their day-to-day work with ED clients?”) as being a question worth asking, particularly if answers informed clinical practice in such a way as to maximize benefit and minimize harm to ED clients. In the following chapter, I describe the approach to inquiry selected as appropriate to answer this question.
CHAPTER 3 – Approach to Inquiry

In this chapter, I describe the approach to inquiry used in the study (interpretive description), locate the approach within the appropriate paradigm of scientific inquiry (constructivist-interpretivist), present methodological considerations relevant to the study’s design, describe the design and data analysis processes, discuss relevant ethical issues, and identify criteria by which the trustworthiness and quality of the product were judged.

3.1 Interpretive Description

Interpretive description (Thorne, Kirkham, MacDonald-Emes, 1997; Thorne, Kirkham, & O’Flynn-Magee, 2004; Thorne, 2008) was employed to explore and understand the professional ethics experiences of eating disorder (ED) therapists with personal ED histories. It was selected on the basis of its utility as a qualitative approach to inquiry for exploring and answering questions that arise in clinical practice in the applied disciplines (Thorne, 2008).

Interpretive description has been described by its originator as a framework for devising a logical research design, not a method (Thorne, 2009). It is undergirded philosophically by naturalistic inquiry, and thus informed by axioms such as those proposed by Lincoln and Guba (1985), including: (1) There are multiple constructed realities that can be studied only holistically. Thus, reality is complex, contextual, constructed, and ultimately subjective; (2) The inquirer and the object of inquiry interact to influence one another; the knower and known are inseparable; and (3) No a priori theory can encompass the multiple realities likely to be encountered; rather, theory must emerge or be grounded in the data (e.g., Thorne et al., 2004). However, interpretive description also takes the position that there can be commonalities across these multiple, constructed realities that constitute “shared realities” (Thorne et al., 2004, p. 3). Interpretive description “generally taps human experience in context” (Thorne, 2008, p. 203). Thus, it aims to understand how individual experiences are situated in, and influenced by,
various contexts of human experience, to the degree possible (Thorne, 2008).

Interpretive description design strategies are drawn variously from grounded theory (e.g., constant comparative analysis, purposive and theoretical sampling), phenomenology (e.g., accessing human subjectivity regarding an experience), and ethnography (e.g., strategies for conducting fieldwork). However, interpretive description explicitly addresses research problems and questions that originate from clinical practice rather than from theory, and emphasizes the practical implications of the research findings. There is also a pragmatic obligation in interpretive description to consider how findings might be used in practice (Thorne et al., 2004; Thorne, 2008). These elements suggest that the philosophy of pragmatism, focusing on the relevance of practical application, improving peoples’ situations, and finding solutions to problems that work (e.g., Martin, 2002; Patton, 1990), also strongly underpins interpretive description.

Other key features of interpretive description include the theoretical scaffolding (literature review plus theoretical forestructure, presented in Chapter 2), which describes the theoretical assumptions, biases, and preconceptions contributing to the study’s design; purposive and theoretical sampling, seeking variation on emerging themes, and gathering adequate amounts and varieties of data to enhance the trustworthiness of claims; and accessing data sources that adequately convey the experience (and variations) of the phenomena under investigation, using a range of data sources, and examining relationships between the data sources and the findings derived from them (McPherson, 2007; Thorne et al., 1997; Thorne et al., 2004; Thorne, 2008).

Regarding analysis, interpretive description employs an inductive process that maintains a holistic, contextualized perspective of the data rather than fracturing data into small, decontextualized segments (e.g., Thorne, 2008). It also aims to produce findings that move beyond self-evident, initial descriptive claims towards more abstracted interpretations (hence,
“interpreted description”). Thus, ‘interpretation’ in interpretive description means generating an interpretive account of the “associations, relationships, and patterns within the phenomenon that has been described” (Thorne, 2008, p. 50) that identifies the potential meanings of the results for the discipline in which the research is situated. Interpretation in interpretive description is also traced to hermeneutics (e.g., Gadamer, 1989, Heidegger, 1982, as cited in Thorne, 2008), with which meaning constructions are analyzed within subjective and intersubjective experience. However, interpretive description holds this heritage lightly given that hermeneutics was developed with intellectual and epistemological purposes in mind that were unrelated to applied disciplinary practices (Thorne, 2008). Another key analytic feature of interpretive description is that, during analysis, the theoretical scaffolding is considered and then ideally moved beyond as new meanings are developed about the phenomenon. Thus, the theoretical scaffolding is not intended as a framework to rigidly guide the analysis (Thorne et al., 2004).

Interpretive description provided a “logic model” (Thorne, 2008, p. 17) for the present study’s design and implementation that resulted in knowledge about patterns and themes among a group of ED-historied therapists’ perceptions of their ethics experiences that have implications for psychotherapy and ethics practice, and that provide ideas for how practitioners might begin to usefully and credibly put this knowledge to direct, applied use in order to enhance practice (Thorne, 2008). The study’s product aimed to be a “coherent conceptual description that tap[ped] thematic patterns and commonalities believed to characterize the phenomenon…and also account[ed] for the inevitable individual variations within them” (Thorne et al., 2004, p. 4). Supported by the outcomes of ‘thoughtful clinician tests’ (see below, under Trustworthiness), the products of this study should be recognizable to practitioners who have expertise and long-term experience as ED-historied therapists and potentially to non-ED-historied professionals working closely with them (Thorne et al., 2004, p. 8). The findings can be used to inform practices that are consistent with the standards of evidence, logic and ethics in the disciplines associated with
psychotherapy training and delivery (Thorne et al., 2004), including counseling psychology. Finally, the findings, because they are an interpretation, represent tentatively claimed, “constructed truths” (Thorne et al., 2004, p. 6) about the ethics experiences of ED-historied therapists that will necessarily evolve as new understanding and meanings emerge regarding these phenomena (Thorne et al., 1997).

Until recently, the interpretive description approach was employed almost exclusively in nursing inquiry, as its originators were qualitative nurse researchers. However, interpretive description research is beginning to emerge in the literature of other applied disciplines, including counselling psychology (e.g., Muscat, 2010; Rostam, 2006). In the following sections, I describe how I designed and carried out the present study, as informed by interpretive description. Prior to this, however, I locate interpretive description within the appropriate paradigm of science and present broader methodological considerations underpinning the study’s design.

3.2 Locating Interpretive Description

Counselling psychology researchers have been directed to explicitly locate their investigations on a number of scientific paradigmatic dimensions (Ponterotto, 2005). In my view, interpretive description is most appropriately situated in the constructivist-interpretivist paradigm of science¹, as per the following.

First, interpretive description assumes multiple, equally valid subjective realities that are constructed by the individual minds of participants, as per naturalistic inquiry (e.g., Lincoln & Guba, 1985). Indeed, Thorne and colleagues (2004) state explicitly that interpretive description yields tentatively claimed, “constructed truths” (p. 6) that will be adjusted depending on context,

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¹ The philosophy of science paradigms have been summarized in the counselling psychology literature as positivism/post-positivism, constructivism-interpretivism, and critical-ideological (Ponterotto, 2005). Each paradigm differs in its perspective towards reality (ontology), knowledge (epistemology), and the role of researcher values (axiology) (Ponterotto, 2005). Qualitative research is most often conducted from within the constructivist-interpretivist and critical-ideological paradigms (Ponterotto, 2002; Ponterotto & Grieger, 2007).
new concepts, and new understanding and meanings (Thorne et al., 1997). Thus, on the parameter of ontology, interpretive description aligns with constructivism-interpretivism.

Second, although many types of data sources (e.g., case reports, lay print, video, etc.) can be used in interpretive description, interviews that access participants’ rich, experiential knowledge of, and meaning-making about, the phenomenon are a primary research tool for understanding participants’ realities. During interviews, as per naturalistic inquiry, the inquirer and the object of inquiry are thought to influence one another – that is, data are co-constructed through a dynamic interaction between researcher and participant. Therefore, epistemologically, interpretive description is most consistent with the constructivist-interpretivist paradigm.

Third, the assumption that knowledge is co-constructed by researcher and participants implies that the interpretive description researcher’s values, beliefs, ethics, etc. will be inextricably woven into the data collection process. In addition, interpretive description scholarship describes the researcher as having the power to determine what constitutes relevant data, how the data will be interpreted, structured, and presented, and how the findings will be disseminated. Thus, the researcher’s axiological position permeates the research project. Therefore, it is critical to explicitly identify and account for these influences by disclosing them in the theoretical forestructure (Thorne et al., 2004). The constructivist-interpretivist position is that the researcher’s values and lived experience cannot be divorced from the research process (Ponterotto, 2005). Thus, interpretive description can be seen to align with this paradigm in terms of axiology.

3.3 Methodological Considerations

Methodologically, the study’s design was informed by an integrated understanding of the research question and purpose, the ontological, epistemological, and axiological

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2 I align my definition of methodology with that of the American Heritage Dictionary of the English Language (2004), which refers to by what means we can come to know a phenomenon. Thus, methodology is conceptually distinct from “method” (i.e., strategies of inquiry) and refers to the theoretical analysis of principles (i.e., ontology and epistemology) that determines how such strategies are employed and interpreted.
underpinnings of interpretive description (including constructivism-interpretivism, naturalistic inquiry, and pragmatism), and elements of the theoretical forestructure presented in the previous chapter (e.g., my personal theoretical allegiances and disciplinary orientation).

Additional influences included the following. To clarify my approach to understanding and interpreting interviewees’ ethics experiences, I aligned with *philosophical hermeneutics*, which views understanding as arising from the process between researcher and researched\(^3\) (Haverkamp & Young, 2007). Furthermore, the meaning of ‘experiences’ was broadly defined to include what participants encountered, underwent, lived through, participated in, or observed (Merriam Webster, 2008). Together, these positionings informed the following design for exploring, understanding, describing, and interpreting the day-to-day ethics experiences of ED therapists with personal ED histories, for the purposes of improving clinical practice.

### 3.4 Study Design

Interpretive description is not prescriptive regarding design choices; rather, researchers select design features that help answer the research question defensibly (Thorne, 2008). The design of the present study was heavily informed by the interpretive description logic model for making design decisions, but also by counselling psychology scholarship addressing the conduct and quality of qualitative research from within the constructivist-interpretivist paradigm (e.g., Morrow, 2005; Morrow, 2007).

#### 3.4.1 Recruitment and Participant Selection

Consistent with interpretive description, participants were purposively selected\(^4\) based on their abilities to provide a useful “angle” (Thorne, 2008, p. 90) on the experiences of

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\(^3\) Two other contemporary approaches to hermeneutics are *validation hermeneutics* (in which the central aim is to correctly represent the speaker’s intent -- thus, understanding means "getting it right") and *critical hermeneutics* (which is concerned with presenting participants with an interpretation of how historical and social forces have shaped their perceptions of meaning). These approaches are associated, respectively, with the post-positivist and critical-ideological paradigms of science (Haverkamp & Young, 2007).

\(^4\) Following Polkinghorne (2005) (and in contrast to Thorne [e.g., 2008]), I use the term “selection” to convey the purposive nature of choosing participants in qualitative research (versus “sample,” which implies a population to which the findings should be generalizable, as per quantitative research [Morrow, 2005]).
professional ethics for ED-historied ED therapists. Given the exploratory aim of the study, I sought as key informants therapists who met the following criteria:

1. Had provided counselling or therapy to ED clients for at least 2 years, and were providing these services currently.
2. Presently carried a proportion of at least 1/4 (approximately) ED clients in their caseloads.
3. Possessed at least a Master’s degree and were members of a professional organization with a code of ethics.
4. Self-identified as having experienced an ED of diagnosable severity (either Anorexia Nervosa [AN], Bulimia Nervosa [BN], or Eating Disorder Not Otherwise Specified [EDNOS]).
5. Were at least 22 years of age.

Exclusion criteria included individuals who did not meet the inclusion criteria; who self-identified as having experienced subclinical EDs (i.e., ED symptoms that did not meet diagnostic criteria), or some lesser form of eating or body image difficulties; and who, when asked directly in initial contact during recruitment, reported currently experiencing an ED of diagnosable severity.

While the desired participants were homogeneous in terms of having had a personal ED history and working as an ED therapist, other appropriate variables of interest were identified, prior to recruitment, for which variation was sought in order to help obtain a variety of angles of vision regarding ethics experiences (Thorne, 2008, 2009). These variables represented either basic demographic characteristics, or seemed relevant to the research question and were drawn from the ethics literature (e.g., on small communities; professional experience level) or inferred as potential influences on participants’ ethics experiences on the basis of my knowledge of EDs.
and therapist professional development. They included age, gender, ethnic heritage, theoretical orientation to therapy, professional discipline (e.g., counselling, social work, psychology), years of experience providing counselling or therapy (overall, and to ED clients), type of ED(s) personally experienced, extent of overlap between ED symptoms and working as an ED therapist, current practice setting (EDs program, private practice, etc.), awareness at the workplace of the participant's ED, and geographical location (urban, suburban, rural).

Participants were recruited via advertisements distributed to electronic mailing lists to professional organizations of counseling, social work, and psychology, and through hardcopy flyers mailed to all ED treatment programs in the province of British Columbia. Recruitment materials appear in Appendix A. The advertising directed potential participants to a website that described the study and what participants could expect. Of the 11 therapists who responded to the advertisements, 4 did not re-respond to my efforts to contact them. Of the remaining 7, one was unavailable during the data collection period, and one did not meet the inclusion criteria. Five individuals met the inclusion criteria and agreed to participate in the study.

However, I perceived this to be an insufficient number of participants for the purposes of the investigation, based on the average sample sizes reported in other interpretive description studies with relatively homogeneous samples (ranging from 5 - 52 participants), and concerns about obtaining adequate amounts of evidence (Erickson, 1986; Morrow, 2005) and producing only a “thin” description (Thorne, 2008). Therefore, recruitment efforts were widened to include two U.S. states. Advertisements were distributed via international electronic mailing lists, advertisements on ED organization websites (e.g., Academy for EDs [AED] and the International Association of EDs Professionals [iaedp™]), and mailouts to selected ED treatment centres.

Of the 8 individuals who responded to these ads, 5 met the inclusion criteria and agreed to participate in the study, and resources permitted travel to their locations (including 2
individuals in a third U.S. state who had received the electronic ad). Thus, the selected participants totaled 10. As data collection progressed, 1 therapist from a rural community was added to enhance variation regarding community size and recency of personal ED history, with the aim of better informing the understanding of ethics experiences related to working in small communities and to being more recently symptomatic. This brought the final number of interviewees to 11. I deemed this an adequate number for fulfilling the study’s aims of initial exploration and understanding. However, I acknowledge that new variations of ethics experiences would likely have arisen had additional participants been included (Thorne, 2008).

In acknowledgment of their participation, the 11 participants were each given one $20.00 gift card to a major online book store. Consent was obtained with participants prior to commencing the first interview (the consent form appears in Appendix B). Consent and the right to withdraw from the study were reviewed at the beginning of each subsequent interview.

3.4.1.1 Characteristics of participant group.

Based on data collected via oral administration of the demographic questionnaire (Appendix C) immediately prior to the first interview, the participants’ characteristics are described in the following paragraphs. They are presented in such a way as to provide a full account of the range of variation within the group, but also to preserve the anonymity of the participants and their workplaces to the fullest extent. This was prompted by statements made by 3 individuals who indicated during the recruitment stage that it would be highly risky professionally for them to participate in the study, and by similar sentiments expressed by some participants during data collection. Several individuals required strong reassurance that they and/or their workplaces would not be identifiable.

As per the inclusion criteria, all participants had provided counselling or therapy to ED clients for at least 2 years and were currently providing such services. The proportion of ED clients in their caseloads ranged from 25% to 100%, with the exception of the added participant
from a small community, who reported ED clients as comprising approximately 10% of her caseload. The reported number of years participants had provided therapy in general (not just to ED clients) ranged from 7 to 32 years ($M = 17.35; SD = 9.81; Mdn = 16$). The reported number of years they had worked with ED clients ranged from 2.5 to 22 years ($M = 11.95; SD = 7.02; Mdn = 10.75$). Each participant reported possessing at least a Master’s degree and being a member of a professional organization with a code of ethics. Highest degrees obtained were either Master's (n = 6) or Doctorate (n = 5). The Master's degrees were obtained in social work, marriage and family therapy, or counselling psychology. The Doctoral degrees were obtained in clinical psychology, school psychology, and/or educational psychology. One participant was registered as a dietitian in addition to being a psychotherapist.

Participants' work contexts included private practice (solo and group), community health clinic, hospital EDs program (treatment and research), regional EDs program, college, residential EDs treatment centre, and mental health centre. Those who worked in two contexts had private practices in addition to their other position. These workplaces were situated in a wide range of geographical contexts, from rural (e.g., population of 20,000) to very large urban (e.g., population of 3,500,000). A range of theoretical orientations was endorsed by participants, including psychodynamic or psychoanalytic (n = 3), humanistic (n = 1), and eclectic (n = 7). Practitioners favouring eclecticism drew from the following orientations (in alphabetical order): behavioural, cognitive-behavioural, cognitive, dialectical behaviour therapy, emotion focused therapy, experiential, family based therapy, humanistic, and mindfulness. One participant reported using manualized treatments as part of providing therapy in a research study.

All participants self-identified as having experienced an ED of diagnosable severity (i.e., AN, BN, or EDNOS) in the past. All reported that they were not currently experiencing an ED of diagnosable severity. Participants disclosed a wide range of personal ED experiences, including AN (restricting and binge-purge types), BN (purging and non-purging types), and EDNOS (e.g.,
all AN criteria met except 85% of ideal body weight or amenorrhea; binge eating or “compulsive” eating). Eight of the 11 participants described having shifted from one ED category to another category or categories (e.g., AN, to BN, to compulsive eating; AN to BN; BN to EDNOS). The duration of the personal ED reported ranged from 2 to 28 years ($M = 11.77; SD = 8.42; Mdn = 10$), although some (but not all) framed their responses as approximate. This was attributed by them to the gradual nature of recovery. Seven of the 11 participants reported that they had not been formally diagnosed with an ED. Several of this subgroup attributed this to having had an ED at time when relatively little had been known about EDs and their treatment. Some in this subgroup stated that they had received treatment, but not within a formal EDs treatment setting (e.g., worked with a therapist who was a non-specialist in EDs). Others reported having received no professional treatment for their ED at all. Participants who had received diagnoses reported that psychiatrists, family physicians, hospital-based programs, or therapists had provided these. When asked how long they had been recovered from their ED(s), participants reported between 3 to 29 years ($M = 16.45; SD = 7.53; Mdn = 19$). Again, some (but not all) framed their responses regarding recency of ED as approximate, based on the gradual nature of their recoveries.

Two participants stated that they had experienced a lapse in recovery while working in the EDs treatment field. Both individuals reported having sought assistance at those times, but not in formal ED treatment settings (i.e., instead, they had worked with a non-ED-specialist therapist and/or had accessed support through 12-step groups). One of these participants disclosed that she currently purged approximately once every 3 months.

When asked if their current workplace(s) were aware of their ED history, 7 of 11 participants indicated “yes,” with 5 of these 7 stating that only selected individuals among managers, colleagues, and/or supervisors were aware. Two participants stated that this question was not applicable, given their solo private practice contexts. Two individuals reported that no
one at their current workplace was aware of their ED history, although they had been more open about this at previous workplaces.

All participants were 22 years of age or older and spoke fluent English. Ten participants described themselves as being of Caucasian-European descent and one as Jewish. At the time of data collection, the participants ranged in age from 28 to 61 years of age ($M = 43.36; SD = 10.29; Mdn = 44$). All were women. After commencing recruitment, I decided to include only female participants so as to keep this variable homogeneous in the sample. This seemed reasonable given that ED experiences for men and women can differ in terms of presentation, and that the prevalence of EDs by sex (e.g., Hudson, Hiripi, Pope, & Kessler, 2007) and early descriptive research on ED practitioners (Barbarich, 2002) suggested that the vast majority of ED therapists with personal ED histories were likely to be female. In any case, no male therapists with personal ED histories responded to the recruitment advertisements.

Data regarding participants’ ethics training was gathered during the second interview, as this seemed to enhance the meaning of certain ethics experiences in terms of ethical preparedness (e.g., self-disclosure training). Participants reported a wide range of ethics training, ranging from no ethics training recalled other than studying for licensing exams, to one or more experiences on the following list: ethics course at bachelor’s level in addition to graduate level; one graduate level ethics course; multiple graduate courses and/or seminars; no dedicated graduate ethics course, but ethics infused into other courses; continuing education; “on the job.” Finally, one participant had sat on an ethics IRB at a workplace. On the whole, younger participants reported more comprehensive and dedicated training in ethics.

3.4.2 Data Sources and Collection

Consistent with interpretive description, as well as with the concept of trustworthiness in qualitative research in counseling psychology, data sources representing “multiple angles of vision” (Thorne, 2008, p. 78) regarding the ethics experiences of ED-historied ED therapists
were sought in order to achieve adequate variety in kinds of evidence (Erickson, 1986; Morrow, 2005). Furthermore, multiple data sources contributed to a “thick description” of the phenomenon, a priority in all qualitative research (Morrow, 2005). Following the constructivist-interpretivist view, multiple sources were incorporated not for the purposes of ascertaining an ‘objective truth’ about these experiences but rather to maximize the “richness, breadth, and depth of the data gathered” (Morrow, 2005, p. 256).

A key aim of data collection was to access participants’ subjective perceptions of their ethics experiences. Therefore, the initial data sources selected were narratives obtained through interviewing. During the data collection phase, extant, relevant first-person written accounts found in the EDs literature were identified and added as a data source (discussed below). Another data source – focus groups with both ED-historied and non-ED historied therapists – was initially proposed but later abandoned when recruitment efforts were largely unsuccessful, when some ED-historied interviewees expressed that participating in such groups would be highly professionally and personally risky for them, and when the rationale for employing this activity was reevaluated. Text in the forms of field notes and reflexive journaling was also incorporated into the dataset (Lal, 1995; Thorne, 2008; Thorne et al., 1997). The data sources and collection activities that were employed in the study are detailed below.

3.4.2.1 Interviews. Following Polkinghorne (2005), I conducted multiple interviews (in this case, three) with each of the 11 participants in order to obtain sufficient richness and depth in the interview data concerning their ethics experiences. Each interview was construed as a “conversation with a purpose” (Dexter, 1970, p. 136, as cited in Morrow, 2005), the purpose being to explore and understand participants’ perspectives on their ethics experiences in their day-to-day work with ED clients. The first two encounters with each participant consisted of in-

\[\text{As per Erickson (1986) and Morrow (2005), the term “adequate variety” is used here instead of “triangulation” to refer to multiple source use because the term “triangulation” is more appropriately associated with post-positivist qualitative research (Morrow, 2005).}\]
person interviews at their workplaces (averaging 90 minutes per interview). The rationale for conducting interviews in the field was to gather data in the context of the naturalistic environment in which participants’ ethics experiences had arisen, and to emphasize the focus of the research on practical, day-to-day realities (Thorne, 2008).

The third interview with each participant (approximately 20-30 minutes) was conducted by phone. This was initially incorporated into the design as an optional feature (i.e., and framed to participants as a possibility that I might wish to contact them by phone for a follow-up). I chose to implement this activity when, after completing the first two rounds of interviews, I determined it would be helpful to discuss emerging themes and patterns with participants in more depth. Thus, sharing with participants what I was starting to think, and ascertaining whether it made sense to them was an objective for the third interviews (Thorne, 2009). In fact, both the second interview and follow-up phone call afforded opportunities for discussing emerging patterns, clarifying previous interview material, asking new questions relevant to the investigation, and learning from participants how well my initial understandings and interpretations of their experiences reflected their meanings (Morrow, 2005). I audio recorded all interviews, which were transcribed by an independent transcriber who had signed a confidentiality agreement.

The first round of interviews employed a semi-structured protocol that allowed for open-endedness and flexibility such that the participants had wide leeway to identify and discuss what they construed as their ethics experiences. Following Kvale (1996) and Morrow (2005), I used short interview questions that invited long, spontaneous, and rich answers. I employed a simple interview guide in every first interview that consisted of two exploratory questions: “Can you tell me what interested you about my study?” and “Tell me about your experiences of professional ethics in working with eating disordered clients.” Probes such as "Can you think of an example or two to illustrate that?" and "Can you tell me more about that?" were used to prompt further
exploration. Demographic information was also obtained verbally in the initial portion of the first interview. After consulting with my supervisor, an additional, informal question (“I am here as a researcher, but is there anything you would like to ask me that might make you feel more comfortable?”) was added to each first interview with the intention of helping increase participants’ comfort levels.

At the beginning of each first interview, after obtaining consent and prior to asking the demographic questions, I made a very brief self-disclosure statement (approximately 1 minute in length) that articulated my own personal history of an ED, the overlap of my initial counsellor training with lingering ED issues, my curiosity about the ethical implications of my history regarding professional ethics, and that I had not found any published qualitative investigations on ED-historied therapists that had accessed their perspectives. The decision to self-disclose my ED history was not made lightly given the likely powerful influence on the data and findings of sharing this personal information with participants. For example, assumptions of shared understandings could have negatively affected description “thickness,” and participants’ comparison of their ED histories and/or ethics experiences to mine might have implied correct and incorrect ways of experiencing these phenomena (Thorne, 2008).

Ultimately, my decision at the study’s outset was to disclose my history for two values-based reasons, and one epistemological one. First, if I remained silent, I believed I would be presenting myself disingenuously and incongruently since it was my own experience that had prompted the project’s very genesis. Second, by saying nothing, I believed I would be supporting silence in the EDs field about ED-historied therapists, which did not align with my values. Third, by disclosing this information, I believed participants would feel more relaxed and able to speak more openly and in more depth if they knew I was an ‘insider’ regarding personal ED experience. In hindsight, I likely still would have disclosed, mainly for the reason of accessing depth of information and less so for personal values, but also for a different reason: contributing
to interview conditions of dialogical safety. In any case, very rarely did participants ask for more information about my personal history and its intersection with professional ethics after my initial, brief disclosure, and very rarely did I spontaneously disclose additional information later in the interviews. On each of these rare occasions, to attempt to moderate my influence, I gently refocused the discussion back to the interviewees’ experiences, and reiterated my interest in learning about their perspectives.

In my view, my personal disclosure of ED history to participants likely shaped the study’s findings significantly. I speculate that the disclosure did enhance the depth and richness of the interview data. All participants expressed appreciation for my self-disclosure, to varying degrees, and many spontaneously stated they felt safe with, and not judged by, me. However, it also may have contributed to some participants feeling they had ‘over-disclosed’ to me beyond their comfort levels, which was also an ethical issue. Indeed, an excerpt from my reflexive journal reads:

She mentioned missing ‘camaraderie’ with other ED-historied individuals…She said she wondered if she had disclosed too much in Interview 1, and said I was ‘easy to talk to.’ This makes me realize I need to be very cognizant regarding ethics [i.e., consent] and my listening/eliciting skills as a counsellor-researcher (Reflexive journal, July 6, 2010).

In subsequent communications with this particular participant regarding this situation, we discussed her thoughts and feelings about the ‘over-disclosure,’ and whether she felt comfortable with it remaining in the dataset.

In subsequent interviewing activities, the questions “Tell me about any reflections you have had since our first conversation” and “Are there any other experiences of professional ethics in your work with eating disordered clients that you would like to tell me about, or any experiences that you would like to expand on from last time?” were the main foci in the second and third interviews. However, additional questions were added to these protocols to reflect what was emerging in the data and to facilitate further exploration (Morrow, 2005) of certain ethics
experiences, including (given one of the key areas of interest in the study) ethics experiences related to participants’ personal ED histories. Indeed, Thorne (2009) recommends that questions should be informed by other interviews and evolve as the direction of the inquiry takes shape.

Throughout all the interviews, I employed active listening skills (e.g., reflecting, paraphrasing, summarizing) to facilitate the processes of interpreting, clarifying, and verifying what I was hearing from participants so as to understand their perspectives (Kvale, 1996; Morrow, 2005). Furthermore, I attempted to approach all the interviews as a curious learner (Thorne, 2008) and “naive inquirer” (Morrow, 2005, p. 254), which was sometimes challenging given that I myself was an ED therapist-in-training with a personal ED history. However, in my view, these challenges were likely moderated by my skills as a therapist in being able to monitor multiple processes in interpersonal interactions, by my general stance as a therapist of curiosity, and by constantly reminding myself of my potential influence on the data. Thus, for example, during the interviewing, I attempted to monitor my verbal and non-verbal responses (e.g., Was I conveying approval/disapproval?) in order to help track my contributions to the co-construction of the interview data (see also the section on reflexivity, under Trustworthiness). Finally, as per Ensign (2003), I occasionally wove educational or therapeutic responses into the interviews, as I perceived necessary. For example, I briefly described social comparison theory (Festinger, 1954) to elaborate on a comment made by a participant about her sense of schadenfreude regarding the ethical missteps of colleagues. And, I responded with empathy to aspects of participants’ stories about their ED histories. The complete interview protocols are contained in Appendix D.

3.4.2.2 First-person published accounts. After all the interviews had been completed, I incorporated into the dataset first-person accounts written by ED-historied therapists that described ethics experiences, in particular those related to their personal ED histories. This decision was consistent with the use of collateral data sources in interpretive description (Thorne, 2008) and with the concept of the emergent design in qualitative research (e.g., Glaser
& Strauss, 1967; Morrow & Smith, 2000). My specific reasoning for seeking such text was to access additional subjective angles on the research topic that had not been shaped by my co-construction (as in the interview data). The personal or professional agendas or biases contained in these texts may have been different from those brought to the study by the interviewees (Thorne, 2008). Inclusion criteria were that such documents had to have been written in the first person by a therapist with a self-reported, personal ED-history (i.e., the text was not quoted and/or re-interpreted by another author).

Based on these guidelines, two documents were selected (Bloomgarden, 2000 and Goldkopf-Woodtke, 2001). Bloomgarden wrote about her ethical decision-making process regarding whether or not to self-disclose her personal ED history to adolescent ED clients to whom she was delivering group therapy. Goldkopf-Woodtke wrote about several personal ED- and ethically-related topics including countertransference reactions, the reemergence of feelings and memories associated with her ED in her work, the complexity of determining her degree of recovery, and how her ED experience informed her work. As per interpretive description, I acknowledged the limitations of these published autobiographical accounts, including that they might have been written with idiosyncratic agendas in mind, might have represented extremes on the continuum of experiences, or might have been influenced by others in unknown ways (e.g., by editors who might contribute to shaping the product based on palatability to, or interest of, intended audiences) (Thorne, 2008).

In fact, the first-person written accounts provided data consistent with the patterns and themes regarding the ethics experiences that had emerged in the interview data (e.g., the notion of ED residuals as influencing therapy in unhelpful ways [Goldkopf-Woodtke, 2001]; the identification of therapist self-disclosure of personal ED history as an ethical issue encountered [Bloomgarden, 2000]). However, new angles on these experiences were also provided (e.g., Goldkopf-Woodtke’s identifying as an ED residual being tempted to try to “save” clients from
their painful emotions), in addition to particularly compelling and well-articulated examples of certain experiences that had already been described by the interviewees (e.g., Bloomgarden’s receiving less helpful ethical guidance and support from colleagues regarding self-disclosing to clients because she felt she could not disclose her personal ED history to her colleagues).

3.4.2.3 Field notes. Another key data source was field notes. I wrote field notes about each face-to-face interview in order to contribute to the adequacy of variety of data (Erickson, 1986; Morrow, 2005), to elaborate my understanding of participants’ experiences and contexts, and to aid me in recalling each data collection encounter as I immersed myself in more and more data (Emerson, Fretz, & Shaw, 1995; Hall & Callery, 2001). I employed chronological recall, and wrote from first- and third-person perspectives to record descriptions of the interview settings (e.g., “The participant works in a building with a huge sign on the front indicating that there is a plastic surgery practice inside” [Field note, March 26, 2010]). I also recorded my observations of participants’ behaviours before, during, and after the interviews (e.g., “She was rotating her foot quite strenuously” [Field note, April 5, 2010]; “Part-way into the interview, she took her shoes off and crossed her legs on the chair” [Field note, March 10, 2010]). On several occasions, I consulted with participants about the meaning of what I had observed (e.g., regarding certain of their behaviours, such as a facial grimace) rather than relying solely on my own interpretations (Emerson et al., 1995).

Following Emerson and colleagues (1995), I wrote formal field notes as soon as possible after each interview (frequently within minutes of leaving the interview site) and avoided discussing my observations prior to writing so as to not re-interpret events and co-construct yet another layer of meaning/data. Any additional first impressions, feelings, and thoughts pertaining more to my own experience of the interviews were written in the reflexive journal rather than in the field notes (although there existed some overlap in this regard between these documents). Informed by Mulhall (2003), I engaged in long-term reflection on the observations I had made in
the field notes in order to ascertain broad patterns appearing therein, and to enhance my understanding of the interview data. For example, the field notes contributed key data regarding participants’ varied comfort levels, which greatly informed the process-oriented findings (e.g., I noted my observations of various non-verbal behaviours that suggested nervousness or cautiousness, such as foot jiggling and hand wringing).

In another example of how field notes contributed to my understanding of broader patterns in the data, information was gleaned from the field notes regarding participants’ openness about their ED histories in their work settings (which ultimately emerged as a category in the findings). To illustrate, below are two excerpts from the field notes that were written following the first interviews with two different participants. The first instance was a post-interview interaction with the only participant not working in solo private practice who had offered me a tour of her workplace. The second excerpt provided a contrasting instance from another participant.

She offered to take me on a tour of the facility. A number of clients smiled and said hello. She introduced me to some of them by my first name and said I was doing a research study and was interviewing recovered ED therapists (Field note, April 5, 2010).

When I had called the participant, she stated that not everyone at her workplace knows about her personal history, so she would not be introducing me to anyone when I came…At the end of the interview, she asked me if I would like to see the facility, and then backtracked, wondering aloud if that would be a good idea. I said that, yes, I would be interested, but that I would leave it to her to decide what was best. She pondered aloud about disclosing to staff there why I was there, if we ran into them during the tour. She suggested we revisit this at our next interview, and we agreed on this (Field note, March 10, 2010).

3.4.2.4 Reflexive journal. Consistent with the qualitative research genre, I wrote frequently in a reflexive journal. Reflexive journal writing was a strategy for helping me critically examine my contributions to shaping the data and the emerging findings in order to enhance the trustworthiness of the findings (Hall & Callery, 2001) (this aspect of the reflexive journaling is discussed later in the chapter). However, it also provided a data source, a notion
consistent with embracing subjectivity within the constructivist-interpretivist paradigm of science (Morrow, 2005). The text in my reflexive journal contributed to the dataset in terms of my subjective observations about participants. It also suggested additional elements for the study’s design. As an example, I wrote the following after my first interview with a participant:

Something endearing to me was that she wryly confessed to me a tacit, strong desire to convey to me that she is over the ED and can work in the field. I very much appreciated that aspect of her noticing and being honest about something of her own process in the interview (Reflexive journal, March 8, 2010).

During the data analysis phase, this excerpt was considered as potential contributing evidence to the category of therapist self-awareness. Moreover, it prompted me to move beyond the content of participants’ ethics experiences to considering the interview process itself as data, and to incorporate an analysis of that data. The participant’s disclosure also suggested to me that there might be influences on participants’ verbalizations about their ethics experiences that might not be manifest. Thus, I was also prompted to include in all the second interviews questions asking participants about their intrapersonal processes regarding the interviews.

3.4.3 Data Analysis

The analytic process in interpretive description should generate a product within Sandelowski and Barroso’s (2003) taxonomy of qualitative findings that represents a ‘thematic summary,’ or, preferably, a ‘conceptual/thematic description’ such that patterns in the data are identified through analytic and interpretive processes (Hunt, 2009; Thorne, 2008). However, interpretive description does not provide a step-by-step recipe for data analysis. Rather, analysis is characterized by a balance between broad prescriptiveness, and creativity and flexibility (Thorne et al., 2004). For example, broad prescriptive elements include engaging in inductive analysis, concurrent data collection and analysis, and constant comparative analysis. Furthermore, broad analytic questions are employed, such as: “Why is this here?”, “Why not something else?”, “What does it mean?”, and “What is happening here?” rather micro-coding.
small segments of data. As per inductive analysis, the initial analytic focus in this study was on specific observations about participants’ ethics experiences, which then moved towards broader generalizations (Thorne, 2008). However, as the researcher, I needed to select appropriate analytic strategies to answer the research question and fulfill the purposes of the investigation (Thorne, 2008; Thorne et al., 2004).

To help me structure and organize the analytic process, I drew on Morse’s (1994) cognitive processes of data analysis as an overarching framework. These four sequential processes are comprehending, synthesizing, theorizing, and recontextualizing. In my study, I conceptualized these processes as corresponding to two stages of meaning making regarding the data: Stage 1 (describing: comprehending and synthesizing) and Stage 2 (interpreting: theorizing and recontextualizing). Within each stage, I employed analytic strategies that helped me undertake the cognitive processes therein. While Morse’s taxonomy added clarity to my analytic process by helping to organize and sequence my data analysis activities, the progression was, in reality, sometimes non-linear, iterative, and/or overlapping. Throughout the analytic process, I met regularly with my research supervisor (and communicated by e-mail) to discuss ideas about themes and patterns emerging in the data. I also met (less frequently) with my other committee members to discuss analysis and emerging patterns and themes.

3.4.3.1 Stage 1 – describing. I viewed the first two processes in Morse’s (1994) cognitive processes sequence (comprehending and synthesizing) as corresponding to Stage 1 of analysis in my study, which was characterized by analytic activities that aimed to produce a coherent, conceptually organized description of what were the ED-historied therapists’ ethics experiences. Within Stage 1, I took two distinct angles on analyzing the data: (1) analyzing manifest content regarding what participants identified as their ethics experiences, and (2) an analysis focusing on more latent, process-oriented elements in the data with respect to what participants were saying about the research topic, how they were talking about it, and their
reported reflections on (and changes to) their practices as a result of their participating in the study.

3.4.3.1.1 Comprehending. Part one (comprehending) of Stage 1 (describing) was initiated at the beginning of data collection. At this point, I attempted to learn as much as possible about participants’ ethics experiences in their day-to-day work with ED clients. Following Morse (1994), I tried to simply absorb all the information I could about anything “remotely relevant” (p. 28) about those experiences, while withholding judgments. To facilitate these endeavors, as per Thorne (2008) and Morrow (2005), I focused on making accurate records, including audio recordings, transcripts, field notes, reflexive journal entries, and analytic memos.

Comprehending also involved immersing myself in the data for significant amounts of time so as to develop a holistic sense of the data. Activities included reading and re-reading interview transcripts (with and without audio) and, later, reviewing the first-person written accounts, in order to develop intimate knowledge of the individual cases. I also frequently reviewed the field notes and reflexive journal. Moreover, after receiving each interview transcript from the transcriber and checking the transcript against the audio recording for transcription errors, I summarized text from each transcript to produce a visual ‘map’ of each interview, within each case (participant), using concept mapping software (Microsoft Visio™). I arranged these maps on the walls of my research office to help me maintain my grasp on the “contextual whole” of the dataset (Thorne, 2008). Following Morse (1994), the process of comprehending continued throughout the analytic process; later, coding and note-making were incorporated into comprehending, which further enhanced my understanding of participants’ ethics experiences.

3.4.3.1.2 Synthesizing. Part two (synthesizing) of Stage 1 (describing) was also initiated when data collection commenced. I undertook a number of analytic activities that, as per Morse
(1994), facilitated a continuous process of sifting through the entire dataset (collected to date) to begin discern what was significant versus insignificant (i.e., which ideas seemed more fundamental to understanding ED-historied therapists’ ethics experiences, and which were compelling but not central to the research question). Identified and extracted were raw data in the form of meaning units (i.e., pieces of information that could stand by themselves, and that were heuristic in the sense of being information helpful to answering the research question [Lincoln & Guba, 1985]), which represented common experiences. In my view, the process of synthesizing corresponded to the analytic process described in interpretive description of moving from “pieces to patterns” (Thorne, 2008, p. 142). At this point in analysis, as per interpretive description, I avoided engaging in too-precise analyses (e.g., detailed coding) (e.g., Thorne, 2008).

Synthesizing was undertaken specifically through reviewing the interview concept maps and drawing lines within and between maps, identifying commonalities and differences among participants’ ethics experiences, and recording initial impressions of commonalities among participants’ narratives on a set of index cards. Examples of card labels included “places of vulnerability,” “examples of self-disclosure,” “contextual issues,” and “how ED enters work.” Also recorded on index cards were words or phrases used repeatedly by each participant in the interviews (e.g., “who does that serve?”, “being real”) as well as my subjective impressions regarding interview ‘undertones’ (e.g., “cautiousness,” “intense,” “self-aware”) based on participants’ verbal and non-verbal behaviours. As per Thorne (2008), I flagged in the transcripts words (e.g., “residuals”), phrases (e.g., “I didn’t think I had sticky bits,” “it’s about the client, not about me,” “parallels and ties that bind,” “I felt like I was being watched”), and other compelling units that seemed to have potential utility for theme development.

Furthermore, I extracted data representing prototypical and contrasting cases (e.g., representing more usual versus unusual types of self-disclosures), poignant (e.g., perceived
ethical mistakes) and common ethics experience examples (e.g., a stated belief that the personal ED was helpful in some way), and elements not previously encountered (e.g., encountering clients when attending 12-step groups). A document containing ‘quotable quotes’ was also initiated in this phase (Thorne, 2008). This included, for example, a striking contrasting view on self-disclosing ED history that brought into particularly sharp focus the boundaries-related question of whose needs might be being met through such disclosures.

In these ways, synthesizing occurred in a manner consistent with the broad analytic questions associated with the earlier stages of analysis in interpretive description (e.g., “What am I seeing here?”, “What is happening here?”,”What am I learning about this?”) (Thorne, 2008). Together, these activities continued to lay a foundation for my deeply understanding the dataset and for beginning to conceptualize how its parts related (Morrow, 2005).

The above activities also set the stage for identifying and describing credible themes and patterns in the dataset. In this study, this occurred first at the manifest content level and then subsequently at a more latent level regarding interview processes. To this end, following Morse (1994), I engaged in speculation, sought confirming and disconfirming evidence, and selected, revised, and discarded emerging themes and patterns. To facilitate this, I began to keep a list of potential themes and categories based on sentence stems such as “ways of” (e.g., talking about the research topic) and “kinds of” (e.g., ‘scary’ ethical experiences described). Moreover, I posed questions among cases such as “I wonder if” (e.g., some participants feel less anxious when talking about ethics during the interviews than others?), and wrote analytic memos about emerging patterns I wanted to keep track of such as “Have I seen other cases of” (e.g., participants who expressed continuing body image concerns). I also formally documented in memos provisional sets of themes and patterns (Thorne, 2008).

I then initiated a more formal coding process to facilitate my sorting and organizing of themes and patterns, testing patterns for relationships, and conceptualizing the relationships into
findings (Crabtree & Miller, 1999; Priest, Roberts, & Woods, 2002, as cited in Thorne, 2008). As per interpretive description, I avoided micro-coding words and expressions at this stage as well; rather, I coded more globally for “themes and ideas” (Thorne, 2008, p. 145). To this end, I incorporated a constant comparative analysis based on Glaser and Strauss (1967) and Lincoln and Guba (1985). In a nutshell, this involved coding, comparing, and contrasting different manifestations of ethics experiences and interview process experiences appearing in the dataset, based on “look-alikeness” or “feel-alikeness” judgments (Glaser & Strauss, 1967; Lincoln & Guba, 1985). Guiding questions from interpretive description included “Why is this different from/the same as that? and “How are these related?” (Thorne, 2000). Specifically, I compared and contrasted meaning units in the dataset, and then sorted these into spreadsheets with broad, unique themes/labels, some of which contained various subcategories. For instance, a spreadsheet entitled ‘boundaries’ contained 27 subcategories on the X axis with participants/cases on the Y axis, whereas another spreadsheet provisionally entitled ‘is history ever really history’ contained no subcategories but only meaning units, by participant.

At this point, a fellow graduate student (from a different discipline, but in the same department of the university) met with me 4-5 times to discuss data analysis strategies, as well as patterns and themes emerging in the data. On 3 occasions, I provided her with meaning units within a particular theme that I had provisionally identified (without telling her the theme) and asked her to sort them, in order to compare and contrast our ways of thinking about the data. This proved helpful, as there were similarities and differences in the way we conceptualized themes and patterns, which stimulated my further interrogating the data.

The next steps in synthesis involved my moving from “patterns to relationships,” (Thorne, 2008, p. 149) by continuing to employ constant comparison and concept mapping, and identifying the descriptions and properties of the emerging categories (e.g., “residuals” were unresolved or under-resolved aspects of the therapist’s ED history that, while not indicative of a
full-blown ED, were perceived as suggesting something less than full wellness or ED resolution). Analytic activities at this stage facilitated my continuing to probe into the data to deeply consider commonalities and differences among participants’ experiences, and to discern what might “legitimately be considered patterns and themes within the overall dataset” (Thorne, 2008, p. 150). A guiding question was, “What ideas are starting to take shape such that I think they will have a place in my final analysis, if it is to do justice to the research question?” (Thorne, 2008, p. 160). Newly identified incidents were judged with respect to whether they would represent the category properties/descriptions I had developed. Sometimes, this prompted new categories or sub-categories (e.g., developed categories of ethics experiences not associated with ED history), or a rearrangement of categories (e.g., moved “sticky bits” into the residuals category). In other cases, I modified the category description and/or properties to accommodate new incidents (e.g., including blind spots into a self-awareness category, as its opposite) (Glaser & Strauss, 1967; Lincoln & Guba, 1985).

At this point, I reviewed the theoretical scaffolding and attempted to identify weak relationships among data that required further challenge (e.g., how did being real, integrated, and self-aware relate to participants’ ethics experiences, and did these notions interrelate to one another?). I asked myself “What pieces of the puzzle am I beginning to see?” (e.g., boundaries, wellness, helpfulness of participant’s ED history as umbrella ethics experiences related to ED history) and “What do they tell me about the puzzle as a whole?” I also asked myself, “What else might be there to see and how would I know that?” For example, this latter question prompted me to think about ethics experiences too risky for participants to talk about – how might I learn about those? As a result, I included a question in the second interview in an attempt to explore this. After completing the interviews, at approximately this point in synthesizing, I decided to incorporate published, first-person, written accounts (described in the data sources section) in order to expand the dataset to include ethics experiences that had not emerged, or been co-
constructed in, interviews, and to try to access ‘outlier’ cases (Thorne, 2008).

In the quest to move “from patterns to relationships” (Thorne, 2008, p. 149), the above strategies were applied first to the manifest content in the interviews and first-person written accounts regarding therapists’ ethics experiences and then later with the second angle of vision on the data regarding interview process. This second focus for analysis was identified when I began to conceptualize the interviews themselves as being a type of “ethics experience” for the participants – not a part of the ethics terrain in their day-to-day work with ED clients, but a new, in-the-moment experience born of discussing this terrain. Thus, synthesizing activities eventually produced two descriptive accounts: (1) participants’ ethics experiences in the form of an ‘ethics terrain map’ that identified categories of ethics experiences, and the interrelationships of those categories; and (2) participants’ experiences of engaging with the research topic, constituting the ‘process-oriented’ findings. These accounts form the content of the Results chapter.

Throughout the synthesizing process, following Thorne (2008), I regularly generated dated, analytic memos that formally documented my analytic thinking and decision-making. Some were kept in an online document on a secure server, and others in a blank notebook I took with me everywhere. Topics addressed in the memos included, as examples, questions I asked myself along the way (e.g., “What are ethics experiences versus beliefs, opinions, thoughts?” [July 31, 2010] “Might I have framed the RQ more narrowly? What would have been lost? Gained?” [December 6, 2010]; hunches (e.g., “There is something brewing in my head about participants being really concerned with the helping and not harming of ED clients [September, 19, 2010]); things I learned that that surprised me (e.g., “a participant described the power held by a group of ED-historied therapists at a workplace” [October 8, 2010]); and a-ha moments (e.g., “probably none of this can be understood without understanding the perceived contexts of these therapists” [September 11, 2010]). Also included were dated thematic conceptualizations, such as the following:
Content analysis: meaning of ethics, my ED hx helps, personal responsibility (to know one's story, to have done one's work, to not make assumptions about clients/their stories/experiences), boundaries; wellness (incl. realness; residuals; wholeness as a part of wellness? i.e., integration of ED), what matters.

Latent analysis: reflexivity *(also some content); relational/social, workplace, and systems spacescontexts (incl. medical model); how does personal responsibility get fostered/facilitated? other context (perceptions of EDs field; what is recovery, moral spaces, etc.), individualistic notions of ethics, ethics of care?, safe dialogue spaces (esp. non-judgment) (excerpted from an analytic memo dated November 18, 2010).

Reviewing the analytic memos permitted me to see the analysis and findings take shape over time, with some aspects falling away and others appearing repeatedly, with some of these latter findings ‘making it’ into the final interpretation.

Throughout the process of synthesizing, I attempted to avoid several pitfalls identified in interpretive description, including premature closure (e.g., through stopping at the first a-ha moments in the analysis, creating a superficial or artificial coherence among data pieces and patterns, or fitting data too quickly into conceptualizations); misinterpreting frequency (e.g., equating frequency with importance, assuming something doesn’t exist because it didn’t appear in the dataset, or attributing more meaning to single pieces of data than warranted); and over-inscription of self, including believing I had accessed especially rich data and therefore had become an important part of the story, and self-absorption (Thorne, 2008; Thorne & Darbyshire, 2005). The last potential pitfall required constant vigilance on my part due to my being an ‘insider’ (i.e., a therapist with a personal ED history who had worked in EDs treatment), and it prompted me to continuously go back to the interview transcripts to ensure that what participants had verbalized was being represented accurately and responsibly in the analysis and interpretation.

3.4.3.2 Stage 2 – interpreting. In Stage 2 of the analytic process, which I conceptualized as consistent with Morse’s (1994) latter two cognitive processes of theorizing and recontextualizing, I engaged in a formal interpretive process in which I developed ideas
about what the description of ethics experiences that had emerged from Stage 1 analysis (ethics terrain map and process-oriented findings) might mean, with a focus on meaning for applied practice.

### 3.4.3.2.1 Theorizing

Part one (*theorizing*) of Stage 2 (interpreting) involved my experimenting with different ideas and making reasonable guesses about the meanings of the themes and patterns that had emerged to form the study’s results, in order to transform these findings into a next level of abstraction useful for informing practice. A broad, guiding interpretive description analytic question was, “What might this mean?” (Thorne, 2008, p. 49). At this point, I returned again to the theoretical scaffolding of the study in order to ask additional questions of the data, to discern how the scaffolding content might usefully inform my interpretations, and to determine its limitations in stimulating fully realized meanings that had useful practice implications (Thorne, 2008).

Specifically, this process involved critically examining particularly noteworthy results among, and interpreting patterns across, the content and process-oriented findings, keeping in mind the interpretive description goal of enhancing the ethics practices of ED therapists with personal ED histories. As examples, I made linkages across the findings that further illuminated the characteristics of the participants’ ethics experiences (e.g., myriad ethics experiences representative of many different perspectives on professional ethics); the specific ethical vulnerabilities participants seemed to experience, particularly early in career or recovery; and the potentially useful skill of ethical discernment for ED-historied therapists. The theoretical scaffolding offered theoretical concepts to anchor this process, some of which remained relevant to the study’s conclusions (e.g., elements of principle, virtue, and feminist ethics perspectives). However, I drew on other literature in psychology and ethics (e.g., positive ethics) to more helpfully illuminate and/or develop other conclusions. In this way, the theoretical scaffolding was considered, utilized, but also moved beyond as new meanings were developed (Thorne,
3.4.3.2 Recontextualizing. Part two (recontextualizing) of Stage 2 (interpreting) in the analytic process was the final step in achieving the aim of the study, which was to generate knowledge that represented a credible understanding of the ethics experiences of ED therapists with personal ED histories, one that would provide knowledge useful for guiding practice. The cognitive process of recontextualizing involved integrating the products of the synthesizing and theorizing activities (i.e., the themes and concepts/ideas contained in both the description and the interpretation), and identifying implications for practice. In this case, the contexts to which I believed the knowledge could most fruitfully and appropriately be applied were the education, training, supervision, continuing education, and self-study activities of ED-historied therapists. By way of this recontextualization, the interpreted description produced could be seen to both “support established knowledge…[and] claim clearly new contributions” (Morse, 1994, p. 34). The practice implications have been formalized as recommendations in the Discussion chapter.

3.4.3.3 Summary. An analytic process was employed that followed the guidelines of the interpretive description approach (e.g., including maintaining a ‘wide-angle lens’ on the dataset throughout the inductive analysis) (e.g., Thorne, 2008), which incorporated as an organizing framework Morse’s (1994) cognitive processes of data analysis, and that employed specific strategies (e.g., data immersion, constant comparative analysis, analytic memoing, etc.) to help fulfill the purpose of the research.

3.5 Ethical Considerations

My ethical stance towards the research process was to conduct it in a rigorous manner, so that the trustworthiness of the results was maximized, the results were maximally useful to applied practice, and participants’ time and energy were honoured (Haverkamp, 2005). Throughout the research, I endeavored to be an ethically aware researcher who adhered to the Canadian Code of Ethics for Psychologists (CPA, 2000) pertaining to the conduct of research.
However, the fluid, exploratory, interpretive, and emergent nature of interpretive description necessitated that ethical issues in this study needed to be considered over the course of the study (Hadjistavropoulos & Smythe, 2001; Haverkamp, 2005).

Major ethical issues arising in the study were: (1) the research topic appeared to be a relatively high-risk and/or emotional topic for some participants, thus necessitating consideration of risks of participant harm; (2) I had a few concerns regarding participant-client boundaries, and thus there were also considerations of risk of harm to clients; (3) I needed to decide what to do with initial ‘off-the-record’ ethics experiences that participants later stated I could include in the dataset if I wished; (4) and I needed to consider and manage pre-existing and emerging dual relationships with participants. To this end, with every encounter with participants, and in all aspects of carrying out the study, I consciously and consistently renewed my commitment to maintaining an ‘ethic of trustworthiness’ (Haverkamp, 2005). Moreover, I wrote reflexively about these situations. Each ethical concern was brought to my research supervisor (whose scholarly focus is professional ethics) for discussion. In those conversations, I engaged in ethical reasoning with her and was helped to reflect on the perceived levels of risk/harm (e.g. mild, moderate, high, imminent), to clarify my evaluations of participants’ stated supports for addressing ethical vulnerabilities (e.g., supervision), and to determine any next steps as per the Canadian Code of Ethics for Psychologists (CPA, 2000).

3.6 Trustworthiness

Criteria for judging the quality/trustworthiness of the present study were drawn directly from interpretive description (Thorne, 2008). These were epistemological integrity, representative credibility, analytic logic, interpretive authority, moral defensibility, disciplinary relevance, pragmatic obligation, contextual awareness, and probable truth. I also employed the thoughtful clinician test from interpretive description as a trustworthiness check. In addition, quality criteria for constructivist-interpretivist qualitative research from counselling psychology
literature were also identified as relevant (Morrow, 2005). These were *fairness*, *authenticities* (ontological, educative, catalytic, tactical), and *meaning* (verstehen, co-construction), as well as two pan-paradigmatic criteria for qualitative research: *social validity* and *reflexivity and subjectivity*. In my view, the second set of criteria was necessary and complementary to the first, given the location of the research as a constructivist-interpretivist enterprise within the discipline of counselling psychology.

Beginning with Thorne’s (2008) criteria, I sought to meet *epistemological integrity* through demonstrating a defensible line of reasoning, beginning with the assumptions about the nature of knowledge, and extending through to the methodological considerations that guided design and process decisions. To help achieve *representative credibility*, I attempted to demonstrate consistency between the knowledge claims I made (i.e., tentative assertions about the ethics experiences of this group of ED-historied participants, how this knowledge might best be applied) and the way in which I selected participants and studied the phenomenon (pursuit of many angles of vision and adequate variation, non-superficial engagement, and multiple data sources to increase trustworthiness) (Thorne, 2008).

I endeavored to meet the criterion of *analytic logic* by making my reasoning transparent throughout this report, from the theoretical scaffolding right through to the interpretations and knowledge claims made. To this end, I presented evidence that an inductive reasoning process had occurred such that the reader can confirm or reject its credibility (Morse, 1994). *Interpretive authority* refers to the trustworthiness of my interpretation as a researcher, which should illuminate some ‘truth’ external to my own biases and/or experiences. I sought to demonstrate this criterion by providing supporting evidence, in the form of direct quotations from participants, for the categories and subcategories of ethics experiences I identified in order to demonstrate that I did not fit the data forcibly and inappropriately into my conceptualizations (Janesick, 1994, as cited in Thorne, 2008). Furthermore, I included contrasting cases as well as
commonalities in the results, in order to illuminate individual versus shared realities among participants (Thorne, 2008).

Thorne (2009) stated that researchers in the applied disciplines should present knowledge with the understanding that others will put it to use. She argued that it is not morally adequate in the applied disciplines to generate only description, but that researchers need to make some claims about what the description might mean, otherwise others will not know what to do with it. I made efforts to meet the criterion of moral defensibility by providing a sound rationale for why the knowledge generated in this study was necessary (including consideration of the potential attendant risks and benefits to ED-historied therapists and/or their clients regarding this knowledge), and by being clear about the study’s purpose. Furthermore, when interpreting the results, I framed interpretations and recommendations responsibly, keeping in mind how the knowledge might be used by ED treatment centres, licensing bodies, professional associations, ethics boards, and by any individuals or organizations "whose purposes may not be consistent with a humanitarian health care agenda" (Thorne, 2008, p. 227). Related to moral defensibility is the criterion of pragmatic obligation, which assumes that health research findings will be applied in practice. Thus, I examined what the research findings might mean for those who will be impacted by them (e.g., most obviously ED-historied therapists and their clients) (Angen, 2000; Emden & Sandelowski, 1998, 1999). I have also attempted to generate knowledge that fits with counselling psychology’s (and other therapy-related disciplines’) moral mandates to benefit society and to provide usable knowledge (Thorne, 2008).

Disciplinary relevance was sought, meaning that the knowledge produced from the research aimed to assist in the development of science in counselling psychology and the other disciplines involved in researching and delivering psychotherapy. In my view, the research has made contributions to advancing science in psychotherapy for EDs (via the content of the findings), counselling psychology (methodology and content), and the broad domain of
professional ethics (methodology and content). Contextual awareness is based on the epistemological claim in qualitative research that new knowledge is located within the broader society, and cultural and historical locations that construct it. Thus, I aimed to present the study’s findings within context, with the understanding that "many supposed accepted realities will not easily withstand the test of time" (Thorne, 2008, p. 229). To meet the criterion of probable truth, I recognized, following Thorne (2008), that some kinds of knowledge are the best truths we have until more compelling ones emerge. I understand that no evaluation standards can possibly account fully for the representativeness of my findings in the world, or can ensure that my findings are completely valid (notions that are linked to the search for absolute truths).

In this study, the thoughtful clinician test was employed to test my conceptualizations with expert scholar-clinicians whose perspectives on, and knowledge of, the phenomenon of the ethics experiences of ED-historied ED therapists were likely to have been developed over time and with considerable experience (Thorne, 2008; Thorne et al., 2004). To this end, two high profile individuals in the EDs treatment field (both open about their ED histories) were consulted for approximately 20 minutes each, by phone, after having had time to consider their spontaneous response to my research question, and then to peruse a summary of the study’s descriptive results. The aim was to ascertain whether or not they found the findings plausible. In each interview, the clinicians stated the findings were recognizable and of value, and any surprises were also discussed (e.g., the encounters with reality TV category). Furthermore, these consultations offered me new angles of vision to consider regarding the interpretation.

The quality criteria drawn from constructivist-interpretivist qualitative research scholarship in counselling psychology also used to judge the trustworthiness of the present study are as follows (Morrow, 2005). To achieve fairness, a variety of constructions were sought and honoured in this study (e.g., multiple participants, first-person accounts). Ontological authenticity was sought by elaborating and expanding individual constructions through the
interview process. Efforts were made to meet the criterion of *educative authenticity* by enhancing participants' understandings and appreciation of the constructions of others through developing subsequent interview questions asked of all participants based on the content of some participants’ interviews, occasionally sharing the views of other participants on a subject if asked by a participant, and, ultimately, by sending a summary of results to each participant (as requested by all).

*Catalytic authenticity* (the degree of action stimulated) was evidenced in the process-oriented findings, in which participants reported reflecting on and changing their ethical practices as a result of the interviews. Related to catalytic authenticity, a degree of *tactical authenticity* was demonstrated through the degree to which participants were empowered to act to change their circumstances (e.g., a participant who brought up the issue of self-disclosure in her ethics seminar in between the first and second interviews). Regarding the quality of the meaning(s) produced by the present study, Patton's (2002) criterion of *verstehen* was aimed for through a deep understanding of participants’ meanings about their ethics experiences.

Regarding *co-construction*, Morrow (2005) suggested the degree of mutual construction of meaning and an explanation of that construction between and among researcher and participants as another quality criterion for constructivist-interpretivist qualitative research. In the present study, I discussed with participants directly the data co-construction aspect of the project in the second interview, and this co-construction has been acknowledged throughout the report.

*Social validity* is a pan-paradigmatic quality criterion in qualitative research, which refers to the understanding and enhancement of human life, and appears similar to Thorne’s (2008) moral defensibility. In this study, the aims were consistent with this criterion and the study was designed and carried out with those intentions in mind. As for *subjectivity*, as per the constructivist-interpretivist paradigm, this was embraced and considered inescapable in the study.
Reflexivity was also sought in attempting to remain aware that I was "engaged with, but still distinct from" (Fine, 1992, p. 220) my participants. Following Rennie (2004), I defined reflexivity as "self-awareness and agency within that self-awareness" (p. 183). Given the objectives of constructivist-interpretivist research, my aims with reflexivity were to be “rigorously subjective” (Jackson, 1990, p. 154) and to embrace perspectival subjectivity (Kvale, 1996). Perspectival subjectivity means that researchers adopt different perspectives to the data, and therefore will develop different interpretations of their meaning. Rather than “biased subjectivity,” which implies sloppy work, perspectival subjectivity involves elaborating meaning thoughtfully within the constructivist-interpretivist paradigm (Haverkamp, 2005)

I regularly journaled reflexively, and engaged in peer/supervisor consultation to help surface my unacknowledged assumptions, explore my personal and emotional involvement in the research topic, and my cognitive and theoretical biases, and interrogate how these shaped the study’s design, implementation, and findings. Reflexive discussion also helped me consider different angles of vision about the study’s design, analysis, and findings. These activities facilitated my decision-making regarding whether or not to, or the degree to which I would, incorporate these influences into the analysis (Morrow, 2005). Furthermore, reflexive journaling helped me identify interpersonal dynamics occurring between me and the participants (Morrow, 2005), thus contributing to the data analysis focusing on interview process. To facilitate the fair representation of participants’ perspectives, I frequently asked them for clarification, interviewed in ways that promoted deep exploration of their experiences, and attempted to maintain a stance of curious learner and naïve inquirer throughout the project to ensure my ‘insider’ status was not over-represented.

3.7 Chapter Summary

In this chapter, I described the interpretive description approach to inquiry, located interpretive description within the appropriate paradigm of scientific inquiry (constructivist-
interpretivist), presented the methodological underpinnings upon which the study was designed, described the methodological considerations relevant to the study's design, detailed the design and analytic processes, and described the criteria appropriate for judging the trustworthiness and quality of the product of the study.

In the next chapter, I present the descriptive results that were generated through analysis, followed by a chapter containing the interpretation of these results and the implications of the resulting interpreted description.
CHAPTER 4 - Results

In this chapter, I present findings that answer the research question, “For therapists with a personal history of an ED, what are their experiences of professional ethics in their day-to-day work with ED clients?” in the form of a descriptive account. The results are organized into two major areas, each containing several categories. Visual displays of these results appear in Appendix E. The reader is encouraged to consult these displays while reading the text in this chapter, for maximum clarity regarding the organization of categories, sub-categories, and sub-sub-categories. Tables detailing the sources (i.e., participant or author) contributing to each category and sub-category are provided in Appendix F. The following chapter (Discussion) offers an interpretation of these results, in order to fulfill the goals of the interpretive description approach to inquiry.

The first major area of findings presented – a descriptive map of the ‘ethics terrain’ encountered by the participants – represents a categorical organization of what participants reported about their ethics experiences in response to the main interview question (“Tell me about your experiences of professional ethics in working with eating disordered clients”), as well as throughout the data collection process. I termed this array of experiences the ‘ethics terrain’ in order to convey a sense of the ethical landscape the participants encountered in their day-to-day work.

The first sub-area of the ethics terrain was comprised of categories of participants’ ethics experiences that they did not explicitly associate with their personal ED histories. As one of the key motivations for conducting this investigation was to begin to explore and understand whether ED therapists’ personal ED histories were perceived by them as ethically relevant, a second, substantial sub-area of the ethics terrain findings categorized and described ethics experiences that participants did associate with their personal ED histories.
The second major area of the descriptive findings answered the research question from a process perspective and centered on patterns that emerged during the interviews. As data collection and analysis progressed, I began to conceptualize the interviews as being a type of ethics experience for the participants – not a part of the ethics terrain in their day-to-day work with ED clients, but a new, in-the-moment experience born of discussing this terrain. The first theme – participants’ degree of comfort with the research topic (including comfort with professional ethics and its interface with personal ED history) – emerged from my observations of their verbal and nonverbal communications when discussing the research topic. A second theme within the process-oriented findings emerged from participants’ indications that they had been influenced by, and had reflected on, our conversations. In several cases, participants had made changes in their practices.

4.1 The Ethics Terrain: Therapists’ Ethics Experiences

Throughout data collection, participants were asked to consider the main interview question: “Tell me about your experiences of professional ethics in your work with ED clients.” In direct response to this question, and throughout the interview process, they identified and described many ethical issues and challenges in their work with ED clients, as well as their beliefs and perspectives on ethical practice with this population.

4.1.1 Overview of the Ethics Terrain

The broad nature of the main interview question elicited many rich descriptions. The inductive data analytic process produced categories that are listed below in order to provide an overview of the more detailed sections that follow.

The first major grouping of categories in the ethics terrain was comprised of ethical issues encountered by participants that were not explicitly linked by them to their personal ED histories. Spontaneously described in response to the main interview question, these ethics experiences fell into the following categories: professional competence and/or scope of practice;
issues concerning client confidentiality and its limits; ED client safety and high risk ED clients; boundary issues; discontinuing therapy; ethical issues relevant to ED clients with comorbid borderline personality disorder and associated resource concerns; and reality television-related issues. The content of these categories suggested that they would be recognizable and likely relevant for ED therapists with or without personal ED histories. The categories are described and elaborated further below.

The second major grouping of categories within the ethics terrain was comprised of ethical issues encountered by participants that they did associate specifically with their ED histories. Because I paid particular attention during data collection and analysis to exploring and understanding the ethics experiences germane to the participants’ ED histories, the descriptions regarding these topics were especially rich. The following categories of ethics experiences emerged, based on participants’ spontaneous responses to the main interview question: self-disclosure of ED history and other boundary issues perceived as connected to those histories; therapist wellness regarding their ED histories; the experience and perception that participants’ personal ED histories had helped ED clients and/or the therapy process; and ethics experiences related to openness regarding therapists’ ED histories. Data extracted from the two published first-person accounts written by therapists with personal ED histories (Bloomgarden, 2000; Goldkopf-Woodtke, 2001) were included in this second major area of the ethics terrain. These categories are described and elaborated later in the chapter.

For each category and sub-category, direct participant quotations are presented for the purposes of providing evidence and illustrations. Participant quotations are considered essential in the presentation of qualitative research because participants’ actual words “persuade the reader that the interpretations of the researcher are in fact grounded in the lived experiences of the participants” (Morrow, 2005, p. 256). During the interviews, participants’ processes of reflecting on, and grappling with, the often challenging nature of applied ethics produced some
comments that may imply to the reader that participants were not always at their ‘ethical best.’ As examples, there were references to handling certain situations differently in hindsight, and some comments illustrated participants’ uncertainties regarding ethical practice. Keeping confidentiality foremost mind, I included some of this more difficult material in order to illustrate certain categories, and to capture the self-reflective process in which participants engaged and the shifts they made in later interviews.

4.1.2 Ethics Experiences Not Associated With Personal ED History

This first grouping of categories in the ethics terrain was comprised of ethics experiences that the participants did not link specifically to their ED histories. These experiences were described spontaneously by participants in response to the main interview question. Many of these categories appeared consistent with professional ethical issues that are commonly the subjects of continuing education ethics workshops and ethics textbooks (see Table 1, Appendix F, for associated data sources).

4.1.2.1 Professional competence and scope of practice. ED therapists’ ethics experiences in their work with ED clients included those associated with professional competence. Participants linked the term “competence” to various therapist skills, knowledge, practices, and characteristics such as the importance of participating in continuing education, not overestimating one’s knowledge in treating EDs, being able to assess each ED client’s particular needs and whether one possesses the competencies to meet them, and providing therapeutic services that explored underlying issues or antecedents (e.g., trauma) in addition to addressing clients’ ED symptoms. Demonstrating a deep understanding of clients’ ED experiences was also believed to be a critical aspect of competence. As one participant stated:

Competence would be feeling that you can understand what they’re going through even if you haven’t experienced it [an ED]. But at some [level of] understanding, you really get what that is (P11-2, 132-134).
This participant elaborated her conceptualization to include the therapist’s ability to use that deep understanding to challenge clients’ distorted and illogical thinking, as well as to tolerate any of her own frustrations arising from this cognitive style typical of individuals with EDs.

Consistent with accepted best practices in the EDs field, participants’ experiences of competence included the appropriate utilization of, and consultation with, practitioners of different disciplines typically involved in treating EDs (e.g., dietitians, physicians, psychiatrists, etc.). For example, a participant stated:

All the pieces are important – the dietary, the medical. You have to understand that those things are important [and] pull those things into your work. If you’re just working with somebody in therapy and they don’t have a nutritionist or a medical doctor…I don’t think that’s very good (P11-2, 139-143).

The need for a multidisciplinary approach was also referenced in the context of the edges/limits of therapists’ professional competence (i.e., scope of practice). The expertise of practitioners from other disciplines was solicited to help assess, interpret, and make recommendations regarding the myriad, non-psychotherapeutic aspects of client care necessary for helping individuals with EDs. For example, participants reported consulting with members of other disciplines about physiological and psychiatric indicators of risk.

Also regarding scope of practice was the experience of working in positions in ED treatment settings where therapist responsibilities included those typically outside of their training in psychotherapy. Participants identified these situations as requiring accurate self-assessment of their competencies to engage in these activities, as well as consultation with practitioners from other disciplines. In one case, a participant described the experience of having the final responsibility at her workplace about decisions made regarding clients’ weights, calories, and meal plans. She noted that she sometimes felt ethically uncomfortable about this responsibility, wondering “whether I’m really competent to be the one deciding what a person’s calorie increase might be” (P8-1, 895-896). Recounting a specific situation concerning a client’s
precipitous weight gain (a potentially serious physiological risk\textsuperscript{6}), and noting that she had consulted extensively about the case with members of her interdisciplinary team, she remarked:

I had the ultimate say, which scares me…I think I did the right thing, but there’s some moments when I think, “Should I be making this decision? What do I know?” Um, so teasing apart, like, how much of that is valid [and] how much of that is my own self doubt (P8-1, 910-917, 921-923).

A different ethics experience relating to scope of practice was described by one participant in private practice who was a registered dietitian as well as a licensed therapist. She perceived this dual training as necessitating ethical consideration regarding which role to adopt in any given moment of a session or phase of treatment, given that some of her clients preferred to be told what to eat rather than engage in the emotional work of therapy. She explained:

I have two hats and I can put one on or take one off. [I]t becomes a decision about what to use…[S]ome of them who want to lose weight end up in a dietician’s office…[but] they still have to step back and figure out why the feelings are translating into misusing food or hunger (P6-1, 535-537, 583-585).

4.1.2.2 Client confidentiality and limits to confidentiality. Another ethics experience that emerged that was not associated with participants’ personal ED histories pertained to issues of confidentiality and its limits. Confidentiality issues were perceived by participants as common in EDs work. This was attributed to the communication required between the many disciplines typically involved in EDs treatment, that clients could be medically and psychologically at risk, and that they were often minors. Experiences regarding confidentiality were articulated by some participants as being complex, lacking clarity, and/or as lying in an ethical “grey zone.”

A specific ethics experience regarding confidentiality concerned balancing, on the one hand, the establishment and maintenance of a strong therapeutic alliance and the protection of the privacy of the minor client, and, on the other hand, the right and/or need of parents to be informed about their child’s treatment. Describing the experience of grappling with this issue

\textsuperscript{6} When refeeding a malnourished individual, refeeding syndrome can occur. This refers to a change in fluid and electrolytes that is potentially fatal (Mehanna, Moledina, & Travis, 2008).
regarding an adolescent client in individual therapy whose parents were divorced, a participant in private practice said:

Mom and dad are asking me for information, back and forth. And this is a minor, of course, so she doesn’t have the same kind of rights to confidentiality that a non-minor has. And so I feel like I need to tread carefully with her case. I want her to trust me. I want her to be able to depend on me and not feel like I’m taking sides with one of the parents. And protecting her privacy…It’s complicated (P5-1, 274-284).

Another ethics experience concerned the approach to confidentiality and informed consent in the context of family-based therapy for anorexia nervosa (AN). A participant noted that, theoretically, this approach posits that the adolescent client cannot manage the ED on her own, requiring her parents to “take over, to help [her] through this first piece of it” (P72, 302-304). She stated:

In individual time, if they say, “I have been purging but don’t tell my parents,” that’s not one of the [limits to] confidentiality criteria. Yet, at the same time, it’s really important. So, part of my informed consent of being in family therapy with the adolescent is, “If you tell me…you are engaging in significant eating disorder behaviour, it is important for us to bring that up with your parents. I encourage you to be the one that does that, but if you don’t, I will” (P7-2, 289-295, 301-304).

Another participant described experiencing “mental gymnastics” regarding confidentiality and its limits when considering an ethical course of action in the case of an adult client who had disclosed serious ED behaviours to her, but had purposefully withheld that information from her physician, psychiatrist, and husband.

The potential to breach client confidentiality when employing real-world, behavioural exposure interventions of potential benefit to ED clients was another ethics experience relevant to this category. For example, a participant reported that, as part of the therapy, she might accompany an ED client to a restaurant or grocery store. Expressing some unease that other professionals might have concerns about this practice, she stated:

I guess [it] might be seen as, um, ethically questionable since, if I’m out in public with somebody – is that, is that, um, breaching some aspect of confidentiality?...I do take confidentiality very seriously with my clients (P5-1, 259-263).
Other ethics experiences associated with confidentiality and its limits were related to the scope and depth of inter-professional communication. For example, anxiety was expressed about ED clients’ risky behaviours (e.g., comorbid substance dependence, working in the sex trade) that were not immediately life-threatening. The non-life-threatening aspect seemed to contribute to a lack of ethical clarity about contacting other professionals regarding those behaviours. One participant in private practice stated:

I have a client who is…substance dependent. And I’m, like, should I be calling the doctor? Should I be calling the police? You know, it’s not at the point where she’s threatening her life. But it’s that grey zone of ethics (P3-1, 339-345).

Illustrating another angle on ethical decision-making regarding inter-professional communication was the experience of gauging how much detail to provide interdisciplinary team members regarding the client’s work in therapy. While close collaboration on interdisciplinary teams was considered by participants to be helpful for effective treatment planning, problems could arise when non-therapy staff inappropriately discussed with clients information that had arisen in therapy, thus potentially undermining the quality of the therapy relationship. Noting that all disciplines did not equally “have the same kind of foundation and understanding of what to do with that information” (P7-2, 347-348), one therapist stated:

[I]t’s ethical in that…we’re all under the same [confidentiality] umbrella of [facility name]…But then there’s this ethical piece of really trying to say the minimum, yet at the same time enough so that we’re all working together in the patient’s best interest (P7-2, 249-254).

4.1.2.3 ED client safety and high risk ED clients. Ethics experiences related to client safety and the physiological and psychological risks frequently present for ED clients emerged as another category in the participants’ ethics terrain. These experiences frequently involved the therapist’s ability and confidence to accurately judge when clients’ ED thoughts, feelings, and behaviours crossed a certain threshold of risk into the life-threatening category (hence becoming indicators of medical and/or psychiatric instability). For example, one participant remarked:
At times during the course of our work, [the client] has become quite unwell. Um, and that – oh gosh – talk about ethical dilemmas – you know, at what point, um, you know, would you construct this as suicidal behaviour? And she’s able to make reasoning decisions and [yet] putting herself at risk (P2-1, 882-885).

Another participant expressed anxiety about a client who was “in really dangerous places, and her potassium [was] in her boots” (P4-1, 877-878), and reported consulting with medical and psychiatric professionals about the client’s degree of risk. The participants who discussed client safety and risk identified interdisciplinary consultation as a critical component of these ethics experiences.

4.1.2.4 Boundary issues. Boundary issues not perceived as being associated with a personal ED history emerged as a category of ethics experience. Participants described more generic boundary and dual relationship situations (i.e., not specific to a client having an ED), such as being attracted to having a friendship with an adult client but not acting on it. However, other boundary issues more specific to working with ED clients were also reported, including ethical challenges surrounding therapists’ responsibility to facilitate client change. Given the ambivalence about recovery demonstrated by many ED clients, and the documented strong feelings and behaviours elicited in health care providers in response to this and other challenging ED client characteristics (e.g., Beumont & Vandereycken, 1998; Williams and Leichner, 2006; Zerbe, 1998), it was unsurprising to hear that participants engaged in ethical reflection on whether it was beneficial for clients to be working ‘too hard’ for, or ‘harder than,’ them. One participant discussed this issue in the context of her efforts to develop self-knowledge regarding how and why she might be contributing to this dynamic. She stated:

It’s a bit – it’s somehow about me wanting to help rather than [about] them. But what’s actually helpful, and being clear on a boundary…I’ve had to learn about that…And kind of hitting another layer of what are [my] identity issues around ‘am I a good person if I’m not good at my job’ kind of thing. And teasing those things apart. (P4-1, 725-727, 749-751).

7 Depleted potassium can result from purging, and can lead to potentially fatal irregularities of the heart rhythm (American Psychiatric Association, 2006).
She noted that working ‘too hard’ for ED clients was a frequent topic of team consultations at her workplace, saying: “[I]t’s been years of learning [and] listening to colleagues, and hearing them talking about, ‘Well, who’s working harder here?’” (P4-1, 733-734).

Other boundaries-related ethics experiences in daily work with ED clients were associated with particular work contexts, and/or the accepted practices and philosophies of those contexts. Participants who worked in residential treatment settings reported that this intensive treatment milieu had forced them to think and act with greater clarity around boundary issues than had been required in other settings where they had worked with ED clients. Heightened relational intimacy with clients in residential EDs treatment was perceived by participants to result from several factors, including: clients living full-time at the facility, often for extended periods of time; therapists engaging in non-formal-therapy contact with the clients within the treatment milieu (e.g., recreational activities during clients’ free time, meal support and/or post-meal observation, outings, celebrating birthdays, etc.); and therapists providing multiple therapy sessions per week to each of their clients. As a result, boundary issues in these settings were seen as particularly numerous and salient, necessitating continuous discernment and assessment of the potential benefits and harms to clients. Describing her experience of this as a balancing act between forming/maintaining connections and preserving helpful boundaries with clients, a therapist explained:

It is a more constant need to be interactive with these women on a 24-hour basis, and yet still maintaining a boundary where you can keep your objectivity, and set firm boundaries, and enforce rules and have expectations of them in a way that they can respect you and relate to you, all at the same time (P9-1, 1048-1052).

Therapists working in residential treatment centres experienced asking themselves many practical and ethical questions concerning boundaries, such as whether staff members’ or the facility’s automobile would be used on outings, whether the facility or the clients paid for outing activities, and whether clients received birthday cards from staff (and, if so, who purchased it
and gave it to them). Reflecting on the types of boundary questions that consistently arose in such a setting, one participant stated:

Every day there’s just stuff, because they live here and you’re with them all the time. And you build relationships with these women, and so it’s constantly happening, I think, to just say, “Is this benefiting the client?” and “What is the therapeutic rationale for this?” Um, “How do we best support their recovery?” And, “How do we keep boundaries in that?” (P9-1, 871-876).

Working in intensive ED treatment contexts appeared to increase therapist awareness of, and alertness to, ethics and boundary issues, which was considered a valuable ethics learning experience. As one therapist stated:

Working with eating disorders here has made ethics – we have to be really – like, it can be fuzzy a lot of the time. It can be fuzzy anyway, but I’m kind of grateful for having this experience early in my career because I think it will make me more cognizant and on my toes about things (P8-2, 1288-1292).

The accepted practices and philosophies of a treatment setting also seemed to prompt particular boundary-related situations, to which therapists responded by considering their discipline’s ethical obligations in conjunction with workplace norms. For example, one participant reported that, at her workplace, staff engaged in various forms of post-treatment contact with ED clients (e.g., weekly ‘alumni’ support groups, a “contact us any time” policy, and post-program surveys). She recalled an instance in which a former client had requested that she meet her for a meal in the community. After much consideration and consultation with colleagues, she and the client had driven separately to a café, met during the therapist’s work hours, and the therapist had “reported back” to colleagues afterwards. She described part of her rationale as an attempt to be consistent with the program’s approach of “modeling [to the client]…this is what people do in the world” (P8-1, 543). She stated:

In any other context, I would have said, “No.” Like, absolutely not. But I went and had dessert with her. And I was thoughtful about it, in the sense that I would want it – like, I don’t – hm – it didn’t feel inappropriate to me because it is part of what we do here (P8-1, 345-348).
Another boundary-related ethics experience that required taking into account the cultural norms within a treatment setting as well as professional ethical obligations, was client-therapist hugs. Ethically, hugging was described as being an issue of fairness (i.e., treating clients alike regarding equal distribution of hugs, particularly given the intense social comparison amongst ED clients) and potential help/harm to clients (e.g., by showing/withholding care, crossing the physical boundary). One participant explained in the second interview that she had hesitated in the first interview to bring up hugging practices at her workplace out of concern that I, or anyone else reading the research findings, would think it ethically questionable. She reflected on her own discomfort with hugging clients while acknowledging that giving hugs was an expectation in her milieu. She stated:

[E]verybody hugs [here]. [I]t’s just in the language of this facility. And it’s a very warm place…But it’s still odd to me…I don’t see myself doing it in another venue. Like, if I were to leave here and go back into private practice again, I wouldn’t do it. And why do I do it here? (P9-2, 78-80, 82, 90-92).

A final experience that emerged regarding contextual influences on boundary issues was that accepted boundary practices in certain work systems or settings were perceived as being incompatible with the therapist’s chosen theoretical orientation. This prompted ethical reflection on reconciling these different perspectives – the setting’s versus the therapist’s – regarding how to best help and not harm ED clients. For example, one participant said:

[T]he ethical dilemmas mostly for me come up around the beliefs of our system around what good boundaries look like between therapist and client…[For example, self-disclosure] is a tool in a toolbox that they will bring out…versus joining someone on their journey. It’s different…I believe in working that way in a system that I don’t believe sees it that way (P10-1, 1592-1595, 1604-1605).

As a result, decisions had to be made regarding how a therapist would choose to work within the context (e.g., adopt the accepted practice or, as in the case above, maintain one’s preferred practice).
4.1.2.5 Discontinuing therapy. Another emergent category of ethics experience involved therapists grappling with the question of when to discontinue therapy. This question arose either in response to clients’ ambivalence and/or apparent lack of motivation to recover, or when clients became too cognitively impaired due to nutritional deficits to receive benefit from talk therapy. Such situations prompted participants’ ethical consideration of concepts such as resource allocation, fairness, and truthfulness in EDs treatment. For example, they reported encountering ethical dilemmas regarding clients who were acutely ill but who did not participate fully in treatment. One participant described trying to help/prevent further harm to an at-risk client while considering that already scant resources were being tied up with such clients who engaged in treatment only sporadically. She recounted:

It’s a story that’s told over and over again: working in an outpatient centre and there’s one woman who’s severely medically compromised – anorexic, purging subtype. [She] will…set up an appointment, and she won’t show. And then, “I’m sorry, I’m sorry, I forgot, dadada, I’m sorry, I’m sorry.”… [A]t what point does that get kind of enabling?…[T]he resources we have are really limited, because every time you tie up [a timeslot] – but when you have somebody who’s medically ill, you can’t [ignore that] (P1-2, 720-733).

The question of discontinuing treatment was also considered when a client was too cognitively impaired due to starvation to be able to engage in therapy. One participant acknowledged the lack of benefit offered to clients in these situations, and the need for the therapist to be truthful with herself and the client about this. She stated:

[W]ith low-weight anorexics, at what point do you stop providing therapy service? Because at what point do they not have the cognitions to absorb anything you’re saying in any kind of meaningful way? And at what point are you creating the belief that you are providing service when actually their needs are very different?...They need medical intervention (P2-1, 870-877).

4.1.2.6 Clients with comorbid borderline personality disorder. Encountering ED clients with borderline personality disorder (a comorbidity amongst some individuals with BN⁸)

⁸ Associations between BN and Cluster B personality disorders (particularly borderline personality disorder) have been reported (e.g., Skodol, Oldham, Hyler, Kellman, Doidge, & Davies, 1993).
emerged as another category of ethics experiences. For example, particular care was taken to establish and maintain firm boundaries with these clients, who were perceived to test and cross boundaries, distort information, and who were viewed as a “chronic, longer term, harder-to-handle” sub-group of ED clients (P4-1, 786).

In addition, resource issues were associated with borderline clients such that these clients were perceived to be underserved. For example, these clients were observed by one participant to wait longer on an ED treatment centre waitlist than clients without a borderline diagnosis. Ethical discomfort was expressed by this participant in response to these circumstances. She said:

[E]thically, I have felt, at times, oh my gawd, these are, like, lost-soul people…and yet our program is overwhelmed with [other clients]...[We’ve started] saying, “Okay, what’s our policy?”...[And] no matter what…if they’re 6 months on the waiting list, somebody has to pick them up. We’re not having rigid boundaries, saying, “Well, they’ve got a florid personality disorder, so they have to go somewhere else first before they can come here” (P4-1, 786-791, 805, 818-819, 826-828).

This participant noted that one such client she had seen briefly had died by suicide, after ‘falling through the cracks’ of the broader mental health system.

4.1.2.7 Encounters with reality television. Communications with television networks about participation in reality television shows about eating disorders emerged as a final category of ethics experience in the ethics terrain not associated with therapists’ personal ED histories. Participants expressed ethical qualms related to their own participation, or to the involvement of clients, in activities that were perceived to be incompatible with basic ethical principles and the ethics codes of their professions. Educating network staff about professional ethics was also reported. Expressing mixed feelings about becoming involved in such a show (potentially a career opportunity, but ethical concerns emerging), one participant described the following:

[They] said, “Can we film you interacting with a client?” And I said, “Absolutely not. Any therapist who tells you that they would, I’d have some concerns about them.” The ethical requirements...are very strict...I wouldn’t ask any of my clients
if they would do that for me, because it says very clearly in the code of conduct that you don’t ask your clients to do favours for you…[It’s] a misuse of the power (P5-1, 808-815).

Another therapist described having been approached by a television network to refer her former clients to a reality show. Expressing ethical concerns that clients would be exploited and harmed by participating, and her disgust at the sensationalizing of the suffering of individuals with EDs, she said:

[I]t feels very freak show…And just another example of not understanding that it is mental health and that it is painful…That it’s not just this funny diet…but that it’s about deeper pain that’s coming through the food, and histories of abuse…[T]hey want [people] to break down crying on camera, so that’ll raise their ratings, but ultimately, it’s about selling commercial time. It’s not about helping (P6-2, 499-510).

4.1.2.8 Summary. In response to the main interview question, participants spontaneously described a variety of experiences, perspectives, and beliefs that were not explicitly identified by them as associated with their personal ED histories, and which aligned well with common professional ethics topics. This area of the ethics terrain included professional competence and scope of practice, client confidentiality and its limits, ED client safety/risk, boundary issues, considering when to discontinue therapy, ethical issues pertinent to ED clients with borderline personality disorder, resource issues, and encounters with reality television. Among these findings was evidence that many of these experiences provoked ethical discomfort or unease (sometimes due to the perceived “grey zone” of the situation), and practitioner consideration of potential helps and harms to clients. Furthermore, workplace context seemed to exert an influence on several types of ethics experiences (e.g., how boundaries and confidentiality were handled).

4.1.3 Ethics Experiences Associated with Personal ED History

The second major grouping of categories in the ethics terrain is comprised of experiences and beliefs that the participants indicated were associated with their personal ED histories. Major
categories that emerged were boundary issues, therapist wellness, helpfulness of the therapist’s ED, and openness regarding therapists’ ED histories. Each of these categories contained sub-categories of ethics experiences or other seemingly important conceptual elements. As one of the key aims of the study was to understand participants’ perspectives on whether and how their personal ED histories were ethically relevant in their work with ED clients, particular attention was paid during data collection and analysis to this area of the ethics terrain. Thus, the findings presented in the following sections are especially substantive. Tables showing the data sources for each category and sub-category appear in Appendix F (Tables 2 to 6).

4.1.3.1 Boundary issues. Boundary issues in therapy emerged strongly as a category of ethics experience associated with therapist ED history. These were described spontaneously by all participants but one in response to the main interview question. One participant succinctly stated that, at the most basic level, boundaries with ED clients meant that, “I know that I am me, and I am separate from them” (P10-3, 125-126), suggesting the fundamental relevance of concepts such as sameness and difference, separateness and connection, and self and other. There were several sub-categories of boundaries-related ethics experiences, detailed below. First, however, a few general findings related to boundaries are presented.

Generally speaking, boundaries were perceived by participants to function as a dividing line between the therapist and client who share a history of an ED, and as means of safeguarding and serving the client regarding that shared history. Establishing boundaries that were therapeutic was asserted to be the responsibility of the therapist, and that boundaries should serve clients’ best interests. One rationale offered for taking particular care to establish and maintain appropriate boundaries with ED clients was that individuals with EDs were perceived as having poor boundaries. This suggested that therapists with personal ED histories with unaddressed boundary issues of their own might need to attend carefully to safeguarding the vulnerable boundaries of their ED clients. Several participants made spontaneous statements
about boundary difficulties in their families of origin (such as parents who were “dominating and controlling,” did not respect privacy, or were perpetrators of sexual abuse).

Certain boundary errors reported as ethics experiences suggested that ED-historied therapists may encounter particular challenges with therapy boundaries early in their careers and/or personal recovery processes. For example, describing her first few years of therapy practice when the ED had been more recent, one participant stated:

You make a lot of mistakes…[Y]ou just keep talking because you think you have to, and my boundaries weren’t there either…the field draws in helpers, you know, wounded helpers…And so we have a hard time saying no and drawing boundaries and dealing with conflict…So, somebody can get in too far (P6-1, 472-493).

Another participant whose ED recovery journey had begun relatively recently compared to the others’ expressed feeling presently vulnerable about therapy boundaries. She reported accessing ongoing supervision and mentorship relevant to this topic. Referring to using self-disclosure, she remarked:

I try out a boundary situation and sometimes I feel uncomfortable…so I don’t have it all together…I can’t always practice it the way I want to because I’m just not that developed yet…I do grapple with it a lot (P10-1, 1727-1732; 1735).

4.1.3.1.1 Challenging assumptions of therapist-client similarity. The first sub-category of ethics experiences related to boundaries and therapists’ personal ED histories involved recognizing and challenging assumptions of similarity between therapist and client ED stories. Ten of the 11 interviewed participants, as well as writer Goldkopf-Woodtke (2001), stated a close variant of the statement “everybody’s ED experience is different.” Adequate self-knowledge was deemed necessary for addressing any false assumptions of similarity. As one therapist stated:

[A]n ethical issue [is] knowing myself enough to know that my experience isn’t the only one, and that I can’t guide my practice based on what worked for me personally (P10-2, 281-283).
Participants described many ways in which they perceived their clients’ ED experiences to be different from their own (e.g., in terms of how the pain and suffering of an ED was experienced; solutions for and paths through/out of the ED). One participant whose therapy practice website states her ED history explained that she is transparent with clients about acknowledging such differences. She commented:

I make a standard statement that everybody’s experience is different…There’s some underlying similarities when one lands on an eating disorder as a method of coping. But I don’t want to make anyone who I work with feel like, “Oh just because I’ve been through it, I know who you are.” I still need to get to know you (P5-2, 35-40).

Ethical reasons offered for examining assumptions of similarity related to minimizing potential harms resulting from misunderstanding clients’ experiences, and to the content and direction of therapy being based inappropriately on the therapist’s ED experience. As one participant said:

[T]here will always be the danger of thinking I understand what they’re talking about when I don’t. Because it’s their eating disorder, not mine. That’s a huge danger in having recovered (P6-1, 1138-1142).

Participants stated that unexamined assumptions of similarity risked the inappropriate imposition of those assumptions on clients. This was perceived as “counterproductive” or otherwise unhelpful, or potentially harmful to clients’ recovery. Examples provided by participants were that clients might quit therapy due to unmet needs, or might acquiesce to the therapist’s needs for similarity by attempting to fit their ED stories to the therapist’s ED story. Both examining assumptions of similarity and recognizing differences were believed by participants to be fundamentally respectful of the client and to foster clinician humility, and were viewed as helping practitioners monitor their expectations regarding the speed or direction of client recovery that might be based inappropriately on the therapist’s personal ED recovery story.

Another ethics experience related to therapist failure to examine assumptions and respect therapist-client differences concerned the therapist’s loss of objectivity. Specifically, “overly
relating” to the client, an “intermingling” of their issues occurring, and “countertransference”
were identified as concerns due to their potential for inviting unhelpful or harmful boundary
crossings. In one example, a participant expressed having strong reactions to clients who, similar
to her own ED experience, displayed a disconnect between the “hell” of their intrapsychic lives
and the put-together exteriors they presented to the world. Describing her reactions and impulses
towards such clients, the therapist said:

[T]hey are really doing some nasty, self-destructive stuff. And then, you know, the
denial and splitting themselves...I guess in terms of countertransference, um, I can
identify having ‘been there done that,’ kind of thing and – but I think, you know, I
know this is bad (laughing), I can’t shake them and say, “Stop doing that!” (P3-2,
953-962).

A related experience reported was observing and/or negatively judging other
practitioners’ behaviour perceived to be problematically over-identifying with clients. In one
case, a participant described her ethical concerns about a colleague’s behaviour and its potential
impact on treatment effectiveness. She stated:

[She] was always a cheerleader for the client because she...had that history...She
always sided with the client when it wasn’t always appropriate...Like, the client is
telling you something and you believe everything...Or, just not really putting the
stops where they need to be put because you can just really relate, because you were
in those shoes, too...[E]veryone’s different, and you can’t use your experience to
generalize (P11-3, 120-123, 127-130, 139-140).

In general, when such observations and negative judgments were disclosed by interviewees –
often with expressed discomfort – they seemed to be used as guideposts for how participants did
not want to practice.

4.1.3.1.2 Centralizing the client’s ED experience. The second sub-category of ethics
experiences that emerged regarding boundaries and therapists’ personal ED histories involved
centralizing the client’s ED experience in therapy, not the therapist’s. All 11 interviewees stated
that therapy was “about the client, not about me” or a close variant of this phrase. Adhering to
this guideline was believed to be the therapist’s ethical responsibility. Furthermore, it was
identified explicitly by one participant as a key aspect of professional competence. On the surface, “it’s about the client, not me” sounded clichéd. However, it seemed to flow conceptually from recognizing and respecting client-therapist separateness and differences, as per the findings presented above. Furthermore, that all the interviewees spontaneously stated a version of this phrase suggested that it may be particularly significant in some way for therapists who share an ED history with their clients (e.g., perhaps representing an acknowledgment of certain vulnerabilities regarding identity or balancing connectedness and separateness in therapy).

When describing what was meant by therapy that centralized the client, participants cited terms and phrases such as therapist “attunement,” “presence,” “keeping focused on [the client’s] psyche,” and being “mindful” of “biases” that had arisen from their own experiences. It was also asserted to mean that therapists did not add to their ED clients’ burdens through the care they provided. For example, one therapist’s explained:

[It means] keep[ing] the framework of the therapeutic relationship so that they can do the work they need to do without worrying about me…Just, really, the focus can stay on them” (P9-3, 112-116).

Meeting one’s own needs in therapy by bringing in and/or attempting to deal with one’s own unresolved issues (including those issues outside one’s awareness) was viewed as the therapist inappropriately centralizing herself. Reported as specific ethics experiences in this vein were participants engaging with an ED client in a friendly way that was based more on the therapist’s unmet needs in relationships, and the desire to “jump in and save” and “overprotect” clients, and remove their pain (Goldkopf-Woodtke, 2001, p. 161). In a compelling example, one participant described characteristics of her family of origin that she associated with the development of her ED. She reported her efforts to maintain awareness regarding how her own need to be heard could enter therapy. She stated:

I was a very internal, ‘I don’t have needs’ kind of child. [It’s] probably part of the reason I was in therapy as long as I was because I liked being heard. I just want to make sure that it [therapy with clients] is not about that…Alice Miller talks about
children who have very good-intentioned parents, but are really narcissistic extensions of them. And so I very much want to make sure that when I’m [saying] something, it’s not for me, that it’s really for the client because I don’t want to repeat that stuff (P8-1, 785-788; 800-803).

Several participants noted that while a therapist’s own ED history could not be undone, ethically it needed to be recognized and “bracketed,” or otherwise managed appropriately, in order to continuously centralize the client, thus enabling the therapist to stay true to the purpose of therapy. One participant described making efforts to both acknowledge her history and keep it out of the way when working with clients:

> [W]hen I’m there with an individual, on some level, we’re just two people talking in a room…But at the same time, the conversation is about them... and it’s important for me to...[be] able to bracket something that might be more to do with me, yet at the same time not going with the blank slate or the idea of, that I’m completely able to – there’s - there’s no divor – I can’t divorce myself *(laughing)* from myself! (P4-3, 139-176).

Noting the impossibility of being unaffected by ED clients and their stories, another participant asserted:

> [T]here’s one saying where, “It’s not about you, it’s about them,” right? But then, of course, we’re all affected...Everyone. So, it might affect you, but that’s not the purpose...That’s not what we’re doing here. It’s not about you (P11-2, 1153-1163).

Implied in these examples was that self-awareness about one’s history and the ability to separate that history from clients’ experiences, without erasing it, informed the establishment and maintenance of boundaries and the centralization of client needs that helped fulfill the purpose and ethical obligations of therapy.

A slightly different angle on centralizing clients concerned experiencing ethical qualms about other therapists with ED histories who engaged in more public types of behaviours that were perceived to be centralizing the therapists’ needs (e.g., for money, acceptance, validation). For example, one participant tentatively described experiencing ethical disquiet about colleagues in her community who regularly and publicly self-disclosed their ED histories. She remarked:
I can’t be comfortable with that…I wonder about who is that serving? I think I probably would be very careful that it can’t come from my need to want to be accepted by this group of people...And, it’s, um, yeah I - I don’t know, I just think great care needs to be taken (P1-1, 788, 797-798, 804).

4.1.3.1.3 Self-disclosing personal ED history. A third sub-category of ethics experiences pertaining to boundaries and therapists’ personal ED histories that emerged strongly was self-disclosure of personal ED history. In response to the main interview question, 10 of the 11 interviewees spontaneously identified this as an ethics experience. The eleventh therapist, when asked in the third interview about her self-disclosure practices, stated that she had disclosed her ED history to clients infrequently. Of the 10 participants who spontaneously identified self-disclosure as an ethics experience, 9 practiced it to differing degrees and one did not use self-disclosure. However, whether or not participants disclosed their ED histories to clients, they all reported considering the ethical dimensions of why/why not disclose, what to disclose, and/or how and when to disclose it.

Due to its high rate of initial endorsement, the practice of self-disclosure was explored in considerable depth during the interviews. Immediately following are more general findings regarding the therapists’ experiences of self-disclosing ED history (e.g., frequency). Subsequently presented is a more detailed description of several aspects of this experience, including participants’ ethical considerations regarding the use of self-disclosure, as well as associated ethical challenges, errors, and regrets experienced. That self-disclosure was mentioned specifically in the study’s advertising and consent materials as an example of a potential interview topic likely contributed to its ubiquitous presence in the data. Nevertheless, it was discussed energetically by participants, which contributed to the substantial richness of these findings. It was also the most reflected-on practice by the participants between their first and second interviews, as discussed later in the chapter.
Participants who disclosed their ED histories to clients reported doing so with varied regularity, ranging from “a handful of times” over an early career, to “occasionally,” to advertising recovery from an ED on a private practice website, and frequent use in sessions. About half disclosed their ED histories to clients without being asked, while others did so only if asked directly by a client, “Have you had an ED?” Both groups rationalized their respective stances on the ethical basis of offering benefit to clients. For example, waiting to be asked directly was asserted to be a way of helpfully maintaining the focus of therapy on the client’s issues and journey. Conversely, volunteering information about one’s ED history was viewed as benefiting the client by modeling non-shame about having had an ED, inviting clients to talk in more depth about their experiences, or introducing a “teaching moment” regarding a skill.

Clients reportedly expressed their curiosity about the therapist’s ED history in many indirect ways (e.g., asking “Why did you get into this work?” “Is this just a job for you?”), which necessitated continuous ethical decision-making in order to provide the most maximally beneficial and least harmful responses. One participant described working in a setting in which therapist self-disclosure of ED history was not an accepted practice, and in which clients also seemed to adhere to this implicit norm, thus rendering self-disclosure a non-issue in the milieu.

Explained the participant:

[I]t was the culture – “Well, if nobody else is asking this question and nobody is answering this question, clearly we [clients] are not supposed to ask” (P9-1, 805-807).

4.1.3.1.3.1 Lacking guidance or preparedness. One aspect of the experience of self-disclosing ED history was lacking guidance and/or preparation in its use. For one therapist, the ethics codes’ lack of explicit directives was perceived to require a more “personal” or “clinical” approach to ethical decision-making. She stated:

When I envision the…code of ethics in front of me, nowhere in there does it tell me: ‘Don’t tell the client about yourself unless it’s clinically relevant.’ But I know that,
and that’s kind of the basis of how I decide what I share and how I share, and maybe
it’s a personal ethic, or clinical, as opposed to legal or professional (P8-1, 577-582).

The desire for more theoretically- and empirically-based ethical guidance regarding the use of
self-disclosure was also expressed. A therapist remarked:

I think having some kind of decision-making model [would help]. Like, how do you
think through this issue? There are decision-making models for other ethical
issues…I was just reading one for dual relationships. So there are people who are
doing research, writing theoretical articles, basing it on examples (P7-2, 471-476).

In addition, there was an expressed need for outcome research on therapist self-disclosure of ED
history that would help ED-historied therapists better understand the potential ethical benefits
and drawbacks of this practice. Also desired were studies investigating the perspectives of clients
regarding the impact(s) on them of their therapists’ disclosures of ED history. These types of
investigations, participants said, could help inform therapists about the potential ethical
consequences of disclosing their ED histories.

Regarding lack of preparedness, some participants described having been unprepared for
how to ethically think through and/or respond to clients’ questions about their ED histories. They
described having had few opportunities to carefully consider how to react to these situations and
the potential impact(s) on clients of their responses. For example, one recounted a situation when
working in an EDs treatment centre:

That first week, [a client] asked, “Do you have an eating disorder?” and that sort of
caught me off guard. Apparently they ask everybody, but I didn’t know that was
going to come up. And I said, “Yes.” And I – and I remember I was kind of – kind
of uncomfortable because I was so off guard. I didn’t know what I was going to say
(P11-1, 271-278).

Another angle on lack of preparedness was provided by Bloomgarden (2000), who wrote about
her attempts to actively avoid engaging with the self-disclosure issue when running an ED group
for adolescents. She stated:

I decided not to make a decision ahead of time – I would play it by ear. Perhaps the
clients would never even ask me, I thought, so why worry now? If it became
important to reveal my experience in order to help clients, perhaps I would do so. But, I secretly hoped not to be put in that dilemma (p. 348).

She noted that questions about her history did, in fact, arise in the group, necessitating that she make ethical decisions regarding how to respond and, ultimately, whether she felt she could continue to run the group.

Norms appeared to play a substantial role in the type of guidance received at the workplace concerning self-disclosure of ED history. The accepted practices were sometimes implicit (e.g., “[It’s] not written anywhere…It’s just really, truly the culture” [P9-2, 226-227]), and sometimes explicit (e.g., “[W]e don’t prohibit [new staff] from sharing [their ED histories], but [ask them] to try to work without that for a little and see how it [goes]” [P11-1, 438-440]). For example, one participant described a workplace in which guidance had come in the form of role modeling versus explicit guidelines or discussion of self-disclosure practices:

[I]t was not something that was talked about at all. Not that anybody ever said it wasn’t okay, but nobody ever did it and so it wasn’t really something that I was necessarily comfortable with at the time...[W]henever clients asked a personal question, it would be processed more – “Well, what makes you curious about that?” or “Why are you asking that?” but not answered (P9-1, 325-328, 385-389).

When one was familiar with a set of norms concerning self-disclosure (e.g., due to training or workplace), moving to a setting with different norms was experienced as a challenging adjustment. For example, the same participant remarked:

When I first got here, I knew it was okay [to self-disclose ED history], but I had to find my way in terms of talking about it... So, it’s the - the grey that I have a hard time with...if it’s not okay, great, I can do that, and if it is okay, great, I can do that. What’s okay, what’s not okay? (P9-1, 397-398, 403-406, 416).

4.1.3.1.3.2 Rationalizing use. Another aspect of the ethics experience of self-disclosing ED history was rationalizing its use. Participants reported asking themselves ethically-relevant questions such as, “Why am I doing this?”, What will the client do with this information?”, and “Will this strengthen the alliance or weaken it?” Participants linked their rationales for self-disclosure of ED history to the direct or indirect benefit of clients. Direct benefits included
helping clients feel understood and reducing their feelings of fear/being judged, shame, and/or hopelessness; using self-disclosure as a springboard for introducing a potentially helpful concept or skill (e.g., “learning from relapse,” or a cognitive-behavioural strategy), or for initiating a discussion relevant to recovery (e.g., regarding client-therapist body comparison); and role modeling health and recovery from an ED. Indirect benefits cited included building and strengthening the therapy relationship (e.g., developing rapport, strengthening the alliance, and encouraging client disclosure and being perceived by clients as a credible or trustworthy helper, and truth-telling). Working in accordance with workplace philosophy was another rationale provided for using self-disclosure (i.e., in settings where it was an accepted practice).

In one of many examples, a participant elaborated on her rationale for considering the use of self-disclosure to ease a client’s fear of being judged, and under what circumstances:

People might be coming in…struggling around trust…very fragile and taking that first step and…they’re feeling very scared and nervous about being here. So, it depends on how that initial interview has gone and if it seems like [self-disclosure] might be something that might be helpful in terms of them being able to feel less judged (P1-1, 444-451).

In an example of using her history as a springboard for introducing a coping strategy, another participant explained that she might say to a client:

“Given that you’re trapped in this behaviour, and that I recall what that is like…I wish somebody had suggested that maybe I try this.” Or, “Do you think you’d like [to try] that?” So, it’s a valuable way of introducing a cognitive approach (P2-1, 240-244).

Regarding credibility, participants stated that self-disclosure of ED history “helps me buy some legitimacy” (P2-1, 239-240) or “street cred” (P9-2, 1107), and that, “[T]hey see me as someone they can trust…who is more real and authentic with them” (P7-1, 512-513).

The one participant who did not self-disclose her ED history expressed several rationales for non-disclosure. For example, hypothesizing that therapist self-disclosure could unhelpfully or
even harmfully contribute to side-stepping or curtailing exploration of the client’s own experiences (e.g., of shame), she stated:

I’ve had plenty of people that felt very shameful, but it’s not compelled me to disclose anything. I like to work on that shame and help them without saying, “Me too.” You know, “Now we should feel better” (P11-2, 215-226).

Furthermore, she questioned the actual benefit accorded to clients via therapist self-disclosure of ED history, noting that it might not facilitate client recovery and could, in fact, prompt potentially unhelpful processes in therapy (e.g., covert client-therapist comparison leading to unproductive therapeutic directions). She explained:

[Disclosing my ED history is] not going to change them. Like, it doesn’t matter that I had that. And my story is also another reason…They compare so much, and if I’m trying to say, “Oh, I could get over it.” but yet I didn’t have this severe [eating disorder] – …So there’s always going to be, I think, something they’re going to find that’s an exception. So, I just don’t go there (P11-1, 293-299).

Regarding other reasons to not self-disclose, another participant remarked that any future public disclosures she might make (e.g., while participating in advocacy) could affect former clients who did not know she had had an ED history.

4.1.3.1.3.3 Considering impact, content, and parameters. A third aspect of the ethics experience of self-disclosure was therapist consideration of impact, content, and parameters. One participant reported considering the ethical pros and cons of disclosing her personal ED history regarding potential impact on clients. Offering a notably self-reflective and rich example, she reported grappling with the impact on clients of conveying her own success in recovery from bulimia nervosa (BN), anticipating that it could be interpreted by them in ways that might or might not be helpful to their therapy process and/or recovery. Specifically, she related this to the instillation of hope, remarking that therapists could use their recovery story inappropriately as a “cheat” or “shortcut” in attempting to engage clients in generating hope for themselves. Moreover, she reflected, while clients might beneficially gain genuine hope upon hearing she was recovered, her own recovery could also convey an “insistence” that clients should be
hopeful and recover quickly, when their trajectories and timelines might be very different from her own. Regarding the potential impact of this on a particular client, she stated:

She doesn’t want that much pressure on her. To be thinking that [recovery] is likely or that she needs to be even imagining it, it feels like pressure to her…so actually reminding somebody of my recovery, I guess, has a bad effect in that case…It makes them panic that they won’t have it, and that they should have it because other people have it (P6-3, 67-88).

She noted, “They can’t have my hope. They have to have their hope” (P6-1, 400-401).

Similarly, regarding the consideration of pros and cons of disclosure/nondisclosure, the lone participant who did not self-disclose her ED history to clients remarked that, by choosing non-disclosure, she was not able to overtly offer to clients the benefit of her own recovery as inspiration. In our second interview, she asked about what other participants had shared as reasons for self-disclosing ED history. Briefly, I recounted several, and, as we talked, this prompted her to remark that a hesitation for her was that, in not disclosing, she might, at some level, be perpetuating stigma or modeling shame about having had an ED. She stated:

I do like the [message] of, like, “You can recover,” and “I had trouble, too, and I’m okay now.” [T]here’s a piece of me that’s thinking about saying something because I kind of want to demonstrate you don’t have to have shame about it. Part of me, when I don’t say something – I don’t have shame about it, but I almost feel like it seems like I do because I don’t share it (P11-1, 385-389).

Another unique ethics experience related to self-disclosing ED history provided by the same participant concerned the potential detriment to therapy relationships as well as collegial relationships at a broader contextual level. She described concerns about negative impacts on client care resulting from the self-disclosing behaviour of a group of ED-historied therapists at one of her workplaces. She perceived that the clients had come to believe that those therapists, by virtue of their ED histories, understood them better than the non-ED-historied therapists. She observed this to result in the clients underutilizing the services of the other qualified, but non-ED-historied, practitioners as well as being an impediment to effective teamwork. Therefore, she
stated, on multiple levels, the clients may not have been helped as fully as possible. She remarked:

[I]t was bad… And it did feel like a split in that it was like the club of the people that did and people that didn’t. It just wasn’t very cohesive, as a team, working together with the clients (P11-1, 458-463).

For this participant, experiencing this division had continued to inform her personal practice of non-disclosure in subsequent workplaces, as well as her stance as a manager of encouraging staff to consider non-disclosure of their ED histories to clients.

In considering the content and impact of their ED history-related self-disclosures, participants also reported evaluating the pertinence of the to-be-disclosed information, the amount of detail shared, what the client was ‘really’ asking for (e.g., information; to feel “gotten”), and client characteristics (e.g., contraindicated for clients with comorbid borderline personality disorder). Two participants described the parameter of not sharing an aspect of their ED history they knew to be unresolved. For example, one described the experience of monitoring a felt sense in her body that signaled to her that a disclosure she was considering might not be in keeping with the client’s best interests. She explained:

[T]he rule I have for myself is that I do not self-disclose something that is charged [with shame] for me. If it [is]…I don’t go there with clients, because [then] I don’t trust that I wouldn’t be working my own stuff with them…I can sense in my body when something is still too loaded, that I don’t trust that I’m going to be grounded in how I share that (P10-1, 892-896, 902-904).

Three participants articulated that self-disclosures that included details such as personal weights or particular ED behaviours were unhelpful and/or potentially dangerous to clients. One of these individuals also described holding back information about unorthodox methods used in her own treatment that had been helpful to her (and that she felt could be helpful to clients).

Offering a different perspective regarding sharing more intimate details, one participant expressed that she shared such details if she believed it might help clients feel less ashamed of
having an ED. She described the experience of filling in for a colleague whose client was having
difficulty talking about her BN behaviours. She recounted:

[The client] came in and I said, “Oh, I’m recovering from bulimia too”…and she just went, “Ohhh”…I’ll often share with them, if I know they’re bulimic, what are the easiest things to throw up. And they’ll kind of laugh about it and they’ll go, “Ohh.” And I’ll say “Ice cream” and, you know, like (laughing), “Isn’t that easy?”… I’ll kind of do that to say “It’s okay, you know, I don’t feel shame.”…So, I want to be able to talk about it from a kind of detached place and join with them…And all of a sudden, it’s okay: [the client feels] “I’m not a freak” (P10-1, 932-944; 1654, 1655).

4.1.3.1.3.4 Making mistakes, having regrets, and coping with challenges. Despite the
benevolent intent expressed by the majority of participants regarding ED-history-related
disclosures, another aspect of self-disclosure was the experience of it “backfiring,” such that it
caus ed problems in the therapeutic relationship, course of therapy, and/or treatment outcome
(e.g., the client scorns the therapist’s experience and quits therapy; the client becomes hostile
and competitive when the work of therapy becomes more difficult).

Participants described experiences in which their self-disclosure of ED history had
resulted in therapeutic challenges or ruptures, or that they had later conceptualized as mistakes
and regretted. One challenge was that, once the therapist’s ED history was known to the client,
this was perceived by the client as a topic wide open for further conversation, necessitating
continuous and careful ethical navigation of the “slippery slope.” For example, clients reportedly
probed for more information such as the recency of the therapist’s recovery, why the therapist
wanted to get better, and other intimate details (e.g., “What was your lowest weight?” and “How
did you know you had recovered?”). Moreover, participants reported experiencing that once their
EDs were known, some clients wanted or expected direct guidance or advice, the provision of
which was not viewed as being particularly helpful to clients. As one participant stated:

One thing is that they want my opinion on things, or me to directly tell them what to
do, which is not how I work, so that’s been a struggle (P7-1, 508-511).
Therapists reported experiences of their ED histories being interpreted in many different ways by clients, sometimes impacting entire treatment environments (e.g., a climate of mistrust developed between clients and practitioners). For instance, a therapist’s self-disclosure to a client about her personal ED history in the context of individual therapy could be interpreted and recounted by the client to other clients in the milieu, who might then re-interpret and recount this information to others. Half of the interviewees and Bloomgarden (2000) reported the experience of feeling ethically and/or personally uncomfortable about having information or misinformation freely circulating about their ED histories.

Illustrating these points, a participant working in a residential treatment setting described disclosing to a client that she had personally received outpatient but not inpatient treatment for her own ED. She stated that she believed the ultimate outcome of this conversation had potentially conveyed an unhelpful message to all clients at the centre and had engendered their mistrust of her, thus potentially impacting her therapy relationships. She noted that this situation had been very difficult for her, both personally and professionally. She recalled:

I left the [individual therapy] conversation feeling like that was a great conversation. And she seemingly felt like it was a healthy conversation. But then…she told the other clients…that I hadn’t had treatment. And so that sort of lingered for awhile and caused some mistrust, where they weren’t necessarily trustful of my recovery or my experience, or whatever…[and] I don’t want to send the message [of] “you don’t need treatment” (P9-1, 478-483, 454-455).

Therapists sometimes attempted to contain the information they shared with clients about their ED histories (e.g., by requesting that clients not share this information with others, disclosing only rarely, or stating to a client that it was not something they typically discussed). Many therapist statements suggested the presence of a ‘grapevine’ not only amongst clients but also amongst practitioners regarding ED-historied therapists. For example, two participants remarked that they knew of colleagues who had ED histories, although the colleagues had not disclosed this to the participants directly.
Participants reported experiencing feelings of regret at having self-disclosed certain aspects of their ED histories to clients. Instances of this were typically reported to have occurred earlier in the participants’ careers. For example, one participant recalled disclosing to a client her lowest weight at the client’s request, which the participant later perceived had increased the risk of harm to the client. She said:

I wasn’t at it long enough to understand the reason or motivation behind…that question. And it really backfired on me because…she took my answer as license to continue dieting…[S]he thought if I could get that low and come back, then she had a ways to go before she really had to worry about it…[It was] awful. Awful. Scary. I don’t discuss those details anymore (P5-1, 324-340).

Another participant expressed regrets about disclosing aspects of her ED history that had resulted in therapy moving in potentially unhelpful directions in terms of boundary issues (e.g., a client wanting to access the therapist’s personal therapist). Some errors in using self-disclosure were perceived to have occurred due to the participant’s insufficient resolution of lingering personal issues. For instance, one stated:

When I’ve…made mistakes with self-disclosure, it’s been when I’ve not worked it enough for myself. That’s when I don’t have good boundaries, or I’m enmeshing myself with my client. You know, I’m seeing their issue as my issue because it’s charged up for me…it’s too predatory (P10-1, 914-920).

Finally, describing a different kind of regret (i.e., about having not self-disclosed) in her first-person written account of grappling with whether or not to disclose her ED history when leading an adolescent ED therapy group, Bloomgarden (2000) stated:

I was left with some regret over how I had handled it. The experience also led me to be more aware of my wish to find the courage to take some reasonable and thought-out risks around self-disclosure with my clients (p. 349).

4.1.3.1.4 Dual relationships. The final emergent sub-category of ethics experiences relating to boundaries and therapists’ personal ED histories involved dual relationships, specifically those resulting from participation in 12-step programs. This category was based on the experiences of two participants who reported finding 12-step models helpful in maintaining
their own ED recoveries. One described the experience of encountering clients at various meetings, evaluating the impact of these boundary crossings on clients, and consequently deciding to find other means of support for herself. She stated:

I finally stopped going to OA because I had clients show up at meetings...I had a bit of a relapse maybe 5 years ago...and so I went to Anorexia, Bulimia and Overeaters Anonymous. But I had a client there, right? And so I couldn’t, really. I only went to a couple of meetings and thought, “No, I’ve got to work this out” (P3-1, 485-494).

The other participant, who worked in a very small community, took a different perspective in that she chose to attend 12-step meetings even though her clients could be in attendance. She explained: “It’s not about the rules that make you have good boundaries. It’s about holding yourself in check and being responsible with your stuff and working it the way you need to so that you can be alongside somebody” (P10-1, 1691-1702).

4.1.3.1.5 Summary. Ethics experiences, perceptions, and beliefs regarding boundary issues emerged as the first major category in the ethics terrain linked to therapists’ personal ED histories. Sub-categories included: challenging assumptions of therapist-client similarity; centralizing the client’s ED experience, not the therapist’s; self-disclosing ED history to clients; and dual relationships resulting from 12-step program participation.

All participants spontaneously identified boundaries related to their personal ED history as ethics experiences, and highlighted several problems that could arise (e.g., disrespecting or pushing clients, enmeshment with clients) requiring self-awareness and diligence to avoid. Participant reports also indicated that such boundaries were likely to be an area of heightened ethical vulnerability, especially in early career or early-in-recovery stages. It seemed noteworthy that, despite identifying potential risks of harm to clients associated with self-disclosing ED history, all the participants (but one) nevertheless engaged in it, basing their rationales on perceived benefits to clients/therapy process. In addition, lack of preparedness in using self-disclosure was identified by participants as problematic. Furthermore, some of the language
used by participants to describe ethical concerns regarding boundaries (e.g., “intermingling” of their issues with clients’ issues, problematic “countertransferences,” mindfulness about not “repeating” one’s childhood dynamics with parents with one’s clients, and attempts to alleviate clients’ feelings of shame) suggested that developing awareness of re-enactments or repetitions of the therapist’s unresolved issues might be indicated. Together, these observations suggested that boundaries regarding personal ED history have particular ethical significance for ED-historied therapists.

In the next section, I present findings describing therapist wellness – a second, substantial sub-category of ethics experiences in the ethics terrain associated with therapist ED history.

4.1.3.2 Therapist wellness. Therapist wellness emerged as a second major sub-category of ethics experiences in the ethics terrain associated with personal ED history. The concept was introduced spontaneously by two participants in response to the main interview question, and was subsequently explored further throughout data collection and analysis. The meaning of therapist wellness that emerged encompassed therapists’ degree of resolution and health regarding their personal ED and their accurate self-evaluation of these, as well as consideration of the potential associated helps and harms to clients. One participant shared her general view on the wellness of clinicians in the EDs field:

There are a lot of therapists in the field that I would probably not consider completely well. I think there’s lots of people that are sort of maybe on the fringe of wellness – or - or not even (P9-3, 153-155).

No consensus among participants emerged during the investigation concerning the required sufficiency of ED resolution to practice with ED clients⁹.

Sub-categories of therapist wellness that emerged included experiencing an active ED while providing therapy to ED clients, experiencing “residual” characteristics of an ED that were

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⁹ This is consistent with recent literature indicating that a consensus on the definition of recovery from an ED has not yet been unequivocally established in the EDs field (McGilley & Szablewski, 2010).
perceived to influence therapy provided to ED clients, integrating one’s personal ED experience in a healthy way into one’s identity and the work, being congruent, having self-awareness/blind spots, and being “real.” Each of these categories and components is elaborated below.

An overarching finding regarding wellness was that it seemed to hold a central position in the ethics terrain regarding therapists’ personal ED histories. That is, it appeared to relate intimately, and be foundational, to at least two of the other major sub-categories in this area (i.e., boundary issues and helpfulness of the ED). For example, participants remarked that therapist wellness influenced the degree to which boundaries in the therapy relationship could be navigated beneficially and safely with ED clients. Wellness was also perceived to influence the degree to which a therapist’s ED history could actually be helpful to clients (e.g., in facilitating the development of the therapy relationship, or modeling recovery).

Insufficient therapist wellness was identified by half of the participants as being ethically problematic due to the potential for increased risk of harm to clients (e.g., therapists’ unresolved ED issues adding to their clients’ already significant burdens) and decreased helpfulness to clients (e.g., conflicting messages conveyed to clients that could hinder client recovery).

4.1.3.2.1 Experiencing an active ED. Experiencing active ED symptoms (i.e., pre-existence or re-emergence) while providing therapy to ED clients emerged as the first sub-category of ethics experiences within therapist wellness. This experience was described by two participants. One participant described having worked with ED clients while symptomatic with BN. She noted that the symptoms had presently diminished to below diagnostic criteria for BN, but remained to a degree. She stated:

I would say I have the occasional bout, but it’s very occasional… I feel about 85% mended… Like, there’s certain triggers… [for] throwing up… [I’d say in the last year, maybe once every three months (P10-1, 188-190, 194-195, 209, 235).

The second participant described experiencing a resurgance of ED symptoms, many years prior, when beginning to work with the ED client population. She stated:
I think [beginning to work with ED clients] kind of triggered the anorexic side because I had a lot of stomach problems. Every time I’d go to the doctor, they would put ‘anorexic,’ and it was just driving me nuts because I didn’t think I was anorexic…I guess I was underweight (P3-1, 192-196).

This therapist also recounted having experienced a more recent episode (i.e., approximately 5 years prior) of other ED behaviours. Both participants reported having found 12-step/addictions models useful in their personal ED recovery processes.

For one of these participants, the ethical obligation to maintain her wellness regarding the ED meant engaging in effective self-care, which entailed “ensuring that my life is balanced, and recognizing my needs and emotions and dealing with them” (P3-3, 34-35). The other participant stated her belief that wellness was about moving towards “wholeness,” which she suggested was facilitated by continuing to acknowledge and address her ongoing vulnerabilities regarding the ED. She stated: “I don’t believe it’s ethical to do this work if you can’t talk about your own wounding” (P10-1607-1608). She commented:

I go back into old patterns and old ways of thinking and I feel shame about it. I feel that whole, like, “I should be over this by now. Why do I still need this?”...Just saying it out loud is part of wholeness for me and wellness (P10-3, 310-315).

4.1.3.2.2 Experiencing ED residuals. The second sub-category of therapist wellness experiences that emerged was the presence of ED “residuals,” a term spontaneously introduced by two therapists in their first interviews. I earmarked this term as having potential conceptual significance for the other participants, and subsequently explored it further with all the interviewed therapists in the second round of data collection. The definition of residuals that emerged was the presence of unresolved or under-resolved aspects of the therapist’s ED history that, while not indicative of a full-blown ED, were nonetheless perceived to suggest something less than full wellness or ED resolution. Typically, residuals were experienced as entering into the therapy they provided to ED clients, or conjectured to be doing so. My relatively deep
exploration of this topic with participants resulted in rich and varied findings regarding these experiences.

Generally speaking, it was expressed that, ethically, therapists’ ED residuals should be identified and appropriately addressed/resolved in order to provide safe and effective care for ED clients. However, it was not always straightforward for therapists to ascertain whether certain phenomena they experienced were normative for all women versus indicative of an un- or under-resolved aspect of their ED. For instance, one participant commented:

I don't know if some of the stuff is residual or not...And yet I feel like I’m fully recovered in terms of my own ability to feel good about my body and eating different foods and those other things...But can I be picky sometimes about body image and things?...I don't know, it’s really weird (P11-1, 95-108).

Several sub-categories/types of residuals emerged during data analysis, including: “sticky bits;” body, weight, and/or eating concerns; pushing oneself, high expectations, and perfectionism; under-reacting to client risk; ‘keeping on top of’ aspects of the work; and saving and protecting clients. These are elaborated below.

4.1.3.2.2.1 “Sticky bits”. The first type of ED residual reported was the unexpected, and usually fleeting, encountering of vestiges or reminders of one’s personal ED (typically thoughts, feelings, and occasionally behaviours). These experiences caused participants to momentarily ethically question the sufficiency of their wellness regarding their ED histories and, for some, their appropriateness to be ED therapists. The term “sticky bits” was taken from one participant’s description of this experience. While other ED residuals were more clearly seen by participants to be entering therapy with ED clients (or speculated to be doing so), sticky bits appeared to be experienced primarily intra-personally.

Regardless of whether they had worked in the EDs field for a relatively short (e.g., 6-8 years) or long time (e.g., 19 years), participants felt some anxiety about sticky bits. Furthermore, the data suggested that therapists could enter the EDs field as professionals vulnerable to, and/or
unprepared for, the appearance of sticky bits. When participants noticed old, familiar ED or ED-like thoughts and feelings resurfacing after beginning to work as ED therapists, they often initially felt aghast. For example, a participant who described herself as having been recovered for approximately 18 years before taking her first ever job as a therapist in an EDs treatment centre, recounted being caught unaware by a familiar thought:

   Until I started working here, I never thought about eating disorders much for years and years...I remember I’d forgotten to eat lunch or something, and I [felt] this kind of ramped up, “Oh great, maybe I’ll lose some weight!” (laughing) And then going, because of where I worked, “Whoa!” (laughing) “What was that?!?” (P4-1, 115-126).

   With time, experience in treating EDs, and repeated sticky bit experiences, participants’ processes of noticing and being able to assess the seriousness of sticky bit phenomena (and determining the appropriate degree of concern), seemed to become more routine and less anxiety-provoking. For instance, the participant quoted above remarked that, over time and with reflection, she had come to locate most of the sticky bits she encountered “within the realm of normal” (P4-1, 305). Similarly, another participant who had provided ED therapy for 9 years described noticing an old, ED-related thought reappearing during a time of high stress. Describing the difference between experiencing that thought within the context of having an ED versus in the context of being recovered, she said:

   I [woke] up one day thinking, “It would just be easier if I didn’t eat today.” I was, immediately, “What the hell are you saying to yourself?!?” (laughing) “This is creepy!” [But], when I think about my life with an eating disorder, that’s still free and clear. Because, so what? They’re thoughts. People have thoughts that come and go all the time...[W]hen I think about the times I was most in my eating disorder [versus now], there’s no comparison in my life. None (P8-2, 934-935, 1033-1034).

   Particularly intense experiences of sticky bits (and/or of vigilance about them) were associated with heavy ED client loads. One participant in group private practice with a 25% caseload of ED clients commented that she “can tell” when she’s worked with several ED clients in one day. She described herself as approximately 20 years distant from her ED experience, and had worked in EDs for all but three of those years. She remarked:
[After seeing several ED clients in one day], I’ll pay more attention to what I’m
eating for supper and how I’m eating it [and] to little eating disorder vestiges like
picking at food or eating standing up, or being very impatient before I eat…I will be
a lot more eating- and exercise-sensitized…I’ll want to move. I want to go for a
walk. I want to go on the treadmill (P2-1, 783-792).

4.1.3.2.2.2 Lingering body, weight, and/or eating issues. A second type of ED residual
experienced by therapists was lingering body, weight, and/or eating issues. This category
included such experiences as continuing to be preoccupied with others’ bodies and weights,
eating to self-soothe, feeling disconnected from one’s body, body comparison or competition
with clients, and it being “easy” to ignore hunger and other bodily signals on busy clinical days.
This type of residual was the one most associated by participants with difficulties in discerning
whether the experiences were emanating from their personal ED histories or represented a more
normative experience for women.

Participants reported that, as with all residuals, experiencing them caused them to
question and evaluate their degree of wellness from their ED and their appropriateness as role
models to clients of healthy and congruent behaviour. They expressed ethical concerns about the
potential entry of these characteristics into therapy in terms of non-beneficial or harmful impacts
on clients, including the undermining of the therapy relationship and “triggering” clients’ ED
symptoms. Other examples of ethical concerns experienced included the propensity, due to one’s
own lingering body image issues, to see clients’ body sizes as more “normal” than they actually
were. This was viewed as having the potential to negatively influence the soundness of the
participant’s decisions about therapy direction and/or level of care. In addition, participant
concerns about aging and ambivalence regarding the use of anti-aging treatments were viewed as
potentially curtailing some clients’ exploration of topics that might be helpful to them in their
recovery. One therapist described wrestling with the ethical implications of this:

I claim to want to help my clients accept themselves, their bodies, and their size. But
I haven’t talked a lot about accepting their wrinkles, accepting their aging…I do
think it’s related to [my] eating disorder. [I]t’s a preoccupation with appearance. I
get rid of it [the line in my forehead]. Is that right? So, is that ethical? Like is that, ah, I don't know…So there’s a question for you…I struggle with that. (P5-2, 336-347).

Furthermore, potentially unhelpful “do as I say and not as I do” (P6-1, 347) mixed messages resulting from un- or under-resolved therapist issues regarding body, weight, and eating (including dressing in a manner in which one was “showing off physically” [P6-2, 229]) were noted by participants. These mixed messages were thought to elicit, for example, client mistrust, which could interfere with building and maintaining the therapy alliance, and therefore impede the client’s recovery process. Or, the client could internalize the “do” rather than “say” messages, which could serve to perpetuate ED mindset and behaviours. Furthermore, it was noted by participants that clients might sense hypocrisy and lose trust in the therapist, and then drop out of therapy. For these reasons, one participant said, some therapists with lingering body, weight, and eating concerns could be highly inappropriate role models for ED clients, depending on the therapist’s degree of difficulty in these areas.

Described by participants as unique aspects of therapy with ED clients were the salience of therapists’ and clients’ physical bodies during therapy sessions, and the intense self- and other-inspection and comparison behaviour often demonstrated by ED clients. These conditions were believed by several participants to render therapist residuals connected to body, weight, and/or eating concerns particularly ethically significant. The significance was not only perceived in terms of potential harms, but also with respect to maximizing helping. For example, a therapist comfortable with her own body could use it to initiate frank, potentially helpful discussions with clients as a way of exploring and beginning to address the body scrutiny, comparison, and related elements of a client’s ED experience. One participant explained:

Sometimes it’s a good jumping off point for talking about how people with eating disorders tend to make a lot of comparisons of their body to other people’s bodies.

10 The overvaluation of weight and shape in EDs can manifest in body preoccupation, including such behaviours as body self-checking and body comparison (e.g., Fairburn, 2008).
And, “Is that something that’s happening with me?” I own that, “Yes, I am a thin person, and what is it like to work with me in therapy?” (P7-1, 535-538).

4.1.3.2.2.3 Pushing, working too hard, high expectations, perfectionism. A third type of ED residual experienced was a constellation of phenomena that included therapists pushing themselves and clients, working too hard, having high expectations of self and clients, and perfectionism. Participants reported considering the ethical meaning of these characteristics relative to their perceived wellness from their ED, and to the potential impacts on clients when these characteristics entered therapy.

These characteristics were frequently described as having been longstanding issues, suggesting that these residuals could persist well into an ED-historied therapist’s career, and that taking steps towards loosening such tendencies might occur slowly and incrementally. For example, a participant who had worked in EDs for approximately 17 years stated that she had only recently implemented a new, more mindful and self-compassionate response to a health (but not ED-related) stressor she was experiencing. She commented:

[H]istorically, I would push and work no matter what my fatigue or pain levels…Of course, it is common knowledge that folks with EDs have tendencies towards perfectionism and I must say one manifestation of that still for me is I tend to push myself way too hard [and] have high expectations re: work performance. Much to my detriment (P1-email, 11-17).

Participants also reported concerns about imposing their own high expectations and tendencies to push themselves onto clients. For example, describing that she sometimes expected clients to feel hopeful because she herself was able to recover, one participant commented:

[My ED history and recovery] might make me push people more. I don’t think that would be a very ethically cool thing. So, I might get pushy or I might be impatient with their resistance they need to keep in place (P6-3, 142-148).

A complex relationship emerged between the helping/harming aspects of this constellation of residuals in that therapists attached both positive and negative consequences to them for themselves and their clients. For example, these qualities were perceived as
contributing positively to the therapist’s ability to maintain high standards of professional accountability. As one participant remarked:

There’s a lot of responsibility to maintain a level of... accountability…That’s an ethical piece for me. It’s one of the reasons I work far too hard, but I just believe you have to do that…[T]he perfectionism and the eating disorder piece! (P2-1, 673-674, 686-687).

Conversely, these characteristics were seen by participants to negatively impact aspects of their performances, such as energy level, availability, and ability to model a balanced life. They were also viewed as potentially contributing to therapists’ avoidance of examining professional/ethical practices in which they feared they might be falling short.

4.1.3.2.2.4 Under-reacting to client risk. A fourth type of ED residual experienced by therapists was under-reacting to client risk. This seemed noteworthy because the seriousness of EDs can be minimized by the individuals who experience them. The participants who described experiences of under-reacting considered its ethical meaning in light of their perceived wellness from their own EDs, as well as its potential impacts on clients. They made statements suggesting that having confidence in clients and remaining calm in urgent situations constituted a more positive, ‘flip side’ to under-reacting.

Experiences in this category seemed relatively more risky for participants to discuss than other types of ED residuals, as suggested by hesitance in speech and flow of the story/example, stated impulses to self-censor, and self-conscious joking. For example, one therapist stated, “[Here’s a] juicy one for you” before describing having a sometimes “cavalier” stance towards client safety. Reflecting on the potential negative and positive ethical implications of under-reacting, and how she might imagine her peers to respond, she said:

I - I sometimes feel cavalier about patients’, um, safety because I’m okay. And, so I’m not very jumpy…I have a lot of confidence because I’ve survived it…And maybe that helps in the work because they can sense that I have hope for them. Um, but I think, to another clinician, it might seem unethical or not careful enough medically (P6-1, 650-661).
Linking under-reacting to having unrealistic expectations of clients, another participant described a training experience in which she had assumed that a client with AN could complete a school term, just as she herself had been able to do while very ill with AN. She noted that her tendency to be “an under-reactor” was due to her own experience of being high-functioning when she had had AN. Similar to the participant quoted above, she described a positive side to under-reacting (i.e., confidence, “we can do this”). She stated that she felt the impulse to “censor more” about this story with me “because I don’t feel especially proud of this” (P8-3, 134). She remarked that her under-reaction could have increased the risk of harm to the client had she not received effective supervision and changed her approach with the client.

4.1.3.2.2.5 Keeping on top of the work. A fifth type of ED residual experienced was described by one participant. She noted that she was “not totally organized” regarding her work, which she attributed directly to an ED “marked by chaotic behaviours [and] a lot of dissociation” (P6-2, 1033-1036). Furthermore, she expressed that it was sometimes challenging to identify and track her thoughts and feelings while in session, which she also attributed to the ED.

4.1.3.2.2.6 Saving and protecting clients. The sixth and final type of ED residual reported was the impulse to save and protect clients from the pain of their EDs and/or the uncomfortable emotional work of therapy. One therapist stated that her desire to save and protect ED clients from their pain related directly to a combination of her own ED experience and its antecedents, as well as to her own desire, when she had been a client, for her therapist to protect her from painful feelings and save her from the ED by moving quickly in treatment. Noting how this manifested in therapy she provided to her own clients, she wrote:

[P]art of me wanted my therapist to jump in and save me, to push the treatment along, not just to listen to my sadness. I wanted her to tell me exactly what I needed to do to make everything better...That desire to “jump in” and save my patients is a vulnerability I have to keep in check…I often just want to take their pain away…I sometimes have difficulty bringing a patient back to painful memories or experiences (Goldkopf-Woodtke, 2001, p. 161, 170).
Turning now from the sub-category within therapist wellness of ED residuals (and its several types), the next sections describe four additional sub-categories within therapist wellness.

4.1.3.2.3 Integrating the ED. A third sub-category of therapist wellness experiences that emerged was participants’ experiences of ‘integrating’ their EDs. Based on the data, the concept of integration seemed to have two components. First, it meant the healthy incorporation of the therapist’s own ED experience into her sense of self (as opposed to its problematic incorporation, for example as in the ego-syntonia frequently present in active AN\textsuperscript{11}. Second, and subsequent to this, integration meant the appropriate incorporation of the therapist’s ED history into her work with ED clients. Integration also seemed associated with three additional concepts that emerged: therapist self-awareness, congruence (i.e., ‘walking one’s talk’ with clients), and being “real” (i.e., genuine, authentic), as described in later sections. Integration appeared to include therapists’ self-acknowledgment of characteristics potentially perceived as being questionable in ED therapists. For example, making a link to authenticity, one participant stated:

If you have [negative] feelings about your body sometimes, does that mean – Oh, my god! I shouldn’t! These are forbidden feelings to have? Like, how do we get to bring all of who we are into this experience? I think that helps the work if done well, if done from a place of we’re there for the client, and if done skillfully and artfully and as best as we can as human beings. I think it’s better to be grounded in our own authenticity (P1-1, 998-1013).

Integration was seen as ethically relevant in terms of its ability to benefit clients. As one participant stated when I asked her what mattered most to her about the research topic:

Wellness and integration for myself as a therapist...and the power of that for what therapists can then offer the clients (P4-3, 349-352).

The healthy integration of the therapist’s personal ED history was also thought to translate into enhanced relational connection with clients. For example, a participant stated:

I believe if you’re working your own stuff [i.e., doing your own personal work/therapy], and if you know what you’re triggered by, and you know what

\textsuperscript{11} From the perspective of clients with AN, the illness is experienced as consistent with their ideal self-image, and is therefore difficult to relinquish (e.g., Touyz, Thornton, Rieger, George, & Beaumont, 2003).
you’re not ready to disclose, and you’re aware of all that stuff about yourself, then it’s a beautiful way to join with people and invite them to not be afraid of their journey (P10-3, 149-155).

A lack of integration regarding ED history was hypothesized to lead to the unacknowledged, avoided, or “split off” part entering into therapy in harmful or less helpful ways (e.g., possibly hindering relational connections, or inadvertently modeling inappropriate characteristics). As one participant suggested: “[A]ny of those bits that we hold back are not really fully in the work,” (P1-2, 179-180), thus preventing those “bits” from being examined for their effects on therapy. Writing about grappling with whether and how to use her ED history in her work, and referring to the impact on her relationships with both clients and colleagues of concealing it, Bloomgarden (2000) stated:

[A]s long as I was trying to block out a whole chunk of who I am and how I came to be, I was creating a layer around myself that was not genuine (p. 349).

Similarly, an interviewee suggested that:

I think I would get disconnected [from clients] when I’m repressing something or trying to push something away (P10-3, 281-307).

Integration, for one participant, was related to the concept of “wholeness” of the self and the ability to acknowledge multiple experiences within oneself, as well as to congruence between who she was as a therapist and as a person. She stated:

I think wellness for me is wholeness…I can really feel people’s pain. I can feel my own pain…I can be in and feel everything, and experience myself…I can sense what’s happening in my body when I’m speaking with somebody…I can live my life as a whole person and I’m not different in a session than I am in my life. I might do different things or utilize different skills, but I don’t want to shut down parts of myself (P10-3, 281-307).

The data suggested that, for ED therapists with personal ED histories, continued integration of their ED and movement towards wellness or wholeness might occur as a result of working in the EDs field. As an example, half of the participants reported that, during their careers working in EDs, and because they worked in EDs, they had experienced further integration regarding a
variety of phenomena related to their ED histories that had resulted in further insights and behaviour change. These included beginning to participate in exercise for fun, experiencing new levels of appreciation for one’s body, a sense of stability in wellness, and enhanced clarity around how difficult one’s personal ED experience had been. Describing another relevant experience, one participant said:

I think [working with ED clients] has allowed me to be more comfortable with vulnerability and my maternal warmth for others…and I think also my comfort with my dependence and other people’s dependence…[M]y mom’s not a very warm person. She wasn’t comfortable with my needs or dependence in any way, which was a huge variable in my eating disorder development (P8-2, 837-844).

One therapist, describing a compelling experience of evaluating her current wellness, notably referred to the process of integration as “knitting together” and “bringing forward” (P4-3, 18) aspects of her ED history. Expressing that she felt she still had some work to do, speculating that un-integrated material was negatively impacting her ability to connect with a particular sub-population of ED clients, and considering personal therapy, she stated: “[I]t’s hard to do the work without integrating these pieces that I feel are unfinished” (P4-3, 85-86).

4.1.3.2.4 Having self-awareness, blind spots. A fourth sub-category of therapist wellness was the therapist’s experience of having and/or developing self-awareness, and of having blind spots (considered the opposite of self-awareness), concerning their personal ED. The concept of self-awareness was mentioned spontaneously and adamantly by two-thirds of the interviewees as being critical to their own ethical practice with ED clients, or was mentioned as a general belief. As summarized by one therapist, this was an ethical responsibility that meant “We should know ourselves to do good work” (P10-2, 79). More specifically, the definition of self-awareness that emerged in this study was the degree to which therapists possessed self-knowledge regarding various aspects of their ED histories, as well as whether they could accurately evaluate their degree of recovery/wellness. It also referred to a more moment-to-
moment type of self- and other-awareness when delivering therapy that necessitated this self-knowledge.

Self-awareness appeared to be necessary for both components of integration (i.e., healthy integration of ED into identity, and then into the work with ED clients), as described above. For example, participant statements suggested that integration first involved acknowledging that the ED had occurred, and then engaging in a process of developing self-awareness by making sense of the ED experience. This was thought to help the ED ‘come to rest’ in the therapist’s being such that the therapist felt “at home” with her history, as well as to help it “settle into the background” when providing therapy to ED clients. Participants identified many specific target areas around which the self-awareness of therapists with ED histories could or should be developed (e.g., regarding food, body, emotional health, biases about treatment based on own ED experience, etc).

Therapist self-awareness was perceived to evolve over time, with maturation as a person and professional, and via training and supervision. Engaging in self-reflective dialogue with trusted others was asserted to be key in developing self-awareness and identifying blind spots. As one participant said: “[T]he unconscious becomes conscious by virtue of someone else participating in it with us” (P8-3, 109-110). Opportunities for effective self-reflective dialogue reported included formal supervision, treatment team meetings, and personal therapy. One participant noted that self-awareness was also likely to improve with experience and distance from one’s own ED. She remarked:

I think early in our careers [our own ED experiences] could be very distracting. We could be very preoccupied with what we just went through. It hasn’t settled into the background yet. And so we might be more self-absorbed in the room rather than actually listening to the other person’s life (P6-3, 176-179).

Other participant statements supported the notion that therapists with more recent ED experiences might be more likely to be experiencing an intensive period of developing self-
awareness about their ED histories. For example, a therapist whose ED history was much more recent than the other interviewees’ reported experiencing a surge of self-awareness over recent years that had been rapid and profound. Noting that youth and inexperience might contribute to lack of self-awareness, another participant remarked: “[W]hen I was a younger therapist, I would probably deny that I had blind spots” (P2-3, 101-102).

A lack of self-awareness (also referred to as having blind spots) regarding aspects of therapists’ ED histories was considered ethically problematic, since unexamined aspects of the therapist’s ED experience would be more likely to enter therapy in unhelpful or harmful ways. For example, a participant who worked exclusively with ED clients commented:

It’s my ethical duty to myself, to my clients, and to the profession to be as aware as possible of every potential repetition or blind spot, or just all of those kinds of things...Self-awareness is a major piece of my ethics (P8-2, 1263-1266; P8-3, 58-63).

Another participant stated:

We’re not plumbers. You know, our stuff can become predatory if it’s not dealt with...It slips out. It’s leaking out...I think the ethical part is you better know how your story impacts the way you see other people (P10-1, 1606-1616; P10-2, 486-487).

Participants’ descriptions of having blind spots revealed to them (or of observing blind spots in other therapists) highlighted that unseen aspects of the self were often more evident to observers (e.g., colleagues hiring panels, the public) than to the practitioner herself. Furthermore, participants’ accurate self-assessment of wellness (or lack thereof) with respect to their EDs was described by some as having occurred in hindsight. For example, recounting her experience of being symptomatic with an ED while working in the EDs field, a participant recounted:

I was asked to give a talk...on eating disorders and, at the end, um, this woman in the audience says, “Well, you’re still eating disordered,” and I said, “No, I’m not.” “Well, just look at you.” I didn’t feel that I had an eating disorder. But I was thin…I was restricting and I didn’t feel like I was (P3-1, 193-203, 221-227).
Recounting a similar lack of insight, another therapist stated that, up until only a few years prior: “I used a lot of denial, right? I didn’t realize how bulimic I was, for a long time” (P10-1, 168-169).

Citing a particularly self-reflective example of a blind spot experience, one participant described with some discomfort making a potentially harmful assumption about a client that was based on the therapist’s personal ED experience. She identified this situation as having been particularly critical because of the potential risk of harm to the client (the therapist was influencing the client to not seek more intensive treatment). Noting that this dynamic had been identified in supervision and that she had reflected on it deeply in hindsight, she said:

I projected onto this client a sense of, like, you don’t have to go to inpatient or residential if you don’t need to because you’re capable enough, and you should get your shit together even though you’re in finals, and everything else that you’re dealing with. Because I was someone who could do that…So, that was my blind spot (P8-3, 165-171).

Therapist self-awareness/blind spots regarding degree of wellness were also discussed by a few participants from the angle of observing other practitioners in the field whom they suspected had not resolved their EDs sufficiently to provide effective care to ED clients. The responsibility for hiring practitioners seemed to bring this into particularly sharp focus. For example, a participant who had recently conducted a hiring process at her workplace said:

I think in people’s heart of hearts they actually think that they’re well. But maybe other people wouldn’t really consider them to be well. So I think there’s probably a kind of grey area in the field where people are maybe not as responsive to [their] eating disorder as they once were and think that they’re beyond it, but maybe, objectively, aren’t (P9-3, 153-156, 174-180).

It was pointed out that blind spots were, by definition, unseen by the practitioner, and were therefore challenging to identify without assistance from others, as well as anxiety-provoking to reflect on ethically, especially regarding harm. One therapist expressed that the anxiety-provoking aspect of blind spots was not knowing “what we’re not aware of” (P10-3, 194).
There were statements made by participants during the interviews that hinted at additional blind spots that could arise for ED therapists with personal ED histories. These instances were analyzed and interpreted, but detailed findings will not be presented as they were highly inferential and not viewed as central to answering the research question. However, briefly, they included a potential disconnect between how therapists saw themselves physically and how others saw them (e.g., not perceiving oneself as thin when others stated one was thin); acknowledging that clients’ experiences and needs were different from their own, yet stating efforts to help clients based on how they would have liked to have been helped during their own ED experience; potential boundary issues and high expectations/pushing oneself regarding the offer of additional support to clients in the form of non-emergency, extra-session communication; and wearing one’s personal ED experience as a ‘badge of honour’ in the treatment milieu and potentially engaging in subtle downward comparison regarding other staff members’ ED experiences. These examples suggested that, while therapist self-awareness and blind spots seemed to be conceptually associated with therapist wellness, their content could include boundary issues.

Seemingly associated with the concepts of self-awareness and wellness, “being human” was spontaneously mentioned by two-thirds of the interviewees (e.g., that therapists were “human,” and therefore imperfect and vulnerable to phenomena such as blind spots). Some participants stated that therapists with ED histories should acknowledge their humanness by developing their self-knowledge about those histories, so that they could better understand the influences of their ED experience on the therapy they provided to ED clients. As one therapist remarked:

[T]he biggest thing that matters to me about this [study] is that it invites [therapists with ED histories] to look at themselves as a person and what effect that has on their work. And I couldn’t feel stronger about that than I do. That, I think, is ethical practice…It just invites a more human way of being as a therapist (P10-2, 525-529).
It was also suggested that the ability to acknowledge one’s humanness specifically in terms of imperfections and struggles (e.g., countertransference reactions to clients emerging from one’s own ED experience) was an indicator of therapist wellness regarding their ED, to a degree. One participant commented:

[Therapists] are human, right?...[N]obody’s going to cope perfectly...But I think that’s healthy that we’re not perfect...[Therapists] that are obviously having struggles, and their bodies are uncomfortable because they’re underweight, it’s probably not a good example of wellness... [Being] cognitively well is the ability to be human and acknowledge imperfections (P11-3, 164-175).

Therapists’ being human was identified as being ethically problematic if objectivity and good boundaries were not maintained. For example, stating her perspective on the impulse to “want to be human” with clients, a participant said:

[If] you lose your objectivity, then you potentially are doing a disservice to the client...I think it crosses that line [because] the client then becomes... something other than client. Then you also have to tell them that they have to finish their meal 100% or that you saw them hiding their food and have to supplement them. So, while I think we want to be human and build a relationship with the clients and allow them to come to us, I think we have to set that line with them...and I’m consistent with that (P9-1, 989-1021).

The concept of being human was also associated by a few participants with a worldview and therapeutic stance of togetherness versus separateness, which was further linked to the ideas that all humans experience suffering and wounds. Unhelpful power differentials were believed by participants to arise between clients and therapists as a result of therapists not being self-aware of their “wounds,” or of “hiding behind” their role in order to present a façade of imperviousness to difficulties or to prevent exposing themselves as imperfect.

4.1.3.2.5 Being congruent. A fifth sub-category of therapist wellness that emerged was the therapist’s experience of congruence. Congruence referred to the perceived degree of consistency between the therapist’s degree of wellness from the ED and her role as a helper of people with EDs (i.e., ‘walking one’s talk’ with clients; avoiding hypocrisy and “do as I say, not
as I do”). That is, participants indicated that it was ethically important to feel and demonstrate congruence between, on the one hand, helping clients overcome problems with food, eating, exercise, and body acceptance, and, on the other hand, demonstrating their own health in these areas. As one participant stated:

I think working with clients with eating disorders tends to keep me honest. And I really don’t like the idea of giving them a piece of advice and then going out and doing the opposite (P5-2, 544-547).

Given that a characteristic of EDs can be the minimization or denial of the ED as a problem, a therapist who successfully “keeps honest” with herself regarding ED symptoms or residuals could be viewed as demonstrating a facet of wellness. Linked perhaps to the idea of honesty with self, the phrase “having integrity” was also frequently uttered by participants in conjunction with references to congruence. Some participant statements reflected uncertainty and anxiety about whether certain behaviours in their more recent histories had signaled incongruence (for example, whether instances of “overeating” had constituted binge episodes), and whether this might therefore signal insufficient wellness to provide therapy to ED clients.

4.1.3.2.6 Being real. The sixth sub-category of therapist wellness that emerged was “being real.” Being real referred to a stance of being authentic, genuine, and truthful when interacting with ED clients. The vast majority of interviewees spontaneously used the terms “being real,” “authentic,” and “genuine,” frequently uttering them together. Bloomgarden (2000) also wrote about wrestling with the meaning of being “real” and “genuine” in her work with adolescents with EDs. As suggested by Goldkopf-Woodtke (2001) and some interviewees, individuals with EDs may cultivate a façade of ‘the well-put-together individual’ while struggling deeply with the disorder, or they may not acknowledge the ED as problematic. Thus, the therapist’s ability to be real, likely in conjunction with adequate self-awareness and good boundaries, could be an indicator of wellness with respect to her personal ED history.
Being real was associated by participants with the appropriate and honest sharing of in-session experiences with clients (i.e., making here-and-now process observations) as well as disclosing aspects of one’s personal ED history. Examples included sharing a clinical opinion with a client, challenging or confronting a client when clinically indicated, not portraying oneself as an expert or seeing clients as ‘other,’ and extending courtesy and respect to clients due to one’s personal ED experience. The ethical relevance of this cluster of therapist qualities and behaviours was identified by participants as benefiting ED clients and the therapy process through demonstration of therapist trustworthiness, honesty, and respect.

The therapist’s not being real emerged in the data as associated with negative consequences for relational connection in therapy with ED clients. For example, Bloomgarden (2000) wrote that the clients in her adolescent ED group had explicitly requested that she “[b]e real” with them and provide them with honest answers (p. 348). She stated that, “like heat-seeking missiles,” they had asked her questions such as, “Do you personally get what we are going through?” (p. 348). She perceived that her constant avoidance of answering these questions had led the group members to feel not understood. She wrote that the situation had resulted in her becoming more “remote,” “distant[,]…quiet [and] disingenuous” as a therapist, which she believed had diminished trust and fostered disconnection in her therapeutic relationships with the group members (p. 348). Unable to resolve the situation satisfactorily, she ceased running the group.

In order to help and not harm clients, participants asserted that ED-historied therapists’ expressions of realness necessitated appropriate boundaries. Identifying this as a critical ethical issue, a participant remarked:

How far do you go in terms of being real or honest?…[W]hat can that mean when you’re in the therapy seat?…If a therapist was, like, “Well, how can I be real?” and disclosing everything – that’s not what [the profession] is about…[I] think you can have genuine, real concern…I show myself [to clients], but I don’t want it to become about me (P11-1, 831, 853-854, 858-964).
Similarly, Bloomgarden (2000) wrote about grappling with being real without self-disclosing her ED history, while also attempting to connect with the clients in her adolescent ED group. She wrote:

I hoped that I’d be skilled enough to maneuver around their questions and still create a sense of connection with them. Maybe there was a way to be “real,” I reasoned, without disclosing that one fact…I tried to think of another way to connect (p. 348).

Providing the appropriate balance between being real and being boundaried was described by two participants as not only ethically preferable, but as necessary for effectively helping ED clients. As one participant stated:

[Clients have] had a lot of false relationships and they don’t need more of that. They need someone who can be a human in the room and interact with them on that level. I think that’s true in all therapy, but there is something about working with women with eating disorders [where it] just seems even more important…And the importance of being someone [who is] all of that and boundaried (P8-2, 158-162, 185).

4.1.3.2.7 Summary. Ethics experiences, perceptions, and beliefs relating to therapist wellness emerged as a substantial second sub-category in the ethics terrain associated with participants’ personal ED histories. Sub-areas of therapist wellness included experiencing an active ED while providing therapy to ED clients, experiencing “residual” characteristics of an ED perceived or speculated to be entering the therapy provided to ED clients (several types), the healthy integration of the therapist’s ED experience into her identity and work, having self-awareness/blind spots, being congruent, and being “real.”

I observed among these findings that participants identified therapists’ active ED symptoms and all ED residuals as being potentially harmful, and certainly unhelpful to ED clients (with one exception: the calm/confidence ‘flip-side’ of the residual of underreacting to client risk). Perhaps unsurprisingly, then, participants conveyed more anxiety about discussing wellness issues than the ethics experiences in the other major categories related to ED history.
(e.g., as suggested by nervous laughter and expressed concerns that lingering ED issues might mean they were not appropriate ED therapists). Reports of increased risks to clients resulting from participant blind spots/lack of insight pertaining to therapist wellness suggested that wellness may be a particularly important ethical issue for ED-historied therapists, particularly early in career/recovery. Some participant statements related to blind spots (e.g., basing treatment decisions intentionally or unintentionally on one’s own ED experience or ED treatment experience, countertransference reactions) suggested that re-enactments or repetitions of unresolved therapist issues could enter ED-historied practitioners’ therapy delivery.

As I reviewed the wellness sub-categories, I wondered, “What, then, is helpful about an ED history?” One possible answer drawn from the data is the growth and self-learning that occur as a result of the recovery process, which may: enable the healthy integration of the therapist’s ED experience into her identity and then appropriately into her work; foster self-awareness and self-knowledge development; and permit the role modeling to clients of congruence. Being “real” about a personal ED experience may be an indicator of recovery from an ED (given that lack of insight about having an ED is often associated with EDs). The data further suggested that wellness might be indicated by ED-historied therapists’ ability to keep their professional ‘hat’ on when they choose to be “real” with clients about their personal ED experiences, so that being real furthers therapeutic goals. Finally, ED therapist wellness seemed a particularly significant category of ethics experience because it was identified as foundational to having good boundaries, but also to the next major category: helpfulness of the therapist’s ED.

4.1.3.3 Helpfulness of the therapist’s ED. In addition to boundary issues and therapist wellness, therapists’ experiences and perceptions that their ED histories had been helpful in their work with ED clients emerged as a third major sub-category of ethics experiences in the ethics terrain associated with therapists’ personal ED histories. As stated by one participant in her first response to the main interview question:
I have encountered colleagues who have expressed their concerns about [therapists with personal ED histories]. Like, not believing that that was a helpful thing, or that people who are working in the field should not have a past history. And, um, it’s certainly not been my experience – it’s certainly been quite helpful (P1-1, 285-288).

The topic of the helpfulness of the therapist’s ED also emerged spontaneously during the course of interviews with several other participants, although not as an immediate response to the main interview question. As one participant stated: “I see [an ED history] as only enhancing your work” (P7-1, 348). Numerous other statements made by participants and by Goldkopf-Woodtke (2001) conveyed the perception that their personal ED histories enhanced the therapy they provided, whether or not they explicitly disclosed that history to clients. The helpfulness of the therapist’s ED appeared to be conceptually linked to therapist wellness, as indicated by the assertion of several participants that a sufficient degree of recovery and distance from the ED was necessary in order for it to be helpful.

While therapists experienced their own ED histories to be contributing positively to their therapy delivery, there were mixed opinions about whether it made them more effective therapists than individuals who had not personally experienced an ED. For some, generally being “a good therapist” was expressed as being more important than having had an ED. One therapist remarked:

[A client] could really screw up looking for a therapist by requiring [an ED history], because you could find someone that’s not a good therapist (P6-2, 53-64, 112-113).

A different perspective was expressed by two participants who stated that ED therapists with personal ED histories were more effective practitioners than those without histories. One stated about working with EDs: “I’m like one of those old school, addictions-era people. If you haven’t been an alchie, you can’t treat alchies very well” (P10-1, 1644-1646). The other participant also professed that ED-historied individuals made better therapists, with the caveat that such therapists must be able to genuinely claim a sufficient degree of wellness. She explained:
If you haven’t had [an ED], I’m sure there must be a gap between the practitioner and the client where there is a sense that there’s a judgment or a miscommunication or something that is not resonating, that will not help you feel that gorgeous, uncritical support that allows you to resolve things…If I get stuck with an eating disorder client, there’s nothing cognitive that will be helpful to me at that point. I’m going with my gut, my intuition, my own experience…I’m looking for something to connect with that I can sort of pull from a deep resource within myself and offer to them. And if I hadn’t had an eating disorder, I would be on page 43 of the text at that point. And that’s not helpful (P2-2, 170-191, 206-238).

One reason suggested by participants for the therapist’s ED history being helpful was the personal work undertaken to address it and any associated/underlying issues, which could enhance the therapist’s therapy skills and/or reduce the risk of harm to clients resulting from the therapist’s unresolved issues. For example a participant who had experienced her ED many years prior stated that her ED history had improved her effectiveness as a therapist because it “gave me a lot of reason to do more self-reflective, in-depth work that I may not have done in the same way” (P8-2, 951-953). Presented below are three sub-categories containing specific ways in which the therapist’s ED history was considered helpful. These included deeply understanding or “getting” clients’ ED experiences; instilling and maintaining hope; and engendering sensitivity, respect, and compassion for clients.

4.1.3.3.1 “Getting” clients’ experiences. The first sub-category that emerged regarding how therapists’ personal ED histories were considered helpful was the therapist’s ability to “really understand,” or deeply “get,” their ED clients’ experiences, and, furthermore, that their clients felt ‘gotten’ by virtue of this shared ED history. It was speculated by two participants that therapists without ED histories “may not get it. They just can’t imagine [it]” (P11-1, 894-902). The ability to “get” clients’ experiences was identified explicitly by one participant as a professional competency essential for providing therapy to ED clients, whether or not a practitioner had a personal ED history. Participants reported experiences of clients telling them that they had liked, appreciated, or found it comforting that the therapist had an ED history because they had felt understood.
The specific aspects of clients’ EDs asserted to be deeply understood by therapists with ED histories included shared experiences such as distorted self-perceptions and other cognitions, the pain suffered by clients “as they try to express…that they no longer can do it alone” (Goldkopf-Woodtke, 2001, p. 160-161), and how an ED makes sense in a client’s life that might otherwise seem irrational if a therapist had not experienced an ED. As one participant explained:

[T]here are parallels and ties that bind those who suffer with eating disorders and there’s a particular way that people with eating issues think. And that’s especially understandable if you’ve been through it. So, I think it’s been really, really helpful…[Clients say] “I’m glad to know that you’ve been through this before. I know you’ll understand” (P5-1, 301-317).

Therapists reported that their deep understanding of clients’ experiences was conveyed both directly (through therapist self-disclosure) and subtly (conveying a 'sense’ that they had had an ED, which a client could pick up on). Regarding the latter, a therapist remarked:

I think they could just feel in the room that I get some of it because I’ve been there. So, I mean, I think it’s an advantage (P6-1, 1144-1145).

The ability to “get it” was viewed as enhancing the therapeutic relationship by building connection, helping the therapist appear credible and trustworthy, diminishing power imbalances, and facilitating empathy. It was also perceived to help the therapist anticipate clients’ directions in therapy. For example, a participant who did not self-disclose her ED history to clients stated:

I kind of know where they’re going sometimes, or what they’re about to say…because I feel like I’ve been there…I know what they know, what that feels like, and [what] that brings up. So, I think that’s the way I’m able to connect with a lot of them because I might…fill in sort of a semblance of what they might be feeling, or kind of paraphrase it, and it’ll be right because I get it (P11-1, 915-924).

This was not to say that participants believed they understood everything about their clients’ ED experiences (indeed, within the boundaries theme, statements were made about ethical practice requiring the avoidance of such assumptions). As Goldkopf-Woodtke (2001) wrote: “I tell them,
'Yes, I understand, but I cannot make sense out of it without you. That is our job together’’ (p. 175).

4.1.3.3.2 Instilling hope, maintaining hope. The second sub-category of how participants’ personal ED histories were considered by them to be helpful was that the ED history was perceived to instill hope in clients, and maintain hope in the therapists. The former was linked by some participants to the idea of ED-historied therapists serving as positive role models for achieving recovery, which was considered an important gift that therapists with ED histories could offer their clients. For instance, therapists stated:

[Clients] like to know that it’s possible that you can be recovered and have a healthy relationship with food and with people and in life (P9-1, 424-426).

Some patients seek me out because they know my history. My presence alone creates a sense of hope for them (Goldkopf-Woodtke, 2001, p. 160).

The latter aspect of hope that emerged was that therapists’ own ED histories enabled them to maintain hope for their clients’ recovery, even when their clients felt scant hope for themselves. Furthermore, the therapist’s ED history was reported to buffer feelings of frustration and hopelessness regarding clients’ recovery trajectories. As examples, participants remarked:

Even if I don’t disclose that I’ve [recovered, my] knowing that they can, I think, helps them (P6-2, 144-145).

There were many years where I didn’t think I would ever recover. And so knowing that it’s possible helps me to encourage them to believe that (P8-2, 818-819).

Such a buffering effect has been recently identified by Warren et al. (in press), who noted that ED-historied treatment providers reported experiencing statistically significantly less burnout than those without ED histories.

For one participant, knowing that the leader of the treatment program she (the participant) had personally attended had recovered from an ED was an important factor in her own recovery. This personal experience seemed to have informed and bolstered her belief in the
benefits offered to clients by therapists who could model genuine recovery by being physically
and psychologically healthy. She commented:

[I]t was so inspiring, at the time when I was really struggling, to see someone who
had a great career, who looked healthy, who was happy. That there really was a light
at the end of the tunnel…I saw her as exactly the kind of person I wanted to be. And
I’m not critical of her body. I can get there, too. And she’s not critical of her body.
That’s what I want (P7-1, 791-799).

4.1.3.3.3 *Having sensitivity, respect, and compassion.* The third sub-category of how
participants’ personal ED histories were considered by them to be helpful was based on their
reports that their ED experiences had engendered in them a strong commitment to treating ED
clients with sensitivity, respect, and compassion. For example, implying that her ED experience
had contributed to an ethos of respect and dignity in her work, as well as to flattening power
differentials in relationships with her ED clients, one participant who rarely disclosed her ED
history to clients commented:

Having had the [ED] experience, I feel very committed to not practicing an
us/them kind of perspective or seeing…[clients] as being those people over there
with problems and somehow I’m removed from that (P1-2, 291-304).

A few participants stated their perception that an us/them stance was a particularly disrespectful
or unhelpful aspect of “mental health” or “medical” models for treating EDs.

Around one-third of the interviewees and one of the authors reported encountering
disrespectful and insensitive attitudes and behaviours among other ED professionals about EDs
and the people who experience them (e.g., using disparaging language to describe clients; talking
about ED behaviours such as vomiting in a sensationalized fashion). For example, one
participant stated:

I think that a lot of times eating disorders get written off in the profession…as,
like, “They’re just crazy,” or “They don’t know what they need,” or “They don’t
know what’s good for them.” And, you know, they certainly have cognitive
distortions and things like that, but what’s important to me is to just always have a
sensitivity that these are, most of the time, just lovely people that have a story
(P9-2, 308-316).
Certain of these negative attitudes encountered were also experienced as personally hurtful. Referring to the strong feelings that disrespectful verbalizations from colleagues had elicited in her, Goldkopf-Woodtke (2001) wrote:

I am always angered to hear a colleague make derogatory statements about an eating disordered patient or to read material that does the same...On one level, I admit that it hurts and saddens me that this disorder is so misunderstood...I believe we should be more cautious when responding to one another, checking our own reactions before speaking or acting them out. We owe this respect to our patients and to one another (p. 176).

4.1.3.3.4 Summary.

Ethics experiences and beliefs relating to the helpfulness of the therapist’s ED emerged as a third major sub-category in the ethics terrain associated with therapists’ personal ED histories, and included sub-categories of “getting” clients’ experiences, instilling and maintaining hope, and engendering sensitivity, respect, and compassion. Helpfulness of the therapist’s ED was linked conceptually to therapist wellness, in that a sufficient degree of recovery and distance from the ED was perceived by participants to be required in order for it to actually be helpful. Participant opinions were mixed as to whether having an ED history made one a better ED therapist than not having had an ED.

I observed across these findings that participants, perhaps unsurprisingly, demonstrated relative ease when discussing these helpful experiences versus when discussing the more potentially pitfalls-associated areas of wellness and boundary issues/concerns. Their verbalizations about helpfulness were almost matter-of-fact, or, as in the case of two participants, very positively skewed towards the greater effectiveness of ED-historied therapists over non-ED-historied therapists. These observations prompted me to wonder whether the perceived helpfulness of therapists’ ED histories might require additional ethical ‘unpacking’ in order to consider what other factors might be at play (e.g., confirmatory bias? client tendencies to not express that they perceived a therapist’s ED as unhelpful?) and what other questions might be
asked (e.g., How is “getting” clients’ experiences different from the concepts of accurate empathy or advanced accurate empathy?) Certainly, the helpfulness category emerged due to the strength with which it appeared amongst participants’ narratives. As suggested by the next major category in the ethics terrain (openness regarding therapists’ ED histories), one potential reason for these strong endorsements could be a reaction to perceived non-acknowledgment of ED-histored therapists in the EDs field and/or distinctly negative assumptions made about them.

4.1.3.4 Openness regarding therapists’ ED histories. The final major sub-category of ethics experience that emerged in the ethics terrain associated with therapists’ ED histories was openness regarding these histories. Two themes or sub-categories emerged within this category. The first was participants’ experiences of the perceived degree of openness at the workplace and/or within the broader EDs field to the presence of therapists with personal ED histories. This aspect of openness initially emerged spontaneously in two participants’ responses to the main interview question, but was echoed in other participants’ comments during the course of the interviews. In considering openness further, I went back to the data and ultimately conceptualized openness as having a second aspect that seemed complementary or reciprocal to the first. This second aspect referred to therapist experiences relating to the degree to which they themselves were open about their personal ED histories. Together, these two aspects of openness seemed to directly influence the degree to which the ethical issues relevant to such therapists were acknowledged and/or discussed.

4.1.3.4.1 Openness of workplaces/EDs field. The first category of openness regarding therapists’ ED histories referred to the perceived degree of openness at the workplace and/or within the broader EDs field to the presence of therapists with personal ED histories. A few participants described working in settings in which therapist ED histories were accepted, and, in some cases, considered an asset to the work. These participants tended to report more positive experiences of interacting with colleagues about ethical issues, including those issues associated
with practitioners’ ED histories. For example, one therapist described her team’s response when problems amongst clients concerning staff members’ ED histories arose in the centre and were impacting treatment delivery. She remarked:

[W]e do a really good job of supporting one another and if anybody hears something, we deal with it right away…We can come in and talk about it, and process it, and what’s going on (P9-1, 486-489).

However, this participant also reported an emotionally painful experience regarding her degree of wellness being distrusted by some staff due to her thin body shape. She reported making extensive efforts to prove her wellness to them (e.g., by doing a lot of meal support with clients), and stated that, as a result, her colleagues had come to view her as demonstrating wellness, telling her “you have built credibility” (P9-2, 856).

In direct response to the main interview question, two participants spontaneously described ethics experiences suggesting that there was non-acknowledgment and/or non-acceptance within their workplaces regarding the presence of practitioners with personal ED histories and the vulnerabilities and ethical issues they might encounter. This type of atmosphere was perceived by participants as having the potential to negatively impact client care in terms of protecting clients from therapists’ unresolved issues and buffering clients against unhelpful therapist messages that could perpetuate stigma about EDs. For example, one participant, referring to her experience of the larger system in which she worked, stated:

How can we not be triggered in this work? Like, ethically, to be in a context that does not accept that, I think is unethical (P10-1, 1639-1641).

In another example, a participant stated that it was not the norm at her workplace to acknowledge or discuss ethical issues encountered by therapists with personal ED histories, such as self-disclosure. She commented:

I’ve been frustrated that this work environment is not open to talking about that…I think it’s really important because half the people I know who work in this field have personal histories. If it’s something that’s happening, it’s a relevant issue for a number of clinicians and researchers, and it’s neglected, it’s avoided, it’s
stigmatized – even within our own field as we’re trying to counter that stigma in the world and with our patients who are living with that – [that’s] a dissonance I don’t like to sit with (P7-1, 309-317).

Regarding interdisciplinary teamwork, its positive aspects were mentioned such as accessing different perspectives on cases/treatment and consulting on topics typically outside of therapists’ scope of practice (e.g., involuntary treatment, nutrition status). However, a few participants who had worked on interdisciplinary teams in which the philosophy tended towards what they described as a “medical” or “mental health” model perceived this climate to be more pathologizing, including of staff. As a result, talk of personal or professional vulnerabilities amongst colleagues was atypical, and the ethical relevance of practitioners’ ED (or any mental health) histories was reported to be either not discussed at all, or not discussed in ways that were ethically useful to the therapist (e.g., a nuanced conversation about countertransference issues). One participant had initially disclosed her ED history to management and a few colleagues, but then realized that no one else disclosed such information. She elaborated:

[W]e use a lot of medical terms here… I fairly freely talked about struggling with [another mental health issue]. But, I even stopped doing that because it’s too easy for my opinion or my presence to be then seen as, “Oh, that’s just [participant’s name mental health issue].” [Y]ou don’t reveal a lot in moments where, in other contexts, one could easily say. [It’s] just the culture here…[around not disclosing any] disorder or pathology (P4-1, 354-366, 375-377).

From this participant’s perspective, this norm had resulted in interpersonal interactions that rendered team consultations unsafe for her, and had inhibited the types of discussions that she would have found effective in helping her grow ethically as a therapist (e.g., in terms of developing self-awareness). Consequently, she said, “I go to work and I do the work, but, in some ways this, this part of me is cut off” (P4-3, 234-235), a sentiment echoed in the writing of Bloomgarden (2000).

Regarding the broader EDs field, one participant stated that it was “not the safest or the most comfortable field to work in” (P1-1, 940) due to negative perceptions about practitioners
with ED histories’ involvement in EDs treatment. She remarked:

[M]aybe this has to do with my experiences, [but there seems to be] the view that if you’ve had a personal experience, that somehow is going to skew your work, and skew it towards the negative (P1-1, 704-708).

Another participant referred to a “taboo” regarding the presence of such therapists in the EDs field that resulted in covert conversations:

I think there’s a lot of misconceptions about therapists that have personal histories and how that influences their work...[Having an ED history] is taboo. When you go to an eating disorder conference...and just to talk to other trainees when so many of them [have ED histories], it’s like this secret conversation that we’ll have, [which] just feels hypocritical...[T]here’s just this disconnect (P7-1, 342-343, 426-431).

Ethically, this type of broader context non-acknowledgment or -acceptance was viewed by participants as having the potential to foster therapist isolation, leading to insufficient or inadequate consultation and supervision. It was also suggested to hamper the development of therapists’ self-awareness and integration of the ED into their work due to there being few opportunities for dialogue. As one participant stated:

[You can’t] see how your own experience is affecting your work...[Y]ou can justify things in a way that doesn’t necessarily translate to good clinical care...[I]f it’s something that you can’t talk about, you miss the opportunity to see where is this coming up for me? Where is it coming up for other people? How are they handling it? (P7-1, 411, 415-416, 420-422).

4.1.3.4.2 Therapist openness. The second aspect of openness concerned therapists’ own degree of openness about their personal ED histories. Interviewees reported a wide range of experiences with respect to disclosing their ED histories to colleagues and/or management at the workplace: to no workplaces past or present; to all workplaces past and present; to all present colleagues/supervisors; to only some present colleagues/supervisors; and initial disclosure to colleagues/supervisors followed by the realization that it was not the norm to discuss this information. Regarding the last experience, for example, describing the norms at one workplace, a participant stated:
I knew other people [staff] who were recovered and also didn’t talk about it. So… like, “Oh, if they’re not, then I’m not.” I never asked anyone (P8-1, 223-225).

Whether therapist self-disclosure of ED history to colleagues was met (or predicted to be met) with acceptance and/or whether or not there was openness in the workplace about other staff members’ EDs or other mental health histories appeared to influence the degree to which participants (1) participated in on-site supervision or consultation around issues that were ethically relevant to their ED histories, (2) felt they could be ‘themselves’ at work, and (3) perceived consultation or supervision meetings as effective and therefore engaged in them fully. For example, one therapist described working with a team of therapists who were open with one another about their personal mental health histories and other personal and professional vulnerabilities. Time had been dedicated in their schedule for weekly process meetings. The participant commented:

[We] have a human team of therapists who are transparent, and we value that on our team. We’re emotional. We’re connected to our own stories…In the last three years [since] we started this, I’ve seen huge transformations in them as therapists. And I know it’s that, because they’ve told me that they’re able to be real at work (P10-1, 533-536, 1270-1273).

In contrast, other participants reported that colleagues had expressed frank disapproval about the involvement of therapists with personal ED histories in EDs treatment delivery or had suggested they keep quiet about their histories. Comments from therapists in private practice indicated that they worried about being judged negatively by colleagues regarding their ED histories if these were to become known, that they didn’t want to be thought of as having an unresolved ED, and that talk of unrecovered practitioners in the field was “whispered in the corners” (P6-1, 1151).

Two participants described experiencing particularly distressing interpersonal encounters at the workplace regarding the involvement of staff with ED histories in treatment delivery. As a result of these encounters, there seemed to be profound and long-lasting implications for these
participants in terms of their sensitivities and/or future disclosures to colleagues. For example, one participant described what she termed a “horrific” situation at a workplace in which negative attitudes and behaviours about ED-historied practitioners had been directed by a team member towards all staff with ED histories. She noted that one ethical impact had been that staff had attended meetings in order to be “in the same room for the sake of clients,” but that team consultation “became far less collaborative and trusting” as well as shorter in duration (P1-1, 604, 616-617). She stated that this experience had increased her sensitivity to colleagues’ negative perceptions, as well as made her “cautious” about disclosing her ED history at future workplaces despite feeling otherwise ethically and clinically supported. She explained:

[My current manager] has made a couple of comments about other people who had been in this position, about their history, and they were out with it…[A]nd so I just thought, “Oh,” you know, “it’s not –” So, I haven’t [disclosed]…[Her comments] weren’t hugely negative, but they were (laughing) slanted in that direction. Like, that experience of the other person had definitely impacted her work in a not-so-great way (P1-1, 102-120).

The other participant described a difficult situation in which she had been approached by a colleague about a weight loss (which the therapist attributed to a period of high psychological distress rather than to the re-emergence of an ED). She recalled that she had been open to hearing this concern and feedback. Sensing a safe opportunity to disclose her ED history to this individual, she stated:

[I said,] “Yeah, it’s something I’m aware of and I’m working on,” and, “No, it’s not affecting my work and, there’s no eating disorder and I know the difference”…And so, [they’re] like, “Well, okay. Don’t tell anyone else that”…I was so angry. I was so angry…It just – it felt very invalidating…So, it’s like, “Did you come to talk to me because you think it’s something that needs to be hidden?” (P7-1, 676-719).

Both participants described feeling observed or “watched” by others at the workplace regarding their ED status when their ED history was known. For one therapist, being told, “You’re looking much better these days” by her colleague made her feel somewhat relieved that her weight was likely no longer being scrutinized.
Even when participants did not experience distressing situations regarding attitudes towards their ED histories, merely the perception or prediction that one’s history would not be accepted positively at a workplace was enough to deter some of them from disclosing this information. For example, in her first-person account of grappling with whether or not to disclose her ED history in her role as a group therapist with adolescents with EDs, Bloomgarden (2000) stated:

Each time I considered the possibility of disclosing to [the clients], I knew it was equivalent to taking a megaphone and announcing my history to all my Renfrew co-workers...I was worried, first, that my colleagues would not approve of my use of self-disclosure, and second, that perhaps some would be judgmental about the information itself...I feared this would undermine my leadership role at work (p. 348-349).

She described regretting not disclosing her ED history to her colleagues, noting that she might have obtained more helpful ethical consultation had she been open with them.

For participants who were not comfortable disclosing information about their ED histories with on-site supervisors or colleagues, having a relationship with a trusted off-site supervisor, consultant, and/or mentor who knew about their ED history in relative depth seemed key. Some participants reported that these relationships were maintained over great geographical distances and had been in place for several years. They were reported to provide a space for participants to talk about “everything” that could come up regarding their ED histories that they did not feel they could discuss safely at their worksite.

4.1.3.4.3 Summary. Ethics experiences, perceptions, and beliefs relating to openness regarding therapists’ ED histories comprised the fourth and final sub-category emerging in the ethics terrain associated with therapists’ personal ED histories. This category included therapists’ perceptions of the degree of openness at the workplace and/or within the broader EDs field to the presence of therapists with personal ED histories and to the ethical issues relevant to them. Openness also included therapists’ own degree of openness about their personal ED histories.
For participants who experienced more positive interactions and openness between and among their colleagues regarding their ED histories, other mental health histories, or other vulnerabilities, the mutual transparency associated with these interactions was valued and was seen to promote and enhance ethical discussions relevant to therapists with ED histories. Conversely, for the therapists who reported that workplace environments and/or their own fears of negative judgments had led them to “cut off,” “block out,” “deny,” or otherwise set aside their ED history at work, there were fewer and/or less useful opportunities to engage with colleagues to explore and integrate the ED-historied part of themselves into their work in supported ways, or to otherwise consider and explore ethical topics relevant to their personal ED histories.

4.1.3 Summary of the Ethics Terrain

In answer to the research question (For therapists with a personal history of an ED, what are their experiences of professional ethics in their day-to-day work with ED clients?), the first major area of findings that emerged described the ‘ethics terrain’ (i.e., ethical issues identified/encountered in day-to-day work with ED clients, as well as perceptions and beliefs). Together, the categories and sub-categories therein represented an initial mapping of the ethics landscape encountered by ED therapists with ED histories.

The first sub-area of the ethics terrain comprised therapists’ ethics experiences that they did not explicitly associate with their personal ED histories (professional competence and/or scope of practice, client confidentiality and its limits, ED client safety and high risk ED clients, boundary issues, discontinuing therapy, clients with comorbid borderline personality disorder, resource concerns, and reality television). The second, particularly substantial sub-area of the ethics terrain included ethics experiences reported by the therapists that were perceived by them as being connected to their personal ED histories.

Categories in this second sub-area included (1) boundary issues (challenging assumptions of therapist-client similarity, centralizing the client’s ED experience, self-disclosure, and dual
relationships); (2) therapist wellness (experiencing an active ED and/or residuals, healthy integration of the ED experience into one’s identity/work, having self-awareness/blind spots, being congruent, and being “real”); (3) helpfulness of the therapists’ ED (“getting” clients’ experiences; instilling/maintaining hope; having sensitivity, respect, and compassion for ED clients); and (4) openness regarding therapists ED histories (perceived degree of openness of workplaces/EDs field about practitioners with ED histories and the ethical issues relevant to them, and degree to which the therapists themselves were open about their ED histories).

Beyond these descriptive findings, I briefly summarized my observations about each major area in the ethics terrain, which initiated the interpretive process. In general, I observed that many ethics experiences reported (particularly those perceived as falling in “grey zones”) were described by the therapists as anxiety-provoking and/or were observed to be recounted with nervous laughter or other indicators of unease. Regarding ethics experiences associated with therapist ED history, those related to boundaries and therapist wellness ethics seemed to elicit particular discomfort and to provoke ED-historied therapists’ consideration and exploration of potential helps and harms to ED clients. The data suggested that participants had experienced early career and/or early-in-recovery vulnerabilities in each of these areas (e.g., based on reports of lacking insight and having blind spots) that may have been associated with elevated risks of harm to ED clients. In contrast, participants identified what was helpful about their ED histories with relative ease. This suggested potential influencing factors on this category, including perhaps a reaction to workplace environments that either did not acknowledge, or did demonstrate overtly negative attitudes towards, ED-historied therapists and the ethical issues relevant to them. The data indicated that such atmospheres curtailed ED-historied therapists’ participating in exploration and dialogue that could be ethically helpful to them.
Next, I turn to the second major area of findings that emerged. Presented below, these findings answered the research question from a process perspective and centered on patterns that emerged from considering data gathering during the interviews.

4.2 The Interviews as Ethics Experiences

As data collection and analysis progressed, I began to conceptualize the interviews as a type of ethics experience for the therapists. This was an unanticipated focus of analysis at the study’s outset, but was stimulated by observing how participants discussed the ethics terrain and were interacting with me. Furthermore, curious about how participants might be experiencing the interviews, I asked them about any reflections and changes occurring in their practices as a result of the interviews. The emergent knowledge revealed more latent patterns among participants’ experiences of engaging in conversation about the research topic, as well as concerning self-reflections and practice-enhancing changes to their practices that had occurred. These results contributed to a more textured and integrative understanding of participants’ ethics experiences.

Two thematic sub-areas emerged in these process-oriented findings. The first sub-theme – comfort with the research topic – emerged from my analysis of therapists’ verbal and nonverbal communications regarding their degree of comfort when discussing the research topic, including discussing professional ethics and the intersection of ethics and personal ED history. The second sub-theme – reflections and changes – emerged from analysis of therapists’ indications that they had been affected by our conversations, reflected on them, and, in several cases, had made changes to their ethics practices. Each of these sub-areas is elaborated in the sections below. Table 7 in Appendix F identifies the sources (i.e., participants) contributing to these findings.

4.2.1 Degree of Comfort with the Research Topic

Many participants expressed feelings of discomfort about the topic of professional ethics itself, and, for the vast majority of participants, talking about the interface between professional
ethics and their own ED histories seemed to add a dimension of risk to our conversations. Thus, degree of comfort with the research topic constituted the first major theme in the process-oriented findings. These findings are divided into two sub-categories: degree of comfort with professional ethics (comprised of several sub-areas), and risks in talking about professional ethics in combination with personal ED history. These categories are elaborated directly below.

4.2.1.1 Degree of comfort with professional ethics. The first sub-category within therapist comfort with the research topic that emerged was therapist degree of comfort with professional ethics. Interviewees’ feelings of uncertainty, anxiety, and lack of confidence about ethics were commonly expressed both verbally to me (e.g., “I don’t feel confident in my ethics”; “Is this ethics?”; “I’m having trouble with the word ‘ethics’”), and nonverbally (e.g., making faces, nervous laughter, fidgeting). One participant remarked that there rarely seemed to be an “easy resting place” or “arrival” with ethics, thus there was inherent discomfort associated with it. Participants stated they wanted to review ethics textbooks, or that they should think more about ethics. One participant remarked that ethics was “a tough subject to stay oriented to.” Two participants who expressed feeling a lack of confidence about professional ethics remarked that they were much more interested in the therapist’s ED history aspect of the study than the ethics component.

A relatively more comfortable relationship with the topic of professional ethics was suggested in the verbalizations of 3 participants. These individuals spoke about ethics and their ethics experiences with more straightforwardness and ease, even when discussing experiences they admitted had been challenging. One characteristic they shared was the type of ethics training they had received, which had been relatively more recent, spread across multiple opportunities, had explored topics in depth, and/or instilled confidence through a positive, reassuring tone and a credible instructor. All of these participants were relatively early-career practitioners. They described their professional ethics education and training as having been
memorable and valuable. They seemed to possess an awareness of their own sense of self-assurance around ethics, relative to what they observed in colleagues. For example, one participant recounted attending an association meeting, where she described the other attendees as having been “bundles of anxiety.” Contrasting this with her own experience, she explained:

[M]y professor was a member of the…[State] Psychological Association and she was the main ethics person there, so I knew she was competent. But her message to us was, as long as you’ve done what you need to do – like, if you’ve documented, consulted, made the best decision, you know ethics, and you’ve used your personal judgment, you’re probably going to be okay…I’ve never felt [anxious] about ethics. (P8-2, 601-607, 639-640).

Commenting on her familiarity with ethics, the second participant in this sub-group commented, “I feel like me and the ethics code are [claps hands together].” This participant reported attending a dedicated ethics class in her graduate training, multiple ethics seminars during her practica, and an ongoing ethics seminar with an instructor who had written books about ethics. About her graduate education, she stated: “Every year, there’s been some component of ethics” (P7-2, 912). The third participant who seemed relatively comfortable with ethics spoke at length about her commitment to maintaining and continuously questioning her boundaries in her work, and noted that she had received substantial boundaries training in her graduate program.

In contrast, participants who expressed unease about professional ethics tended to have received their ethics education/training many years prior and/or had difficulty remembering what components had been included therein. Some described ethics as an “abstract” concept that was challenging to reconcile with the more “embodied,” everyday work of therapy. They tended to express more uncertainty regarding whether certain topics they brought up in the interviews constituted ‘ethics’ or were ethically relevant, as well as more anxiety about being judged negatively regarding how they engaged with ethics. Some made statements indicating concerns about providing correct answers and a few described frankly negative associations with the
concept of professional ethics. Each of these factors seemingly associated with reduced comfort
with professional ethics is elaborated below.

4.2.1.1 Ethics as ambiguous and abstract. The first sub-category of discomfort with
professional ethics that emerged was that ethics was perceived as being ambiguous and abstract.
Describing how perceived ambiguity and lack of certainty around ethics contributed to her sense
of uneasiness, a participant remarked:

I think any conversation [about ethics] feels highly inadequate (laughing). It’s
such an incredibly complex thing…Ethics is sometimes in the in-between. It’s -
it’s hard to put language to it. And it’s – and it’s kind of like…Well, in this
situation, this, and in this situation, this, and then they can be so (laughing)
completely different…I think good ethical decisions leave some sense of, “Hmm,
was that the right kind of thing?” (P1-2, 675-680, 689-693, 700-704).

Other participants commented that they perceived ethics as an “abstract,” “left hemisphere,”
“thinking word” or concept that was challenging to connect with the more “intuitive” or
“embodied” experience of delivering psychotherapy. For example, making a process observation
about her feelings of uncertainty in talking about ethics versus her personal ED experience, a
participant stated:

It’s interesting because I can talk all about me right? But when it comes to the
textbooky things then I’m, like, “Oh, ethics?” That’s such an out there – like, just the
word ‘ethics.’ It is abstract. So, you’re having to pull from these abstract concepts
that I feel like are not within me…I’d have to study it almost to give you a good
response (P11-1, 763-768).

Certain aspects of ethics (e.g., record keeping, secure storage of notes) were viewed as less
abstract and ambiguous than others (e.g., self-disclosure).

Furthermore, there was uncertainty expressed by some participants about whether some
subjects they brought up were relevant to ethics. Brief interviewer prompts, paraphrases, and
summaries seemed to orient these participants to the ethical dimensions of the topics they were
uncertain about having brought up (e.g., whose needs were being served in therapy, the
pertinence of self-disclosures, what is responsible caring, the relationship of client-therapist
differences to boundary issues). Typically, I observed participants’ hunches about what to discuss as ethics experiences to be ethically relevant. For example, a participant remarked:

P: Um, ethics around working too – well, I don't know if it’s an ethical – is that an ethical issue in terms of working too hard for the client or that kind – is that ethics or is that…or not? I don’t think that’s ethics so much but…
Interviewer: Well, tell me what you were thinking about…
P: Well, just – just, ah, willing to help – facing that issue of wanting to help and getting too - too much invested – it’s a bit – it’s somehow about me wanting to help rather than [about] them, [versus] what’s actually helpful and being clear on a boundary (P4-1, 721–727).

Similarly, another participant became uncertain about whether what she was saying about therapist self-disclosure of ED history constituted ‘ethics:’

P: So, am I talking about ethics? I don't think I am. Um…
Interviewer: I mean, you’re talking about disclosing that information to clients, with a specific purpose in mind, um…
P: But the disclosure has to be pertinent. Because otherwise it becomes – I mean, to me, it’s not professionally conscionable (P2-1, 255-261).

Explaining her uncertainty about what constituted professional ethics, another participant stated:

[T]he ethics course was so long ago, and sometimes I forget what’s ethics and what's not ethics. I sometimes get intellectually confused around [it]…So what do I think of [as ethics]? Dual relationships, which I [discussed]…I should go look at the chapters from that book (laughing) (P4-1, 959-974, 990).

Dual relationships, and other more common ethics topics (e.g., professional competence), as well as the more transgression-related aspects of ethics (e.g., violating standards), seemed to function as particularly salient reference points for some participants. However, some of these individuals expressed difficulty in being able to connect these topics to their day-to-day work with ED clients. For example, a participant initially commented that “the typical ethical things” such as “dual relationships” didn’t apply in her work with ED clients. For her, professional ethics was synonymous with “breaking an ethical code…I don’t see the potential [for] ethical violation so much [in eating disorders]” (P3-2, 693-701).

4.2.1.1.2 Getting it right. The second sub-category of discomfort with professional ethics that emerged involved therapist perceptions that there were right and wrong answers. For
example, I always referred back to the main interview question to ascertain if there were any other ethics experiences participants wanted to tell me about. One therapist responded:

P: I’m having such trouble with the word…I guess because, when I think about that…[pauses]
Interviewer: Hm. Tell me about that…
P: Well, okay, when I think ‘ethics,’ I think – Okay, here it is [reaches for book]. I pulled it right out. The ethics manual…[It’s] about complaints, violations, um, our code of conduct, concerns for others’ welfare, social responsibility, competence. Um, I’m - I’m just not sure what it is you want me to say….Like, I don’t know. I just feel like, is there a right and a wrong here? (P5-1, 785 – 800).

This exchange had occurred after the therapist had eloquently described a variety of her ethics experiences including self-disclosure, confidentiality, caring for clients, supervision, scope of practice, and consultation. Her comments implied a concern, perhaps elicited by my return to the main interview question, that I was evaluating her responses against some standard of correctness or completeness she had not yet met.

I had been careful to try to convey in the interviews that I was not looking for right or wrong answers, and that I simply wanted to be curious about and understand participants’ ethics experiences. Accordingly, the main interview question had been constructed very broadly so that participants could go in any direction they chose. However, the question’s breadth (eliciting “That’s a big question” responses from a few participants) and lack of explicit topical direction from me provided few footholds in terms of expected answers. With no specific guidance, some participants asked for direction or reassurance that they were on the right track (e.g., “Can you give me some prompts?”; “Is this the kind of thing you are looking for?”). I typically responded to these questions by paraphrasing and/or empathizing with their desire for more direction, and stating that I was interested in hearing their perspectives. I also showed interest in and explored contextual information that participants shared with me (e.g., interpersonal interactions on teams, workplace norms and philosophies, etc.), which may have been puzzling for some of them in terms of perceived relevance to professional ethics.
Some participants expressed wanting to know whether they were ‘on the right track’ as compared to the other interviewees in terms of their responses. For example, one stated:

I’ve noticed I was feeling like I wanted to know how I did (laughing), which is so silly in a way because it’s a research study...But it’s like I - I wanted to know – I’ve been really curious about what did other people say? And how did my stuff fit with that and did I – I don't know – I just had the sense of, did I do it right? Or did I do it well? And that’s a weird kind of, um, experience (P10-3, 13-21).

Participants also asked me about the other participants’ perspectives concerning a variety of specific experiences and practices (e.g., self-disclosure, team dynamics), wanting to find out how their perspectives compared or contrasted.

Explicit concern about being covertly evaluated on the quality and/or ethicality of her work was also expressed by one participant. Perhaps perceiving an expectation from me that changes should be occurring in her practice over the data collection period, and feeling momentarily uneasy about the motives of the research, a participant and I had the following exchange after I had asked her in the second interview (as I did a variant with all the participants), “Are you thinking about ethics differently or are you doing anything differently since our first conversation?”:

P: I just had this little paranoid piece rise in me...[T]hey have all these tricky studies [that] have a bunch of people in a movie and they’re evaluating the movie, but really you’re measuring how much popcorn they’re eating. And so, um – so, I just started wondering – is there another piece to this? Interviewer: No, there’s no deception...I think that would be pressing the boundaries of ethics. P: [Y]ou’re not evaluating me. Interviewer: No. I mean, I’m trying to understand your work (P6-2, 624-634, 639, 645, 684-688).

When participants felt concerned about my or others’ negative judgments, it may have felt risky for them to talk about subjects they perceived as being in ethical “grey areas,” unusual, inconsistent, or about which they felt ethically uncertain. For example, describing her deliberations between our first and second interviews about whether or not to tell me about hugging clients (an accepted practice at her workplace), a participant said:
I hesitated to bring up that hugging thing, because I was like, “Oh, is she going to think that’s not okay?” or, you know, or - or whoever listens to this, are they going to go “Hoh!” or whatever…[I wanted to convey that] I’m really ethically appropriate (laughing). I really do think I have good boundaries…And then it seemed, like, would that cause her to question that if I bring up that particular topic? (P9-2, 595-599).

Unease about ethics was also attributed by one participant to perfectionistic tendencies. She and I spoke at some length about our shared perception of her ‘freezing up’ when I had uttered the word ‘ethics’ in our interviews. In reflecting upon her reaction, she described the challenge of wanting to have all the answers and yet not wanting to engage with the research topic in a perfectionistic way: “In my golden days, [I’d] look it up and try to be perfect” (P11-1, 1068-1069).

4.2.1.1.3 Negative associations with ethics. The third sub-category emerging within discomfort with professional ethics involved therapists’ frankly negative associations with professional ethics. A few experiences were described, including those relating to shame, self-silencing, and a perceived ethical/unethical dichotomy. For example, when asked what professional ethics meant to her, a participant stated:

Oh, wow. Well, it feels like something really shameful and unspeakable and legal and, I mean, it just brings up ways to screw up…it feels very black and white, like there’s ethical and unethical…[W]e go to these regular conferences…(laughing), and there’s always a lot of light bulbs, like – “Um, wow – almost did that. I guess that wasn’t a right thing to do” (P6-2, 760-762, 769-774).

At times, unpleasant feelings about, or associations with, professional ethics were revealed when the interviewee felt more relaxed. For example, at the end of our second interview, I asked one participant if we could turn on the recorder again, as she had begun to spontaneously describe in more depth her feelings about ethics. She stated:

[I]t’s my insecurity around ethics…I’m not a left brain person, so I don’t remember detail and points. And I can’t recite rule number X blah blah blah…Maybe, that was my interest in getting involved [in the study] was maybe I am breaking some ethical thing and wanting to know (P3-2, 154-163, 1328-1339).
Despite reporting feelings of insecurity about ethics, this participant had spoken eloquently about client safety, confidentiality, and keeping clients’ needs at the forefront of her work.

**4.2.1.2 Double risk in talking about ethics and personal ED history.** The second sub-category of degree of therapist comfort with the research topic was therapist risk in talking about the combination of professional ethics and their ED histories, which I came to conceptualize as being a potential ‘double risk.’ While the topic of professional ethics alone seemed anxiety-provoking for many (but not all) of the participants, talking about the interface between professional ethics and ED history seemed to add another dimension of risk to the conversations for all the therapists. As one participant noted:

> When you have had an eating disorder, and when you tell people [that], you are revealing an aspect of yourself that’s pretty, um, intense. You’re – you’re – you – you are saying that you’ve had a - a severe mental problem (P5, 662-665).

Certain participant behaviours suggested that there were risks for them even in participating in the study, particularly in terms of privacy. Prior to their agreeing to participate, I had telephone conversations with two therapists in which they requested assurance that their workplaces would not become aware of their participation. During some interviews, I observed therapists to speak in more hushed tones when discussing aspects of their personal ED history versus other ethics topics, regardless of the level of sound blocking technology in their offices. When I brought this up, the participants stated they had been unaware of this behaviour. In only 1 of the 7 team settings where I interviewed participants was I introduced to colleagues and offered a tour of the facility (a centre in which staff members were described as being open about, and valued for, their personal ED histories). Another participant disclosed that she had considered touring me around her workplace, but was unsure about whether that would be comfortable or safe for her.

Several participants also admitted to being conscious of, or feeling uncomfortable about, how I perceived them and whether, given their ED histories, I was evaluating their degree of
recovery and/or their professional competence or clinical judgment. Spontaneous feedback was provided by many participants that they did not feel judged by me. Nevertheless, one participant stated:

I’m conscious of having qualified [to you that my weight loss last year] wasn’t the eating disorder piece coming back up…And I’m aware of having really tried to make that distinction, and kind of qualify that statement…saying, “I don’t have an eating disorder (laughing) because I lost weight” (P7-2, 774-782).

Another therapist remarked:

I definitely want to leave the impression that I’m competent in what I do. I don’t believe I have an eating disorder. I - I - I have my issues about – about, um, aging, about my body staying fit, but I think I have a pretty good handle on my food (P5-2, 300-308).

Discomfort was also expressed by two participants about the possibility that the way they perceived their own ED histories or their work might be altered by participating in the study – for example, that they might discover they were not recovered enough to be practicing effectively, or that they were engaging in unethical practices. For example, one therapist remarked:

As I’m talking with you, I have this intense desire or pressure to - to prove I don’t have an eating disorder (laughing) because I just believe that it would be really unethical for me to be working here if I did…Maybe I’m afraid of finding out as I [participate] in this research, gosh, maybe I’m more troubled in this area than I should be (P4-1, 260-271).

4.2.1.3 Summary.

A theme that emerged when analyzing the interview process concerned participants’ degree of comfort with the research topic. This contained two sub-themes: (1) degree of comfort with professional ethics, and (2) the double risk involved in talking about ethics and personal ED history. The risks involved for participants in discussing the ethical implications of their personal ED histories were likely present for participants during the interviews. Nevertheless, participants engaged with the subject matter in considerable depth despite their discomfort, suggesting that the interview conditions had been conducive to their sustained engagement with it. In the next
section, I present findings regarding outcomes of the interview process suggesting that it had catalyzed participants’ ethical self-reflection and practice-enhancing changes.

4.2.2 Reflections and Changes

The second major theme that emerged from the process-oriented analysis involved therapist reflections and changes regarding their practices as a result of participating in the interviews. The great majority of participants stated that they had reflected on specific aspects of their practices, particularly between the first and second interviews. Many participants expressed that their interview participation had prompted them to examine the interface between their ED history and professional ethics in new or more in-depth ways, or for the first time. Self-disclosure was identified as the most frequently reflected-on practice. Participants reported that the interviews had prompted realizations and developments of the following types: reviewing and assessing their ethics knowledge and clinical practices, enhancing self-knowledge and/or clarity, increasing their feelings of comfort and self-assuredness about ethics and/or their practices, and catalyzing action. Being triggered regarding ED thoughts, feelings, and behaviours, and reflecting on these phenomena, was also reported as an outcome of participating in the interviews. These experiences are elaborated below.

4.2.2.1 Reviewing and assessing ethics knowledge and practices. The first type of therapist reflection and/or change resulting from participation in the interviews that emerged was the experience of having been stimulated to think about professional ethics and therapy practice with ED clients. Said one participant:

"Your questions really got me thinking…. [T]he more I think about it, the more this field is rife with ethical issues" (P2-1, 968-969, 984-985).

Participants reported that they had reviewed and reflected on specific aspects of their ethics practices such as assessing the degree to which they felt versed in professional ethics,
recognizing knowledge deficits, and re-committing themselves to developing and maintaining their ethics knowledge. For example, a participant commented:

Your questions have elucidated that I really could use some extra training, because I would like to be able to answer questions about ethics more thoroughly, with more of a knowledge base...There’s a reason why the licensing board has made ethics such an important part of our continuing education, and I think I’ve been taking shortcuts (P5-2, 1019-1025).

The clinical practice most frequently reviewed by participants between interviews was the use of self-disclosure (5 participants). For instance, in the first interview, one seasoned participant had reported disclosing aspects of her personal ED history to clients relatively regularly. In the second interview, she stated that she had “done a [mental] rewind” of this practice and was asking herself more questions before employing it. She said:

When I find myself using “I” in my sessions, I’m definitely thinking twice about who am I doing this for? Am I doing this for me? Because I like to talk about myself? Am I narcissistic? Or, am I really doing this for my client because I think that it’s useful for them to know? So, yeah, I think it’s brought something to light – to – to my consciousness (P5-2, 246-251).

In another example, an experienced participant had initially reported using self-disclosures related to her ED history occasionally in her practice. In the second interview, she noted that she no longer believed therapist self-disclosure was necessary. She remarked:

[The first interview] helped clarify my focus on attuning to them and not sharing, self-disclosing – I don’t think it’s necessary. If someone has shame issues, that can be about their shame issues. It doesn’t have to be me self-disclosing to make them feel better (P3-2, 1359-1362).

4.2.2.2 Developing self-knowledge and/or clarity. The second type of therapist reflection and/or change resulting from participation in the interviews that emerged was an experience of self-realization, self-awareness, and/or clarity around personal beliefs, biases, values, degree of wellness, decision-making, and meeting one’s own needs as a person and a professional. For example, a participant remarked:
[I]t’s always good to talk about things in safe, intimate ways, which this kind of feels that way, because I think it helps us to clarify what we think and really believe in (P8-1, 1065-1067).

In a particularly compelling example, one participant spoke of feeling “awakened” after the first interview regarding what she had believed was helpful for her ED clients, and had subsequently evaluated her practices and supervision needs. This participant had begun her ED recovery process approximately 3 years prior, and we had spent the majority of the first interview discussing her personal history. She stated:

I don’t think I realized what a strong belief I had about the way to treat eating disorders… I just thought it was the truth. You know when you realize your truth is maybe not the truth? That’s what happened for me, and so then I thought, “How do I know that?” “How do I know that for some people that they need a direction that would be different than what I received to help me?” So, I mean, that is a pretty big revelation…and then that’s a little humbling (P10-2, 163-172).

This participant continued to discuss her growing self-awareness around these issues into the third interview. Furthermore, she identified client “informed consent” as an ethical issue emerging from this self-awareness (i.e., informing her clients of her approach to treatment and helping to identify alternative options for them and/or referring elsewhere if they wanted or required something different).

For another participant, over the course of the three interviews, there seemed to be a process of moving towards clarity regarding stresses she was experiencing at work, her ED history, her current subjective sense of wellness, and steps she felt she might need to take to address these issues. She had indicated in our first interview that she was interested in participating specifically as an opportunity to learn about the connection between her ED history and ethics in her work. She initially mentioned a hunch about “a piece of personal work to do” concerning her ED history (P4-1, 665-668). She also noted that entering personal therapy might help her ultimately connect better with a subgroup of her clients, and might be a needed step in terms of her self-awareness and self-care as a practitioner. In our second interview, her clarity
and self-awareness seemed to be deepening. She remarked:

[S]everal times you said, “A personal history of an eating disorder” and it’s really moving to me…to hear you – to talk with you like this about all my work and all this stuff and sit with myself…I just feel, again – a personal history of an eating disorder. A personal history of an eating disorder. It’s been, like, so long ago, in some ways, for throwing up and the tightly knit place I was in. And it - it – yet it’s here. Oh my god, it’s here. And part of the work I could do in personal therapy [is]…I need to go through my teen years…I need to kind of knit a few things together, bring a few things forward…that would be helpful (P4-2, 1109-1121).

Another participant noted that the interview process had been helpful for clarifying her needs for connection and openness about her ED history, so that she could better prevent them from intruding into therapy with her clients. She commented:

It kind of reminded me of being at an OA meeting and how good it felt to just be open about [my ED]…It made me realize I miss that place where I can expose my struggles…I think a lot of that is just self care – recognizing my own needs and meeting them so that I’m not unconsciously sliding into something that’s more self serving than other serving (P3-2, 17-21, 58-60, 260-261).

4.2.2.3 Increasing comfort and self-assuredness. The third type of therapist reflection and/or change resulting from participation in the interviews was the experience of feeling decreased anxiety about professional ethics, or its intersection with personal ED history. For instance, one participant who had initially expressed feeling “not confident in my ethics” in the first interview stated that, upon reviewing an ethics book in between interviews, she realized she possessed an “embodied” sense of professional ethics. She commented:

[W]hen you see things like ‘expertise’ and ‘competency’ and ‘dual relationships,’ you realize that you are doing things without really thinking about them necessarily…I think generally I’m confident with the guidelines that I probably hold that are those internal things, that I don’t maybe have the right labels for when I’m not looking at the book (P11-2, 34-37, 284-287).

In our third interview, I admitted to this participant that I had considered switching around the question order (though ultimately had not) such that questions containing the word ‘ethics’ were posed last, in an attempt to protect her from feeling anxious at the beginning of our final conversation. We shared a laugh about this, and, suggesting the potential influence of exposure,
she stated that, as a result of our conversations: “I think I habituated to it, because I didn’t have that reaction [this time]” (P11-3, 236).

Other participants also expressed that, upon reflection, they felt more confident about how they had been handling certain ethical issues (e.g., self-disclosure and other boundaries issues). After reviewing her self-disclosure practices between the first and second interviews, another participant stated: “[F]or the most part I have felt okay about the way that I’ve presented me and my experience [to clients]” (P5-2, 14-15). Some participants reported that reviewing and assessing their practices had resulted in increased feelings of pride, confidence, or self-assurance about the ethicality of their work. Said one: “I can feel really good about my work” (P6-2, 818).

4.2.2.4 Stimulating action. The fourth type of therapist reflection and/or change resulting from participation in the interviews that emerged was the experience of being prompted to take particular ethically-relevant actions, including initiating an ethics conversation and entering personal therapy. For example, one participant described that the first interview had catalyzed her to broach the subject of therapist self-disclosure in her weekly ethics seminar (in which not all participants were working in EDs). She recounted:

And so I brought up, “There’s a lot of people in the eating disorder field who are recovered themselves and who are doing therapy….And, you know, even if you’re not, your patients are wondering and want to ask you, and I get asked it all the time.” So, without me saying I had one, and it just happens. [I framed it as,] “This is an issue that comes up that all therapists have to deal with, regardless of what population” (P7-2, 76-86).

She indicated that she had felt disappointed by the seminar group members’ and instructor’s responses, which she had perceived as avoidant due to their discomfort with the subject.

Nevertheless, she said, this experience had piqued her interest and inspired her to further action around how self-disclosure was being addressed in graduate training. She said, “I could really go on a campaign about this (laughing). There’s a lot of education needed in the field” (P7-2, 81-92).
In another example of taking action, the participant who was considering taking a leave from work and accessing personal therapy reported having done so in our third interview. She reported that this had been “a good thing to do” (P4-3, 9), since it had been “hard to do the work without integrating these pieces that I feel are unfinished” (P4-3, 85-86).

4.2.2.5 Being triggered. A fifth type of reflection and/or change resulting from participation in the interviews that emerged was the experience of being triggered regarding one’s personal ED. Two participants reported experiencing this, to differing degrees. These participants both conveyed that this had been a learning experience for them. These participants’ characteristics and demographics ranged greatly in terms of the amount of time they had spent during the interviews talking about the specifics of their ED histories, as well as their reported ages (span of 16 years), years of experience as a therapist (span of 18 years), years working with ED clients (span of 6 years), and recency of diagnosable ED (span of 26 years). However, it seemed that, for the participant with the more recent the ED experience (and who reported more traumatic antecedents), the interviews triggered more severe ED-related phenomena.

One of the participants had worked for decades in EDs and had identified as being recovered for approximately 20 years. She described her experience after our first interview:

[H]aving separated myself from my eating disorders such a long time ago, reconnecting on sort of a very powerful level instead of talking about my clients, talking about my own process brought up – it’s - it’s like – how would I describe it? It’s like going back to a place you’ve left and smelling something familiar. It’s like a very almost primitive memory. It encourages me to waken up the obsessive part of my brain that loves to be eating disordered…I’d certainly be exaggerating to say I’ve gone back to having an eating disorder, but it’s been much more prevalent and a part of my thinking than it was prior to our interview…I know that I went at lengths with you to say that it’s really pretty well as resolved as it ever will be…[Y]ou know what? Fascinatingly, hm, maybe it wasn’t (P2-2, 24-48, 324-327).

She continued that the experience of having “woken up the beast a little” had enhanced her practice with clients, such that she was providing a “much better connection,” “better
awareness,” and “much more patient” service as a result of having emotionally reconnected to her history (P2-2, 65-66, 335).

The other participant noted that, although she had been receiving ongoing supervision and personal therapy for a number of years regarding issues associated with, and underlying, her ED: “I’ve never sat and talked about my own bulimia in that much length – ever” (P10-2, 64-65). In the second interview, she described the triggering of ED behaviours and trauma responses as a result of talking about her history in the first interview, saying:

Talking about how I healed from bulimia – it just brings all that [trauma] up and I get, like, flashbacks…And so that was really powerful to sit down and tell the whole story and never has it been said out loud in that way (P10-2, 109-121, 1089-1090).

She expressed that she had experienced “a few slips” since our first interview regarding engaging in purging behaviour. She stated that what she had learned from the experience was that, “Whenever I talk about my story in any way, I will be heightened…so it takes me a couple of days to come down” (P10-2, 125-127). This therapist reported having several supports in place (e.g., professional supervision, consultation, mentorship, as well as personal therapy) where she could address these issues.

4.2.2.6 Summary. Participants reported that they had engaged in ethical self-reflection and made changes to their practices over the data gathering period. These included: reviewing and assessing their ethics knowledge and clinical practices, enhancing self-knowledge and/or clarity, increasing their feelings of comfort and self-assuredness about ethics and/or their practices, catalyzing action, and learning about themselves as a result of being triggered regarding ED thoughts, feelings, and behaviours. These findings suggested that the interviews, characterized by an atmosphere of non-judgment, curiosity, and empathy, had helped to catalyze such reflection and change in spite of participant discomfort about professional ethics and/or the risks involved in discussing its intersection with their personal ED histories.
4.2.3 Summary of the Process-oriented Findings

Participants’ experiences of participating in the interviews and discussing the ethics terrain they encountered were analyzed and conceptualized as ethics experiences. This was seen to answer the research question in an unanticipated way, from a process perspective. Two major themes emerged in these findings. The first was participant degree of comfort in discussing the research topic, both in terms of professional ethics (ambiguity and abstractness of, getting it right, unpleasant associations), but also personal ED history as it related to ethics (e.g., risks related to privacy, and perceived recovery status and ethicality of practice). The second sub-area was comprised of several categories demonstrating ways in which the participants’ ethical self-reflection and practices had been influenced positively by their participation in the interviews.

Together, these findings suggested that, for ED-historied therapists, talking about ethics, particularly in relation to personal ED histories, is likely to be anxiety-provoking. However, the interview process appeared to facilitate participants’ engagement with myriad uncomfortable ethical issues (many in considerable depth), and prompted positive ethical reflection and changes between interviews.

4.3 Summary of Findings

In answer to the research question (For therapists with a personal history of an ED, what are their experiences of professional ethics in their day-to-day work with ED clients?), two major areas of findings emerged in the form of a descriptive account: (1) the ethics terrain identified/encountered by the therapists (i.e., ethical issues that they either did or did not associate with their ED histories); and (2) therapists’ experiences of participating in the interviews, which resulted from analyzing more latent interview content. This second area of results contributed to a more nuanced understanding of participants’ ethics experiences, and answered the research question from a process perspective. Initial observations about these descriptive findings suggested the beginnings of certain implications for practice.
In the next chapter, as per interpretive description, I take a next step in the interpretive process to push these initial understandings beyond description in order to offer a more integrative interpretation that helps identify what the findings might mean in terms of applied practice, and why they matter.
CHAPTER 5 – Discussion

The ethics terrain map presented in the previous chapter answered the research question (For therapists with a personal history of an ED, what are their experiences of professional ethics in their day-to-day work with ED clients?) at a descriptive level that represented an organization of what participants reported. Of course, “all description entails interpretation” because no ‘facts’ are acontextual or divorced from the describer (Sandelowski, 2000, p. 335). However, the ethics terrain map resulted from a relatively low level of interpretation/inference regarding the data, and was supported with participant quotations such that what I described would likely be agreed upon by most observers as being “there” (Sandelowski, 2000).

However, the product of interpretive description should minimally represent a thematic summary or, preferably, a conceptual/thematic description according to Sandelowski and Barroso’s (2003) taxonomy of qualitative findings (Hunt, 2009; Thorne, 2008). That is, interpretive description findings should move away from being close to the data as given towards being more transformed/abstracted in order to tap into the subtleties of experience (Sandelowski & Barroso, 2003; Thorne, 2008). Latent patterns in the data should be identified, and portions of data interpretively integrated (Sandelowski & Barroso, 2003). In the present study, this next level of transformation began with analysis of the interview process, from which emerged latent patterns regarding participants’ experiences of engaging in conversation about the research topic, and their self-reflections and changes that had occurred over the course of data collection.

The approach taken to the discussion chapter represents an effort to further transform the ethics terrain and process-oriented findings from “telling what it is that [I] observed” (Sandelowski, 2000, as cited in Thorne, 2008, p. 47) to interpreting and concluding “what might this mean?” (Thorne, 2008, p. 49), and why it matters. As per interpretive description, combining description and interpretation values both the “careful and systematic analysis of a phenomenon
and an equally pressing need for putting that analysis back into the context of the practice field” (Thorne, 2008, p. 50). Thus, this next level of transformation involved considering both the ethics terrain and process-oriented findings in new ways that were informed by the practice goals of interpretive description (Sandelowski, 2000; Thorne, 2008).

The rationale for the study was informed by the potential for there to be ethical issues and concerns associated with the ED therapist/ED history/ED client intersection that required better understanding. Thus, to better understand the ethics experiences of the ED-historied participants in this study, I drew upon my knowledge of professional ethics, eating disorders, and the disciplinary values and underpinnings of counseling psychology to critically examine particularly noteworthy results among, and interpret patterns across, the terrain and process-oriented findings in a manner consistent with the interpretive description goal of enhancing the ethics practices of ED therapists with personal ED histories. From this process emerged patterns, concepts, and ideas that contributed to a more integrative understanding of participants’ ethics experiences (Sandelowski & Barroso, 2003; Thorne, 2008). These resultant patterns, concepts and ideas enhanced the clinical applicability of the study’s findings, and represented my conclusions regarding what is particularly important about the findings (Thorne, 2008; see also Morrow, 2005).

The chapter is organized as follows. It begins with a brief reiteration of the study’s rationale. Next, I present my interpretation and situate several of its components in relation to bodies of extant literature. While portions of the literature presented in Chapter 2’s analytic forestructure remained relevant to some of these conclusions, other literature in psychology and ethics more helpfully located, illuminated, and/or developed other conclusions. Subsequently, implications for practice and research are discussed, in the form of recommendations. The chapter closes with a discussion of delimitations and limitations of the study, and a concluding summary.
5.1 Review of Rationale for the Study

The ethics codes of psychology and counselling direct practitioners to monitor personal factors that can influence potential benefits and harms to clients. Consequently, therapists who have a mental health history (in the present study, ED therapists with a personal ED history) have a professional ethical obligation to evaluate how that history influences their interactions with clients and to “integrate this awareness into all efforts to benefit and not harm others” (CPA, Standard II.10, p. 17). While limited conceptual literature and descriptive research had implied an ethical dimension to the provision of EDs treatment by therapists with personal ED histories (e.g., advantages and limitations), no research had yet (1) employed an explicitly professional ethical lens in investigating this topic, and (2) accessed the perspectives of ED therapists with personal ED histories on this topic. The absence of this knowledge was not trivial given that clients with EDs represent a vulnerable, high-risk client population; therefore, the ethical stakes are high. Furthermore, ED therapists with personal ED histories appear to comprise a sizeable proportion (approximately one-third) of professionals working in the EDs field (e.g., Barbarich, 2002). Thus, empirically-based knowledge on this topic was likely to be relevant for a relatively large group of practitioners, as well as to other stakeholders (i.e., their instructors, supervisors, and colleagues) involved in their training and in the provision of EDs treatment more generally.

The primary objective of the study was to begin to explore and understand the ethics experiences of ED therapists with personal ED histories in their day-to-day work with ED clients (e.g., ethical issues identified and encountered). The research question was designed broadly in order to ascertain whether the participants identified their personal ED histories as having professional ethical relevance in their daily work with ED clients. The knowledge produced by this study was intended to be pragmatic, so that it could be used to enhance such therapists’ ethical practices. As such, the ultimate aim was to generate knowledge to assist ED-historied
therapists in providing maximally safe and ethical therapy services to ED clients.

5.2 Interpretation of the Therapists’ Ethics Experiences

The first area of new knowledge produced by the investigation was an initial understanding of the ethics experiences described by the study’s participants, in the form of an ‘ethics terrain’ map. Based on an inductive analysis of perspectives gleaned from interview data and from two first-person written accounts, the map described and organized the ethical issues and concerns these individuals reported (as well as, to some degree, the ethical beliefs they held).

A second area of emergent knowledge that contributed to a more integrative understanding of participants’ ethics experiences was a description of the interviewees’ experiences when discussing the research topic (conceptualized as a more processual, in-the-moment type of ethics experience). These latter experiences indicated that the research topic was not a particularly comfortable subject for most of the participants, but that engaging with it prompted behaviours (e.g., ethical self-reflection, changes in practice) that seemed practice-enhancing. Together, these two main areas of descriptive findings (map and process, respectively) represented first and second levels of interpretation regarding the data.

In the following sections, I present a further, more abstracted, level of interpretation. Specifically, what follows is my interpretation of what I considered to be the most salient and important ideas, themes, and concepts from among the ethics terrain and process-oriented findings for enhancing the ethics practices of ED-historied therapists. From these, I have drawn conclusions that have direct implications for practice. Specific foci of the interpretation include: the enumeration of the ethical issues and concerns of the participants; the complexity of their ethics experiences; potential obstacles to full engagement with relevant ethical issues; early career and early-in-recovery ethical vulnerabilities; and the skill of ethical discernment. Together, these areas informed implications for practice and research, which are presented in the latter portion of the chapter.
5.2.1 Ethical Issues and Concerns Enumerated

A useful starting place for interpretation was acknowledging that the ethics terrain map constituted a first step in generating an empirically-based understanding of the specific types of ethical issues and concerns that may be encountered by the subset of therapists in the EDs field who have personal ED histories. Several aspects of the ethics terrain map, considered in light of the process-oriented findings, prompted my further consideration and interpretation, for reasons of application to practice. These are elaborated, below.

First, the variety of categories and sub-categories characterizing the ethics terrain map indicated that many ethical topics are relevant to ED-historied practitioners in their daily work with ED clients. Participants demonstrated capability in thinking about and articulating myriad day-to-day work experiences using a professional ethical lens – a fundamental duty of being a professional. However, some conveyed worry about whether some of the topics they described were ethically relevant, whether they were getting ethics “right” concerning their daily work with ED clients, the desire for more ethical guidance, and wanting to know how other participants were approaching ethics in their work. Together, these patterns suggested to me that the many ethical issues appearing on the map would be recognizable to other ED-historied therapists, who might also wish to feel more certain about the ethical dimensions of their work. Thus, opportunities to consider and explore these issues may meet a professional need for ED-historied therapists’ in terms of their feeling prepared to provide safe and ethical therapy to EDs clients.

Second, some of the categories of ethics experiences that emerged in the ethics terrain seemed applicable to any ED therapist, with or without a personal ED history, (e.g., professional competence and scope of practice, confidentiality, client safety, discontinuing therapy, clients

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12 Consistent with the constructivist-interpretivist paradigm of science in which this study is located, no claims of generalizability are made; rather the attainment of a first, exploratory step is emphasized.
with personality disorders, resource issues, participation in reality television, and boundary-related issues such as the degree of responsibility assumed by therapists for client change). Thus, some of the ethics experiences of ED therapists with personal ED histories likely do not differ markedly from those of their non-ED-historied colleagues. Other categories did appear to be associated specifically with ED history (e.g., boundary issues such as not assuming therapist-client similarity, degree of therapist wellness in relation to ED history, the perceived helpfulness of the therapist’s ED, and openness regarding therapists’ ED histories). These latter indicated that there were issues associated with participants’ personal ED histories that they viewed as ethically relevant.

Arguably, some categories and sub-categories of ethics experiences related to ED history, such as self-disclosure of ED history and therapist wellness, could be applied more broadly to all therapists working in the EDs field (e.g., therapists without ED histories would need to consider the ethical implications of disclosing their non-history, as well as assess their degree of wellness concerning food, body, and exercise). However, my interpretation is that there may be different meanings and ethical implications, risks, and/or consequences for clients, treatment milieus, and for the therapists themselves involved for historied versus non-historied practitioners regarding these issues. For example, does therapist disclosure to a client of an absence of ED history have the same ethical implications in therapy as disclosure of the presence of an ED history? Regarding therapist wellness, is the meaning of acute body image distress or training for a half-marathon the same for ED-historied versus non-ED-historied practitioners? Nevertheless, participants’ acknowledgment of ethics experiences associated specifically with personal ED history as ethically important suggested that ED-historied therapists’ safe and ethical practice with ED clients would benefit from their considering and exploring ethical issues relevant to that history (such as boundaries and wellness), in addition to more general ethical issues relevant to providing EDs treatment. Such opportunities could assist these practitioners in meeting their
ethical responsibilities to cultivate awareness concerning their personal ED histories and to evaluate the associated ethical implications (e.g., CPA, 2000).

I observed amongst participants a range regarding the degree to which they verbalized their ED histories as being ethically relevant to their work with ED clients (based on spontaneous answers – or not – to the main interview question; degree of depth in which they reported ED-history-associated ethical issues; degree of importance explicitly assigned by them to these issues; and degree of expressed interest in these topics between and during later interviews). Nevertheless, over the course of the interviews, all participants demonstrated ethical self-reflection and/or practice changes related specifically to their personal ED histories. Thus, regardless of participants’ initial degree of endorsement of their personal ED histories as being ethically relevant, the interview process appeared to engage them in considering the ethical dimensions of those histories.

Importantly, the ‘double risk’ for many participants in talking about ethics and its intersection with their personal ED histories suggested that opportunities for considering and exploring ED-history-related ethics topics would be most effective if offered in a manner sensitive to the perceived and/or actual significant professional risks for ED-historied clinicians in disclosing a personal ED history in professional settings. My interpretation is that if these topics are to be explored openly and with minimal fear of perceived or actual negative consequences for ED-historied practitioners, safe environments are required. For example, opportunities with an interpersonal dimension (e.g., supervision, training) would be best facilitated by individuals aware of, and sensitive to, these concerns.

Finally, with respect to the variety of ethical issues and concerns enumerated in the ethics terrain map, several of the map’s categories corresponded to literature addressing ethics and EDs treatment provision (e.g., professional competence, client safety, etc.). As examples, there is established literature on the ethical dimensions of clients’ medical safety (e.g., Manley, Smye, &
Srakameswaran, 2001) and their ambivalence about recovery (e.g., Bentovim, 2000; Bulik & Kendler, 2000), and on practitioners’ professional competence (e.g., Buhl, 1993; Garner, 1985; Sargent, 1992; Thompson & Sherman, 1989; Williams & Haverkamp, 2010; Yager & Edelstein, 1987). Furthermore, among the myriad ethics experiences on the ethics terrain map, the categories unique to therapists with ED histories offered a new angle on extant literature regarding the benefits, drawbacks, and suitability of involving ED-historied practitioners in EDs treatment (Costin & Johnson, 2002; Johnson et al., 2005). That is, these issues were identified by the participants in the present study explicitly as ethical issues, thus tying them clearly to professional responsibility. As examples, phenomena described as “disadvantages” (e.g., enmeshment of therapist’s and client’s issues, risk of relapse, being impatient and overly driven) and “advantages” (e.g., superior empathy, knowing and challenging ‘the tricks’ of EDs, role modeling recovery, representing hope) in previous literature were identified by participants in the present study as ethical issues, and the potential helps and harms acknowledged. That some portions of the ethics terrain map contained recognizable issues that corresponded to extant literature and that other portions extended the literature to formally acknowledge professional ethics lends credibility to the map, since it was therefore not characterized completely by idiosyncratic or unrecognizable ethics experiences.

5.2.2 Complexity of Ethics Experiences

Considered together, the ethics terrain and process-oriented findings suggested that ED-historied therapists’ ethics experiences are complex and multi-faceted. My interpretation is that a full understanding of this complexity requires acknowledging and integrating several areas of professional ethics, including the following: (1) the broader, more aspirational aspects of the codes regarding helping and harming; (2) specific standards in the codes regarding practitioner impairment; (3) ‘standard’ ethical topics appearing in the codes such as dual relationships and professional competence/scope of practice; (4) certain beneficial therapist stances; and (5)
interpersonal interactions and workplace environments that constitute or influence therapists’
ethics experiences. Such an integrative understanding could provide a strong basis from which
ED-historied therapists could comprehensively consider and explore the many ethical
dimensions of their work, thus helping them achieve high levels of ethical practice in their day-
to-day work with ED clients. If only some areas are acknowledged (e.g., the “typical ethical
things” such as dual relationships and competence mentioned by participants as memorable
topics), only partial consideration and exploration of the full range of ethical issues likely to be
encountered by such therapists is possible, which is not likely to most fully benefit and prevent
risk of harm to ED clients. Immediately following, I elaborate my interpretation regarding the
five areas of professional ethics enumerated above (helping/harming; impairment; ‘standard’
topics; therapist stances; and interpersonal/workplace environments). Interspersed throughout, I
discuss elements of my interpretation in relation to extant literature in order to help locate,
illuminate, and/or develop my conclusions.

First, across the study’s findings, a pattern emerged suggesting that participants
considered their ethics experiences primarily in terms of helping and avoiding harm to their ED
clients. I interpreted this to mean that the concepts of helping and avoiding harm are likely to be
core components of an integrative understanding of ED-historied therapists’ ethics experiences.
Standards in both the American and Canadian Psychological Associations’ codes of ethics make
general assertions that psychologists must “take reasonable steps to avoid harming [others]…and
to minimize harm where it is foreseeable and unavoidable” (American Psychological
Association, 2002, Standard 3.04), and to “take care to discern the potential harm and benefits
involved” in interactions with others (Canadian Psychological Association, 2000, p. 15).
Furthermore, values statements in these codes state that responsible caring involves offering
services only when potential benefits outweigh potential harms, and using interventions that
minimize harms and maximize benefits.
Numerous, specific instances emerged across the data that corresponded to these broad directives. Examples included that participants reported consulting with members of other disciplines in order to prevent harm to, and more fully help, their clients. They considered the balance of help/harm when attempting to foster connection with clients while maintaining appropriate boundaries, and when encountering seriously ill clients who engaged in therapy sporadically. They asserted that serving their own needs when providing therapy was unhelpful and could be harmful to clients. They evaluated potential direct and indirect benefits and harms to clients and to the therapy process of disclosing their ED histories. They described potential helps and harms concerning their own and their colleagues’ degree of wellness with respect to ED history. They articulated that being integrated, congruent, appropriately “real,” and self-aware regarding their ED history was helpful, whereas being “split off,” incongruent, inauthentic, and having blind spots was unhelpful and potentially harmful. In addition, they identified several specific ways in which they experienced their ED histories as particularly helpful to clients and the therapy process. Thus, issues of helping and harming cut across multiple ethics experiences in the ethics terrain.

This pattern illuminated that the broad ‘benefit/don’t harm’ obligations in the codes are highly relevant for ED-historied therapists. Moreover, participants’ narratives revealed many specific ways in which they made efforts to fulfill these ethical duties. In addition, participants’ considerations of helping and avoiding harm suggested that they ascribed to conventionally accepted notions of professional ethics (i.e., the meta-ethical principles of beneficence, or doing good, and nonmaleficence, or avoiding harm) that underpin the codes of the applied mental health fields. Together, these observations implied that, for ED therapists with personal ED histories, considering and exploring potential helps and harms to clients (both related and unrelated to personal ED history) could constitute a critical component of their ethical practice with ED clients.
Directly related to the concepts of helping and harming, a second area of professional ethics that, based on participant narratives, seemed important for an integrative understanding of ED-historied therapists’ ethics experiences concerned the standards in the ethics codes regarding practitioner impairment, specifically with respect to practitioners’ active EDs. Relevant here are specific ethical standards in the codes that require practitioners to assess, consult around, remediate, and, if necessary, cease professional activities when personal problems interfere with their provision of competent services (e.g., Standard II.11 in the CPA [2000] code; Standards 2.06 a/b in the APA [2010] code). A clinician demonstrating impairment due to active ED symptoms (e.g., impaired cognitive processing due to starvation, as seen in AN) who does not carry out these duties would not be meeting these standards. Unfortunately, the nature of active EDs is frequently such that the individuals who experience them may not acknowledge (or be able to acknowledge) the ED as problematic. This suggests the importance of support for therapists struggling with active ED symptoms to help ensure they are meeting these standards in the codes. Support could take the form of supervision, consultation, and an ethical commitment by colleagues to respectfully initiate ‘difficult ethical conversations’ regarding their concerns, as stipulated in the codes (Behnke, 2006; Haverkamp, 2007).

Interestingly, the topic of practitioner impairment was not explicitly verbalized by any participants despite reports of personal ethics experiences of practicing with an active ED and observations made about the questionable wellness of other practitioners. Given that concerns about practitioner active ED symptoms and relapses have been identified as a serious concern in the EDs literature in terms of posing risks to clients, as well as risks to the professionals themselves (e.g., Johnson et al., 2005), I interpreted this absence as meaningful. It suggested to me that impairment may have been a very high-risk subject for participants to discuss. Certainly, participants who disclosed having practiced with active ED symptoms expressed feeling vulnerable regarding these disclosures. Taking a further step to verbalize the degree to which
their work might have been impaired while symptomatic might have represented too great a risk for them. Furthermore, other participants reported that they had observed colleagues who seemed “on the fringe of wellness” regarding an ED, but they expressed reluctance to question their colleagues’ wellness unless, for example, an ED was “very apparent” (see also Bowlby, 2007). This suggested that participants’ ‘ethical threshold’ for approaching a struggling colleague might be high and/or that taking action concerning colleagues’ wellness or potential impairment might also have been a relatively risky topic to discuss. Several participants stated fears of being scrutinized by others (e.g., colleagues, me) regarding their degree of wellness with respect to their ED, and reported concerted efforts to not unfairly judge other ED-historied practitioners regarding this. Some participant statements also conveyed a ‘judge not lest ye be judged’ stance. These observations regarding the data suggested that the thornier ethical aspects of ED-historied therapist wellness (i.e., impairment) could be tempting to avoid. This implies that it would be all the more important to include issues of practitioner impairment in an integrative understanding of ED-historied therapists’ ethics experiences that can usefully inform practice. In my view, reticence on the part of any therapist to approach a colleague with a wellness concern (or a reluctance to assess, evaluate, and remediate one’s own wellness concerns) is ultimately a disservice to struggling professionals and, most importantly, to their clients.

A third area of professional ethics I interpreted as being an important component of an integrative understanding of ED-historied therapists’ ethics experiences included topics in the ethics codes that are frequently the ‘standard’ subjects of ethics workshops and textbooks. These included dual relationships and professional competence. Given that participants frequently referred to both dual relationships and professional competence as “the typical ethical things” that came to mind first in the interviews, these topics are likely important for ED-historied therapists’ ethical consideration and exploration, particularly regarding any meanings specific to their work with ED clients. Yet, stopping there (as many general ethics exploration activities
might) would omit other, critical ethical issues for ED-historied ED therapists. While these are important ethical topics for all therapists, the data suggested that they have specific meanings for ED-historied therapists. For example, ED-historied therapists who ascribe to the 12-step model in their own recovery would need to carefully assess the dual relationship implications of attending 12-step meetings with their clients. Moreover, all ED-historied therapists might need to consider the possibility of a more tacit dual relationship at play in moment-to-moment therapy interactions when practitioners shift from interacting as professionals with clients towards interacting with them as fellow ED sufferers, as noted by Hecksher (2007) in her study of substance abuse counsellors. Regarding professional competence issues, the findings of the present study indicated that, for ED-historied ED therapists (and perhaps all ED therapists), considering one’s scope of practice in relation to other members of an interdisciplinary team is ethically relevant.

A fourth area of professional ethics I interpreted from the findings as contributing an important component to an integrative understanding of ED-historied therapists’ ethics experiences concerned certain therapist stances identified by participants as beneficial in their work with ED clients. When reporting their ethics experiences, participants stated the importance of these stances that, while not necessarily unique to ED therapists with personal ED histories, were specifically linked by them to their work with ED clients, some to their personal ED histories. The ethics experience stories within which these helpful therapist stances were contextualized provided concrete examples of how they were being specifically operationalized (or striven for) in their work. As examples, participants reported cultivating *objectivity* in order to manage the inappropriate intrusion of their personal ED story into therapy with ED clients, and reminded themselves to maintain *integrity* when they were tempted to minimize how their personal ED residuals were entering therapy unhelpfully. One reason these therapist stances seemed important for an integrative understanding of ED-historied therapists’ ethics experiences
was that they represented clearly positive, strengths-based, and aspirational facets of their experiences. Thus, their identification might serve to inspire ED-historied therapists to strive for high levels of ethical practice in terms of professional character and behaviour.

Specifically, the reported stances (with associated examples in brackets) included: 

*humility* (about the limits of one’s knowledge of EDs based on personal ED experience, and about having made ethical errors with ED clients related to one’s ED history); *collaborativeness* (with members of other disciplines involved in EDs treatment in order to maximize benefit and avoid harm); *objectivity* (keeping one’s own ED story separate from clients’ stories); *accountability* (offering high quality services); *integrity* (being congruent and honest with oneself, for example about any lingering personal ED phenomena, and with one’s clients); *genuineness* (being authentic by embracing one’s ED history whether one discloses it or not); *restraint* (using prudence when being “real” with self-disclosure); *credibility* (using the trustworthiness conferred on one by clients due to one’s personal ED history to strengthen the therapy alliance); *respectfulness* (towards clients’ ED experiences that differ from one’s own); *egalitarianism* (non-othering and/or -pathologizing of clients and their ED experiences, emerging from one’s own experiences of having felt othered or pathologized); and *sensitivity* and *compassion* (regarding clients’ suffering with respect to their EDs, which was engaged through empathy towards oneself regarding one’s personal ED experience).

These stances corresponded directly to therapist characteristics identified in the psychology literature on virtue ethics (e.g., Jordan & Meara, 1990; Meara, Schmidt, & Day, 1996; Meara & Day, 2003), feminist ethics (e.g., Gilligan, 1982; Noddings, 1984), investigations into the characteristics of master therapists (e.g., Jennings & Skovholt, 2006; Jennings, Sovereign, Bottorff, Mussell, & Vye, 2005; Sullivan, Skovholt, & Jennings, 2005), and conceptual literature on ED therapist characteristics that have been proposed as fostering therapist effectiveness (e.g., McGilley & Szablewski, 2010). That these attributes are found in
extant literature lends support to their credibility as being useful for ED-historied therapists to consider and explore with the aim of enhancing their ethical practice with ED clients.

A final area of professional ethics I interpreted from the findings as being an important component of an integrative understanding of ED-historied therapists’ ethics experiences involved interpersonal interactions and workplace atmospheres that constituted or influenced participants’ ethics experiences. All participants disclosed a degree of unease about discussing aspects of the intersection of ethics and their ED histories with me, and some described significant, perceived professional risks in disclosing their ED histories in professional settings. These risks are unsurprising if there is indeed a “taboo” in the EDs field concerning practitioners with ED histories, as was perceived by some participants (see also Bowlby, 2007; and L. Cohn, personal communication, June 23, 2011). Overtly negative attitudes conveyed by colleagues resulted in some participants silencing themselves in ED training settings and workplaces about their ED histories because it felt unsafe. These experiences suggested that certain contexts in the EDs field could hinder ED-historied therapists’ consideration and exploration of the ethical dimensions of their personal ED histories. For example, participants reported disowning their ED history at work if it felt unsafe, which they noted had inhibited self-reflection and/or conversations about that history that could have served to enhance their ethical practice with their ED clients.

To summarize, my interpretation of the ethics terrain map and process-oriented findings suggested that ED-historied therapists’ ethics experiences are complex and multi-faceted. Based on the study’s findings and patterns across those findings, I interpreted several areas of professional ethics (helping/harming; impairment; ‘standard’ topics; therapist stances; interpersonal/workplace environments) as being key components of an integrative understanding that can adequately portray this complexity. Together, they can provide a more complete basis from which ED-historied therapists can comprehensively consider and explore the full range of
ethical issues in their daily work with ED clients, thus helping them to maximize benefit and
prevent harm to their ED clients.

As is likely apparent, the survey of ethics literature presented in Chapter 2’s theoretical
forestructure (including sections of the ethics codes; principle, virtue, and feminist ethics; and a
conceptual framework for applied ethics) were relevant to this interpretation. For example, the
particularly strong emphasis in participant narratives on helping and avoiding harm indicated
that the corresponding concepts of beneficence and nonmalefience from the principle ethics
approach were highly pertinent. Another particularly noteworthy component of this integrative
understanding of ED-historied therapists’ ethics experiences is the interpersonal interactions and
workplace atmospheres that constituted ethics experiences and/or negatively influenced such
therapists’ engagement with the ethical implications of their personal ED history. Given that the
ethics codes place professional responsibility upon the individual practitioner, this situation
potentially puts ED-historied practitioners in the difficult position of needing to carry out certain
ethical obligations within contexts that may not support them in doing so. This implies a
potential ethical dilemma involving the balance of ultimate help and harm to clients as a result of
disclosing or not disclosing one’s personal ED history to supervisors, who might be able to offer
helpful viewpoints on, and assistance regarding, the influence of the practitioner’s ED history on
service delivery.

The role and impact of contexts (i.e., interpersonal, workplace, and perhaps ED-field-
wide) with respect to participants’ ethics experiences can be illuminated further by considering
them in relation to the model of postmodern ethics advanced by psychologist Isaac Prilleltensky
and colleagues (a seminal part of which, the conceptual framework for applied ethics, was
described briefly in Chapter 2’s theoretical forestructure) because these authors advocate most
strongly in the psychology literature for the primary role of context in professional ethics. One of
their central claims is that professional ethics “takes place within a social space that provides the
limits and possibilities for individual [action]” (Rossiter, Prilleltensky, & Walsh-Bowers, 2000, p. 86). Their program of research revealed that a “safe space” for ethically helpful dialogue was desired by workers. A safe space was an environment in which workers could “deeply examine their own motives, feelings, countertransferential reactions, and political values,” and felt free to be vulnerable “in order to deeply examine their own participation within the ethical dilemma” (p. 92). Many factors (e.g., power relations, systemic cutbacks, and interpersonal conflicts, fear, and distrust) were identified as threats to “safe space” and, therefore, as factors that constrained ethical dialogue (Rossiter et al., 2000).

The authors argued that it is, therefore, an ethical responsibility to reduce fear and promote respect in organizations in order to foster unconstrained ethical dialogue. They stated that, “[W]ho is frightened to speak and why” should be the key question for keeping ethics central to professional practice (Rossiter et al., 2000, p. 98). Considering the findings of the present study in relation to this literature suggested that ED-historied practitioners may be trainees/workers who are ‘afraid to speak’ (i.e., about their histories and the associated ethical dimensions) in certain circumstances, despite the increased benefits and harm prevention likely offered to clients by engaging in these types of ethics dialogues. Certainly, participants identified that perceived non-acknowledgment or non-acceptance in the workplace and EDs field of ED-historied therapists could ultimately foster the ethical isolation of such therapists.

Indeed, participants who described feeling not professionally safe did not disclose and/or avoided discussing their ED histories with on-site supervisors and/or colleagues, with the result that ethics conversations relevant to personal ED history were not engaged in, or were not perceived as maximally useful if they did occur. Specific examples of avoided topics, participants said, were countertransference issues and the use of self-disclosure of personal ED history to clients, two key ethics experiences emerging in the ethics terrain. Or, ‘the heart’ of an ethical issue relating to ED history was not discussed; thus, the ethical concern was discussed
only superficially. Participants noted that inhibited help-seeking in terms of consultation or supervision, leading to ethical isolation, could result in the inadequate protection of clients from therapists’ unresolved ED issues. As Costin has identified, the lack of opportunities to engage in adequate supervision regarding personal ED history is a serious concern in the EDs field, a proposed solution to which is the stepping forward of knowledgeable, skilled, ED-historied mentors to offer this service (personal communication, June 27, 2011).

Considering these participant experiences in light of Rossiter et al.’s model of postmodern ethics suggested to me that meeting the ethical responsibilities of treating ED clients would include rectifying perceived or actual professional cultures of “taboo” in the EDs field concerning ED-historied practitioners that constrain ethical dialogues related to this issue. Furthermore, developing interpersonal and organizational “safe spaces” for dialogue would be indicated. Benefits of unconstrained dialogue were highlighted by Bloomgarden and colleagues (2003), who described that their disclosures of their personal ED histories in a workshop delivered to colleagues had changed the atmosphere in their ED treatment facility workplace toward more openness and discussion regarding issues pertinent to ED-historied practitioners (e.g., self-disclosure and countertransference issues). They stated that, ultimately, this had resulted in improved ethical decision-making around these issues. Bloomgarden et al.’s (2003) observations and statements made by the present study’s participants suggested that if the ethical responsibilities to reduce fear, promote respect, and foster unconstrained dialogue are to be carried out in organizations (as per Rossiter et al., 2000), this will also require the courage of ED-historied practitioners to participate in these conversations.

The concepts of environmental safety, practitioner courage, and open dialogue are consistent with recommendations made by the interviewees themselves when I asked them directly in their final interviews, “How do you think ED therapists with personal ED histories could best be ethically supported in their work?” These findings were not presented in the results
chapter (Chapter 4), as I did not perceive them to answer the research question directly. However, they are included in Appendix G. In short, participants’ recommendations were overwhelmingly dialogue-focused, with suggested venues for conversation including supervision, personal therapy, training, education, and professional events.

Given participants’ disclosures about challenging ethical situations as well as about their anxieties regarding ethics and its intersection with personal ED history, the interviews themselves seemed to offer a safe enough context (although obviously not completely devoid of risk) for discussing some of the more vulnerable aspects of participants’ ethics experiences. Explicit feedback from participants (in answer to the question “How was this for you?” at the end of the interviews) indicated that they had found me easy to talk to, and that they had felt safe and not judged overall, even when awkward moments had occurred. The conversational space of the interviews, aimed towards curiosity and seeking understanding, and demonstrating immediacy and transparency during those awkward moments, seemed to facilitate participant self-reflection on their ethics experiences, thoughtful conversation about their feelings, thoughts, values, intentions, and beliefs, and exploration of the ethical dimensions of their work. Bolstering the idea that an adequate degree of interpersonal safety combined with active engagement with anxiety-provoking material was associated with effective ethical self-reflection and positive change, the interviews stimulated participants’ continued self-reflection in between interviews, as well as practice-enhancing changes in their work. Rogers’ (e.g., 1959) core conditions of congruence, unconditional positive regard, and empathy, proposed by him as necessary for facilitating therapeutic change, seemed relevant to these outcomes.

Taken together, the integration of all five areas of professional ethics discussed above (i.e., significance of helping/harming; impairment; ‘standard’ ethics topics such as dual relationships and competence; helpful therapist stances; and interpersonal/workplace environments) are consistent with the positive ethics approach in psychology (e.g., Gottlieb,
Handelsman, & Knapp, 2008; Handelsman, Knapp, & Gottlieb, 2002, 2009), which was not included as part of Chapter 2’s theoretical forestructure. The integrative nature of the positive ethics perspective seems to adequately capture the complexity of ED-historied therapists’ ethics experiences, and further illuminates the change-producing nature of the interviews. Following is a brief description of positive ethics followed by an elaboration of its application to the study’s findings.

The positive ethics perspective advocates a “balanced and integrative approach” (Handelsman, 2009, p. 731) that promotes the consideration of ethics within a broader context, including personal and professional values and aspirations, and social influences, within an atmosphere of openness rather than fearfulness (Handelsman et al., 2009). This approach is hypothesized to encourage practitioners to “aspire to their highest ethical potential” (Handelsman, 2009, p. 731) and is characterized by the following: practitioners’ reflection on (and discussion of) their values, motives, and feelings that can impact their ethical judgment and behaviour; ethical sensitivity (the ability to recognize the ethical dimensions of situations beyond ethical dilemmas and the ethical minimums in the codes) (Knapp & VandeCreek, 2003); and self-care practices that support practitioners’ movement towards their wellbeing, happiness (Norcross & James, 2005), and highest aspirations (Handelsman et al., 2009).

The positive ethics perspective illuminated that the interview process in the present study may have offered a kind of ‘positive ethics experience’ that fostered participants’ engagement with all of these domains, from reflecting on and discussing their ethics experiences, to increasing their ethical sensitivity, to promoting self-care (e.g., eliciting intentions to get personal needs met better; increased clarity about entering personal therapy), to inspiring participants to be more ethical practitioners such that they continued to reflect between interviews and make changes in their practices. Other proponents of positive ethics in psychology have suggested that practitioner self-examination that permits the confrontation of
one’s ethical vulnerabilities fosters ethical resilience. Certainly participants in the present study did discuss their ethical vulnerabilities and struggles (including errors and anxieties). This, in turn, may enhance ethical protective factors within practitioners and reduce vulnerability to committing future ethical errors and infractions (Tjeltveit & Gottlieb, 2010).

5.2.3 Potential Obstacles to Full Engagement with Relevant Ethical Issues

Further interpretation of the ethics terrain and process-oriented findings suggested four potential obstacles to ED-historied therapists’ full engagement in the wide range of ethical issues relevant to their work with ED clients. First, some participants’ relatively narrow focus on certain salient professional ethics topics appeared to limit their identification of ethics experiences (at least initially) to the more standard/“typical” types of ethical issues (e.g., dual relationships; professional competence) or to a more generic, “don’t violate standards in the codes” stance. I identified as a second potential obstacle feelings of discomfort or unease about professional ethics in general. A third potential obstacle appeared to be discomfort in relation to discussing the intersection of professional ethics and personal ED history, which related to a fourth obstacle also found in participant narratives: spaces (i.e., interpersonal professional relationships, workplaces) perceived as not safe for ethical dialogue. An implication of these obstacles is that they could limit therapists’ consideration and exploration of the full range of ethical issues relevant to them (as enumerated in the ethics terrain map), including ethical issues related to personal ED history. I elaborate on my interpretation, below.

First, regarding a narrower focus on professional ethics, a few participants initially reported equating ethics with a limited number of topics (particularly dual relationships and professional competence) and/or with violation of standards in the codes. While I have proposed in the previous section that these are important topics for including in an integrative understanding of the ethics experiences of ED-historied therapists, those participants who described professional ethics primarily in this manner, or who focused mainly on these issues,
also stated that professional ethics seemed “abstract” and/or challenging or to apply in their daily work with ED clients. Given the apparent complexity of ED-historied therapists’ ethics experiences, one implication is that adopting a narrow focus regarding professional ethics may not serve to maximize practitioners’ safe and ethical practice with ED clients because it limits their engagement with the full range of ethical issues and concerns relevant to their work. Thus, it may be that some ED-historied therapists do not receive needed ethical support or supervision on this wide range of ethical issues due to focusing on only a few, salient topics.

Second, I observed interviewees who seemed to focus on these more standard/“typical” types of ethical issues to convey more discomfort than others about professional ethics in general. Evidence for this included their expressed desires to re-read ethics textbooks, concerns about providing correct answers, and feelings of anxiety about not knowing whether they were “breaking” ethical standards in their work with ED clients. This contrasted with other participants who expressed feeling relatively comfortable with professional ethics; tended to identify with relative ease myriad ways in which ethics applied in their work with ED clients (including with respect to their ED histories); and discussed incidents or beliefs in relative depth, including those that they stated feeling uncomfortable about. This contrasting group, on the whole, consisted of participants whose graduate level ethics training had been more recent and comprehensive. This suggested a potential link between therapists’ narrower focus on ethics and their having experienced more limited ethics training in graduate school. Dedicated ethics courses in graduate psychology training, for example, have been a relatively recent development. Thus, some participants may not have felt as confident in having ethics ‘language’ with which to describe their ethics experiences versus others with more recent and comprehensive training, but may nevertheless have been enacting ethics appropriately in their work. Indeed, some participants noted that, after initially struggling with the word ‘ethics’ or asking “is this ethics?”, they had realized from participating in the interviews that they in fact possessed a relatively
sound, internalized (or “embodied”) sense of professional ethics.

Another pattern in the data concerning anxiety was that participants generally appeared to find it more anxiety provoking to discuss some of the more day-to-day, applied aspects of their ethics experiences (e.g., making prudent judgments, evaluating oneself accurately, making the least harmful ethical decision) versus their ethical beliefs. The applied aspects were discussed more tentatively, were associated with more feelings of discomfort and uncertainty, and were labeled as the “fuzzy” and “grey” areas of ethics. This was perhaps unsurprising given that the greatest challenges in ethics typically lie in their application to real-world clinical situations. Indeed, participants described grappling, weighing, balancing, considering, questioning, and making decisions, sometimes expressing concern about the accuracy of their ethical judgments with a client population they described as vulnerable, often high risk, complex, and with many needs (e.g., medical, psychological, psychiatric, nutritional, etc.). In contrast, participants tended to articulate their ethical beliefs with relative confidence and clarity (e.g., “I believe interdisciplinary teamwork is important”). One implication of these observations is that articulating one’s ethical beliefs, values, and perspectives concerning work with the ED client population may be valuable in its own right (e.g., in terms of locating oneself, developing clarity, and/or identifying some of the more aspirational aspects of ethical practice with ED clients). However, there is likely also value (e.g., in terms of examining and perhaps making adjustments to one’s ethical practice) in exploring in some depth the more uncomfortable, “fuzzy” and “grey” ethical issues that arise in everyday practice, as seemed to be supported by the process-oriented findings regarding participants’ continued self-reflection and practice changes.

My interpretation regarding participant anxiety led me to speculate further that ED-historied practitioners might respond to discomforts they experience regarding professional ethics and/or its intersection with their personal ED histories on a continuum of avoidance/engagement. If more of an avoidance response is provoked, important ethical topics
might remain unexamined. For this reason, some ED-historied therapists may not be self-reflecting on, or receiving support or supervision regarding, ethical issues or concerns pertinent to their work with ED clients. In contrast, if anxiety prompts more of an engagement response, uncomfortable ethical topics are more likely to be examined and addressed, which is then likely to enhance practitioners’ ethical practices. As noted above, the interview process in the present study seemed to offer an engagement opportunity regarding professional ethics and its intersection with personal ED history, which was, for most participants, an anxiety-provoking subject. As a result of this engagement, participants reflected on their practices and made positive changes. It must be kept in mind that this particular group of participants seemed to experience anxiety at levels that did not prevent their participation in the research. Other individuals might have found the topic too anxiety-provoking to participate in the study at all. One participant offered a compelling case for the benefits of ethical engagement: she reported decreased anxiety about professional ethics due to, in her words, becoming “habituated” to the topic over the course of the interviews.

Furthermore, my interpretation of patterns in the data regarding participant anxiety suggested that one potential aim of engagement with professional ethics could be to harness practitioner anxiety in such a way that it serves as a useful ‘red flag’ regarding ethically questionable situations and practices. Indeed, in the present study, several examples among the ethics terrain findings indicated that participants seemed to be using their sense of unease effectively as an indicator of ethical “grey areas” or concerns. These areas included: discomfort about hugging clients; their own or their clients’ participation in reality television; their scope of practice regarding dietary and medical concerns; clients with personality disorders waiting longer on treatment waitlists; colleagues’ regular and public self-disclosing behaviour or inauthentic claims of ED history and recovery; and managing client confidentiality appropriately. Ethical discomfort was also expressed by participants in relation to personal
vulnerabilities, including the degree of resolution from one’s personal ED, acknowledging a blind spot, and worry about as-yet-unidentified blind spots.

The positive utility of practitioner anxiety in professional ethical engagement can be illuminated further by considering Hare’s (1981) and Kitchener’s (1984, 2000) ordinary moral sense, which is one component of the immediate, intuitive level of moral thinking in ethical decision-making (described briefly in Chapter 2’s theoretical forestructure). This quick, prereflective response, often signaled by discomfort that something is ‘not sitting right,’ is a precursor for engaging in the next level, critical-evaluative tier of moral reasoning that involves considering ethics codes, and ethical principles and theories (Kitchener, 2000). Thus, when participants in the present study reported more ethically ambiguous and confusing situations, their immediate, intuitive level of moral reasoning may have been appropriately engaged (e.g., indicated by ethical unease, negative judgments about the behaviour of colleagues). The opportunity to verbalize and reflect on these scenarios in conversation with a curious listener during the interviews seemed to help participants clarify for themselves what was their deeper ethical concern in these situations (e.g., self-disclosure related to questions of whose needs were being met; hugging as a boundary issue).

Finally, my interpretation of the patterns regarding participant anxiety reemphasized that safe environments (i.e., interpersonal, workplace) would be more likely to promote ED-historied therapists’ engagement with even the most anxiety-provoking aspects of professional ethics in general, as well as with the specific ethical issues related to their personal ED histories. In safe environments, the broad range of ethical issues ED-historied therapists encounter in their daily work with ED clients could be discussed in such a way as to help practitioners not shy away from them, and to develop confidence in identifying and addressing them.

5.2.4 Early Career and Early-in-Recovery Ethical Vulnerabilities

Another angle of interpretation on the ethics terrain findings indicated that there may be a
period of unique vulnerability for ED historied therapists when they are in early career and/or early-in-recovery that may be associated with increased risk of harm to ED clients. This interpretation was based on participants’ reports of their ED histories entering therapy in unexamined ways in their early career/recovery, which they said had led to ethical errors associated with increased risk of client harm. These errors were related to self-disclosure practices and therapist wellness, which are elaborated further in separate sections, below.

Participants’ descriptions of these more problematic ethics experiences in early career or recovery may have represented hindsight bias, errors in retrospective recall, and/or a self-protective distancing. Nevertheless, participants’ perceptions of the timing and gravity of the incidents were noteworthy, suggesting that beginning ED therapists with personal ED histories may need early support and guidance in identifying and being mindful of these ethical pitfalls.

5.2.4.1 Self-disclosures related to personal ED history. Evidence from among the study’s findings on therapist self-disclosure of personal ED history indicated that this was an area in which early career or early-in-recovery practitioners might be especially ethically vulnerable. For example, a participant reported self-disclosing her personal lowest weight, which was interpreted by the client as legitimizing the client’s further weight loss. This participant attributed her behaviour to her professional inexperience at that time, and stated she no longer disclosed this type of information, as the potential consequences for clients were “scary.”

Participant narratives suggested that their early vulnerabilities with self-disclosure might have been due, in part, to insufficient guidance in its use. They reported experiences of having been, as novices, unprepared for the high likelihood that clients would ask about practitioners’ personal ED histories, as well as for effectively managing these requests for information. Furthermore, they reported finding it challenging in early career to navigate the subsequent “slippery slope” of clients’ desires to hear more details about the therapist’s ED and recovery process. Practitioner lack of understanding about the impacts on clients of certain therapist
disclosures (such as personal lowest weight) was also reported to have been experienced in early career. Furthermore, general ethics training and resources on the subject of therapist self-disclosure seemed to have been experienced by participants as inadequate. Participants noted that there was scant explicit guidance in the ethics codes about therapist self-disclosure, and many of the more seasoned participants stated they had not received a dedicated ethics course in their professional education and training programs, let alone specific guidance regarding the ethics of self-disclosure. In addition, one participant described the experience of having raised the issue of therapist self-disclosure in a training context between the first and second interviews, and perceived that this had been met with instructor and student avoidance.

Some participants expressed the desire for more empirical guidance and training around the use of therapist self-disclosure of personal experiences. Increased clarity around workplace norms and expectations concerning therapist self-disclosure of ED history was also endorsed. These wishes for guidance and clarity seemed to reflect participants’ awareness that self-disclosure was an area of ethical concern for ED therapists with personal EDs, as well as perhaps a depth of desire to be ethical. Thus, self-disclosure of personal ED history seemed to represent an area of high ethical awareness, high ethical uncertainty, and high ethical concern for such therapists. These observations have direct practical implications in terms of early and ongoing preparedness regarding whether or not to self-disclose personal ED history to ED clients, and what to disclose.

Certainly, therapist self-disclosure has long been a subject of interest in psychotherapy (e.g., Henretty & Levitt, 2010; Jourard, 1959). However, various definitions (see Knox & Hill, 2003), conflicting research findings, vague ethical guidance (Deomenici, 2006), and scant training (Beutler, Crago, & Arizmendi, 1986) have been identified as problematic (Henretty & Levitt, 2010). More recent recommendations offered by Henretty and Levitt (2010) on the use of therapist self-disclosure, based on their synthesis of available empirical research, might serve to
partially address the knowledge and skills gaps identified by participants. These recommendations are presented, in brief, in the Recommendations for Practice section later in the chapter.

5.2.4.2 ED symptoms and residuals. Another area suggested by the data in which ED-historied therapists could be particularly ethically vulnerable seemed to be regarding wellness, in terms of experiencing active ED symptoms or significant ED residuals. (The definition of “residuals” that emerged in this study was the presence of perceived unresolved or under-resolved aspects of the therapist’s ED history). Those participants who reported practicing with an active ED and/or experiencing relapses stated these experiences had occurred early in career (i.e., early in overall career as a therapist, or soon after moving into working with ED clients), or early in their recovery process.

Participants with varied career lengths described current experiences of ED residuals (to differing degrees), suggesting that even the most experienced ED-historied therapists may experience these phenomena. Thus, being an ED-historied therapist of any age or years of experience might be characterized by these phenomena to some degree. In addition, a highly experienced participant (approximately 30 years in practice) reported a relapse occurring 5 years prior to the interviews. However, particularly compelling examples of the influence of ED residuals on service delivery, or practicing with active symptoms, were described by participants within the context of being in early career and/or early in recovery. These included a reported lack of awareness about one’s own very thin appearance and dietary restriction, which the therapist noted in hindsight was “the anorexic side;” “denial” that one was experiencing an active ED, or had blind spots around ED residuals; and inappropriate self-absorption with one’s own recovery experience when delivering therapy services. In one example, a participant described the experience, as a trainee, of discouraging a client from accessing more intensive treatment, which the participant realized in supervision had been influenced directly by a blind
spot regarding her own ED history.

Participant narratives indicated that others (colleagues, hiring panels) had at times been better positioned to observe potential lingering ED issues than ED-historied therapists themselves. Furthermore, participants stated the importance of dialogue with “objective” others for identifying blind spots, including regarding ED history. These comments, in addition to the process-oriented findings that suggested the positive impact of the interviews on participant self-reflection and practice changes, indicated that ED-historied therapists’ ethical self-reflection regarding their degree of wellness could likely be effectively stimulated with the participation of others, in conditions of relative safety.

5.2.5 Ethical Discernment

In light of the standards in the ethics codes that direct therapists to evaluate how their personal experiences influence their interactions with others and to integrate this awareness into efforts to benefit and not harm others, my interpretation of the study’s findings also included attention to ED-historied therapists’ development of ‘ethical discernment’ (my label) regarding personal ED history. To *discern* means to detect, recognize, or come to know (Merriam-Webster, 2011). A brief literature search revealed that the concept of ethical discernment appears in the nursing literature (e.g., in relation to creating spaces for pause and ethical reflection [Rushton, 2009], and ethical competence among nurses [models of ethical discernment; Clark & Taxis, 2003; Scanlon, 1994]), as well as in the social work literature (e.g., equated with using perspectives such as principle, virtue, and feminist ethics [Abramson, 1996]). However, it seems absent in the psychology literature. Nonetheless, with respect to the present study, I believed it accurately reflected and encompassed several ideas and concepts specific to participants’ reported ethics experiences that translated directly into abilities or skills worthy of ED-historied therapists’ attention and development. These included: (1) identifying one’s personal ED as ethically relevant; (2) coming to know and understand one’s ED experience (self-knowledge);
(3) detecting the influence of the ED on service delivery (self-assessment); and (4) recognizing the ethical implications of the results of that assessment, and taking appropriate action.

First, as noted above, standards in the ethics codes specifically instruct mental health practitioners to “evaluate how their own experiences…influence their interactions with others, and integrate this awareness into all efforts to benefit and not harm others” (Standard II.10, CPA, 2000, p. 17). Thus, therapists’ recognition that their personal ED history was a personal experience having ethical relevance would be a key component of ethical discernment for ED-historied therapists. The findings revealed that participants in this study did discern that their ED histories had ethical relevance in their daily work with ED clients, amidst many other ethical issues they described encountering. Spontaneous answers to the main interview question regarding self-disclosure of ED history, wellness issues, and the helpfulness of their EDs in delivering therapy support this assertion. It may have been that the relatively high median number of years post-ED among participants ($Mdn = 19$) was a factor in this finding (i.e., most participants had had substantial time to reflect on their personal ED experience and discern its ethical implications for their work with ED clients). However, even the most recently-in-recovery participant (approximately 3 years) spontaneously broached the ethical aspects of therapist wellness in her first interview. This suggested that awareness of personal ED as an ethical issue may not be tied to the recency of the therapist’s ED, and perhaps that the ethical dimensions of such a history would be understandable to early-in-recovery therapists.

Furthermore, participants raised and discussed as relevant to ethics (with considerable interest and energy) the topic of self-disclosure of personal ED history. Some expressed curiosity about what other participants had said about it; others reflected on, and made changes regarding, this practice in between interviews. Interestingly, simply offering up the topic of the ethical relevance of ED history seemed valuable, as exemplified by one participant who expressed that she had never considered examining the interface between professional ethics and her personal
ED history until she saw the ad for the study. When provided the opportunity to consider this intersection in the interviews, she spoke thoughtfully and eloquently about the ethical implications of how her ED history was, or could be, entering her work with ED clients.

However, identifying one’s ED history as a personal experience with ethical relevance would be predicated upon acknowledging that one has, in fact, experienced an ED. This is a simple but important point, given that part of the clinical presentation of EDs is that individuals who experience them often may not acknowledge (or be able to acknowledge) that they have an ED, let alone that it is a concern.

Second, I interpreted the findings regarding therapist self-awareness to suggest that ED-historied therapists’ coming to know and understand their ED experiences would likely be another key component of ethical discernment. The concept of self-awareness was noteworthy because it was described adamantly by the majority of participants as being one of the most critical aspects of practicing ethically in their daily work with ED clients. Indeed, self-awareness emerged as a sub-category of ethics experience in its own right within the category of therapist wellness because participants referred to it mainly in that context – that is, self-knowledge about various aspects of their personal ED histories, but also the degree to which they were accurately evaluating their degree of recovery/wellness.

Self-awareness also emerged elsewhere in the findings with respect to ED history, including with respect to the healthy integration of the therapist’s ED into her sense of self so that it could be integrated appropriately into the work with ED clients (e.g., in order to model congruence, and be appropriately “real” with clients); examining one’s false assumptions about clients that are based on one’s personal ED experience; separating one’s personal ED story from clients’ ED stories; and keeping the client’s ED story central in therapy. Furthermore, self-awareness was linked by some participants to the degree to which their ED histories could actually be helpful to clients and the therapy process. For example, self-awareness regarding
personal ED was perceived as necessary for “getting” clients’ experiences and, at the same time, for avoiding the “intermingling” of therapist-client issues. Thus, self-awareness seemed a concept central to the participants’ ethics experiences, that was relevant to issues of beneficence, nonmaleficence, competence, and boundaries. An implication of these findings is that ED-historied therapists’ ethical practices may benefit from paying particularly careful attention to developing self-awareness, perhaps as an important component of developing ethical discernment.

Participants stated that self-awareness evolved over time, and through maturation and accrued experience as a person and professional. The ‘hindsight’ awarenesses described by some participants (e.g., regarding ethical errors they had made and episodes of illness earlier in their careers) lend support to these perceptions. Some participants also suggested that therapists who were more recently in recovery might be more likely to be in the midst of an intensive period of developing self-awareness, and therefore perhaps might also be self-absorbed with their personal ED histories in such a way that detracted from keeping clients’ ED experiences central. As one therapist put it, the ED might not yet have appropriately “settled into the background yet.” One implication is that beginning ED-historied therapists especially might demonstrate less than full self-awareness about how their histories were entering therapy. This suggests that early training and supervision experiences may be important for stimulating their awareness, consideration, and exploration of how their ED histories could influence ED clients in helpful, unhelpful, and/or harmful ways. However, even seasoned therapists in the present study grappled to varying degrees with the ethical meaning of lingering aspects of their ED histories (e.g., ‘bad days’ with body image, “picky” eating, episodes of “overeating”), were concerned that blind spots around the ED could still be revealed to them, and reported relatively recent relapse experiences. I interpreted these participant experiences to suggest that ongoing attention to self-awareness and potential blind spots regarding ED history may be helpful throughout one’s career as an ED
The theme within the process-oriented findings indicating that the interview process prompted ethical self-reflection and practice changes supported the idea that self-reflective dialogue in conditions of relative safety may help develop ED-historied therapists’ self-awareness (perhaps in addition to gaining experience as a therapist). As examples, a participant described what she characterized as a profound new realization that her heretofore strong beliefs about what worked in treatment had been based on her personal ED recovery experience, and might not fit for all ED clients. She reported that this had prompted her to consider discussing more varied treatment options with her ED clients (including referral elsewhere). Another participant reported in the third interview that she had begun to participate in personal therapy to increase her awareness around how certain aspects of her ED history might be impacting her work with ED clients. Other participants expressed that, as a result of the interviews, they had become aware that they had, for the most part, been engaging with professional ethics appropriately and in a committed fashion in their daily work.

My interpretation of self-awareness as being a key component of ethical discernment for ED-historied therapists is bolstered by the interest long taken in it, conceptually and empirically, in the psychology and counselling literature. It has been described as requiring specific training (Jevne, 1981), and as an essential practitioner competency area requiring systematic assessment (Uhlemann & Jordon, 1981). Self-awareness has also been identified in research as a characteristic of master therapists (Jennings et al., 2005). More recently, Williams and colleagues (e.g., 2008) have differentiated self-awareness as self-knowledge or self-insight (e.g., about one’s “own issues, biases, strengths, and weaknesses” [Williams, Hayes, & Fauth, 2008, p. 303]) (which is consistent with how participants conceptualized self-awareness in the present study), from self-awareness focusing on one’s moment-by-moment internal states (also mentioned by a minority of the present study’s participants).
Some participants’ statements concerning boundaries and wellness issues regarding ED history (e.g., “intermingling” of therapist issues with clients’ issues, countertransference reactions, basing treatment decisions intentionally or unintentionally on one’s own ED experience or ED treatment experience, mindfulness about not “repeating” one’s childhood dynamics with parents with one’s clients, and therapist attempts to alleviate clients’ feelings of shame) suggested the potential for re-enactments or repetitions of unresolved therapist traumas entering ED-historied practitioners’ therapy delivery. From a post-positivist perspective, new developments in neurobiology and trauma research indicate that re-enactments are behavioural, emotional, physiological and/or neuroendocrinological attempts to dissipate incomplete kindling in the brain’s amygdala as a result of traumatic experiences (e.g., Josephs & Zettl, 2010; Van der Kolk, 1989). Thus, re-enactments occurring for ED-historied therapists in the context of their therapy delivery to ED clients may represent an area worthy of therapist self-awareness development (i.e., how any personal, unresolved issues or traumas may be influencing the course of therapy and treatment decisions). Based on current research, developing self-awareness in these areas may require somatically-based approaches (e.g., somatic experiencing [e.g., Levine, 2005], sensorimotor psychotherapy [Ogden, Mintor, & Pain [2006]], self-regulation therapy [Josephs & Zettl, 2010]) rather than cognitive ones.

Based on my interpretation of the findings on ED “residuals,” the next component of ethical discernment for ED-historied therapists I propose is skill in detecting the influence of one’s personal EDs on one’s practice (i.e., undertaking an accurate self-assessment process to discern the impact on ED clients of a personal ED history). This would necessarily be informed by therapist self-awareness, as described above. Participants of all experience levels reported challenges, to varying degrees, in accurately assessing the seriousness of ED residuals such as “sticky bits,” body image dissatisfaction, “overeating,” and “picky eating” in terms of whether these indicated problems with wellness. Furthermore, they reflected on the potential ethical
impacts of their ED residuals on clients in terms of, as examples, inappropriate role modelling or lack of practitioner integrity/congruence. Unfortunately, research suggests that, in general, professionals’ accuracy in self-assessment is poor, and that even the most exceptionally committed, self-directed learners are unlikely to rectify a deficit if they lack awareness of its existence (e.g., Eva et al., 2004). In light of this, ED-historied practitioners (particularly those who are inexperienced) may need assistance in accurately assessing the potential impact of their ED residuals on ED clients. This could take the form of self-assessment resources outlining potential areas of exploration, or could occur in the context of clinical supervision. The discomfort and vulnerability associated with addressing these professionally high-risk topics reemphasizes that any person-to-person assistance would likely need to be offered by trustworthy, sensitive, and empathetic others (e.g., supervisors, trainers, colleagues).

My interpretation regarding accurate self-assessment led me to identify certain ethically relevant, but not easily answerable, questions regarding accurate self-evaluation of practitioner ED history. For example, in order to practice safely and/or beneficently, how important is it for ED-historied therapists to be able to accurately distinguish between eating, weight, and exercise issues that are related to their ED histories versus being normative experiences? Furthermore, what range (i.e., frequency, type) of “sticky bits” or other residuals is appropriate for this population of therapists to experience, beyond which it is considered an ethical concern? For whom and under what conditions might ED-related thoughts, feelings, and behaviours threaten one’s sense of wellness as a therapist – and when should they? How might a therapist know if she is accurately assessing their seriousness? Might a therapist’s ability to acknowledge personal ED residuals be beneficial in terms of understanding (and potentially conveying to clients, as did one participant) a lack of black and whiteness concerning recovery from an ED?

Finally, I interpreted that a fifth component of ethical discernment for ED-historied therapists was practitioner skill in recognizing the ethical implications of the results of the self-
assessment undertaken, and then taking appropriate action. For example, participant statements indicated that accurately self-assessing one’s degree of resolution from a personal ED was required for protecting clients from adversarial effects of one’s ED residuals or active ED symptoms entering therapy – thus, it was tied by them to avoiding harm to, and benefiting, ED clients. The next step would be to take any necessary actions to minimize potential harms identified, so as to maximize therapeutic benefits to ED clients.

To summarize, in considering the directives in the ethics codes that therapists must evaluate how their personal experiences influence their interactions with others, and to integrate this awareness into efforts to benefit and not harm others, my interpretation of the study’s findings led to my proposing the concept of ‘ethical discernment’ as an important, multi-component skill for ED-historied therapists. Elements included: the skills of (1) identifying the personal ED as ethically relevant (predicated upon recognizing that one has personally experienced an ED); (2) coming to know and understand one’s ED experience (self-knowledge); (3) detecting the influence of the ED on service delivery (self-assessment); and (4) recognizing the ethical implications of the results of that assessment and taking appropriate action.

5.2.6 Summary of Interpretation

My interpretation transformed the descriptive findings in the previous chapter to a next level of abstraction, thus extending their meaning and identifying why they matter. To this end, I critically examined particularly noteworthy results among, and interpreted patterns across, the terrain and process-oriented findings in a manner consistent with the interpretive description goal of enhancing the ethics practices of ED therapists with personal ED histories.

My interpretation of the findings began by identifying that ED-historied therapists’ ethics experiences in their daily work with ED clients appear to be complex, and involve many ethical issues (both associated and not associated with their ED history) that relate to several different areas of professional ethics (e.g., helping/harming, clinician impairment, ‘standard’ ethical topics
such as professional competence and dual relationships, helpful therapist stances, and interpersonal and workplace environments that can foster or inhibit ethical engagement). One implication of this interpretation is that ED-historied therapists’ ethical practices would likely benefit from considering and exploring the full range of ethical issues relevant to their work with ED clients.

Furthermore, my interpretation revealed potential obstacles for ED-historied therapists in exploring this complex array of issues. These obstacles seemed to include a narrower view on professional ethics that focused on only a few salient ethics topics; anxiety about ethics and/or its intersection with practitioner ED history; and spaces perceived as too unsafe for engaging in ethics dialogue relevant to these issues. Moreover, my interpretation suggested that there may be a period of vulnerability for ED-historied therapists in their early careers and/or early recovery potentially associated with increased risks of harm to clients (primarily related to self-disclosure practices and therapist wellness regarding personal ED). Finally, my interpretation suggested that the skill of ethical discernment may be useful for ED-historied therapists to develop regarding their personal ED histories. Components of this skill, drawn from patterns in the data, were suggested to be: (1) identifying one’s personal ED as ethically relevant (after discerning that one has, in fact, personally experienced an ED), (2) coming to know and understand one’s ED experience (self-knowledge/self-awareness), (3) detecting the influence of the ED on service delivery (self-assessment), and (4) recognizing the ethical implications of the results of that assessment and taking appropriate action.

These interpretations suggested that comprehensive early and ongoing ethics training and support seems warranted for ED-historied therapists that, if effective, could set the stage for career-long consideration and exploration of the full range of ethical issues likely to be relevant to such practitioners, including those related to personal ED history. However, exploring and discussing ethical issues pertaining to personal ED history appears to be a risky endeavor for
ED-historied therapists. Unsafe-feeling interpersonal and workplace professional cultures may constrain discussion of these important and sensitive ethical topics. Thus, safe environments are indicated in which ED-historied therapists can have ‘positive ethics experiences’ that can facilitate their self-reflection and invite practice-enhancing changes. My interpretation has direct implications for practice and research, which are the subjects of the following sections.

5.3 Implications

The approach taken to the implications was the development of a series of recommendations for clinical practice and for research based on the interpretation of findings presented above. Consistent with the interpretive description approach to inquiry, underlying each recommendation was the aim of facilitating ED-historied therapists’ maximally beneficial and safe service delivery to ED clients.

5.3.1 Recommendations for Practice

I have divided my recommendations for practice into those intended for: (1) ED-historied therapists; (2) instructors, trainers, and supervisors of ED-historied therapists; and (3) the broader EDs field.

5.3.1.1 ED-historied therapists. Based on my interpretation of the study’s findings, I recommend that ED therapists with personal ED histories (as well as ED-historied individuals who plan to become ED therapists) seek out training, supervision, and continuing education that offer opportunities for early and ongoing engagement with the wide range of ethical issues and concerns likely to be encountered by them in their daily work with ED clients, including those associated with their personal ED histories. This instruction and training would be in addition to completing a dedicated, foundational, graduate-level course in professional ethics that is relevant to general psychotherapy practice.

I have a number of further recommendations specifically regarding the ethical dimensions of personal ED history when working with ED clients. First, I recommend that ED-
historied practitioners develop ethical discernment skills that will help them assess and evaluate the influence(s) of their ED-histories on their therapy delivery, in order to use the resulting information in their efforts to benefit and not harm ED clients. Questions such as, “If I am still experiencing X symptom(s) or residuals, and they seem to have Y impact(s), what might that mean in terms of potentially helping, not helping, or harming my clients?” and “Now, what should I do?” may be helpful in engaging ethical discernment. In addition to these cognitive skills, ED-historied therapists may find it beneficial to develop their self-awareness regarding any traumatic re-enactments that they may be bringing to the therapy they deliver to ED clients, which would likely involve employing somatically-based approaches (e.g., Levine, 2005; Ogden et al., 2006; Josephs & Zettl, 2010).

Furthermore, my interpretation also suggested that particular attention to self-disclosure practices and wellness regarding personal ED history in early career/early-in-recovery stages is likely warranted. Given the findings regarding ED residuals and relapse experiences, I also encourage ED-historied practitioners to adopt a stance of openness towards career-long exploration of the ethical dimensions of their ED histories, an openness that was demonstrated by all the participants in the present study. Striving towards the aspirational, strengths-based therapist wellness characteristics (i.e., realness, congruence, integration, self-awareness) and positive therapist stances (e.g., integrity, humility, etc.) that emerged in this study may be helpful in cultivating this openness and commitment.

Engagement and skill development regarding all the professional ethical issues relevant to ED-historied therapists are likely to involve clinical supervision, as well as self-reflection and self-study. Importantly, the findings suggested that any supervision and/or consultation activities are likely to be most effective when undertaken with other professionals with whom ED-historied practitioners feel safe to discuss, in sufficient depth, the full range of ethical issues related to EDs treatment, especially those issues related to personal ED history. The study’s
findings indicated that such relationships are likely characterized by a “good fit,” non-judgment, trustworthiness, curiosity, skilled listening, understanding, transparency, and an agreement to strive towards good ethical practice. Thus, I recommend that ED-historied practitioners seek out supervisory relationships of this nature in which they can have positive ethics experiences that: facilitate practitioners’ self-reflection, exploration, and discussion of the full range of their ethics experiences; increase their ethical sensitivity; promote their self-care; and continue to inspire them to be ethical practitioners in their work with ED clients (e.g., Handelsman et al., 2009; Knapp & VandeCreek, 2003; Norcross & James, 2005).

Furthermore, I recommend that, within the context of safe supervision, ED-historied therapists/trainees muster their courage to take risks with trusted supervisors to disclose their ED histories, so that they can be effectively assisted in their efforts to provide safe and ethical therapy to ED clients. This may include the identification of blind spots regarding ED history that are influencing service delivery. Finally, I recommend that, given the ethical vulnerabilities that may be experienced by early-career and early-in-recovery ED-historied practitioners and the potential ethical errors involved, beginning ED-historied practitioners consider deferring providing therapy to ED clients until they can access safe supervision. Options other than one-to-one supervision may include attending consulting groups with other ED-historied therapists. This was the experience of one participant, who, at the beginning of her career in EDs treatment, attended a consulting group with more experienced ED-historied therapists, which she stated had been very helpful. I also recommend that ED-historied therapists practice adequate self-care, and seek therapy and/or other personal supports when needed in order to meet their ethical responsibilities to ED clients.

5.3.1.2 Instructors, trainers, and supervisors. Based on my interpretation of the study’s findings, I recommend that professionals involved in the training and supervision of ED-historied therapists actively provide opportunities for ED-historied therapists to engage with the
full range of ethical issues likely to be encountered by them in their work with ED clients. The findings suggested that relevant topics would include: (1) ethical issues generally related to providing therapy to ED clients (e.g., scope of practice, clients with personality disorders, medical risk, confidentiality); and (2) ethical issues associated with therapist personal ED history (e.g., boundaries, therapist wellness, helpfulness of the therapist’s ED). The ethics terrain map generated in this study could be used as a starting point for identifying pertinent topics, with the understanding that this research was based on 11 participants and that our knowledge of the ethical issues encountered by ED-historied therapists is likely to evolve significantly with further research.

To adequately address the complexity of ED-historied therapists’ ethics experiences, I recommend that a range of ethical perspectives be employed in their training and supervision. My interpretation suggested that these perspectives would include: (1) the ethics codes, particularly the broad directives concerning helping and harming, and standards regarding practitioner impairment; (2) ‘standard’/“typical” ethics topics appearing in the codes such as dual relationships and professional competence/scope of practice; (3) certain therapist stances (e.g., integrity, humility, objectivity) likely to be beneficial when working with ED clients; (4) and acknowledgment of the role of interpersonal interactions and workplace environments that constitute or influence therapists’ ethics experiences.

Further to specific content areas, my interpretation suggested that therapist wellness and self-disclosure of ED history be given particular and early attention in training and supervision. The aspirational aspects of wellness (emerging as realness, congruence, integration, and self-awareness) could be presented in order to complement attention to concerns/safety issues about wellness, and to encourage positive, strengths-based professional character development amongst ED-historied therapists/trainees. Based on my interpretation, I recommend providing ED-historied trainees/therapists information about the skill of ethical discernment regarding ED
history. Helping trainees/therapists to develop the specific ethical discernment skills would need to be offered appropriately, given privacy issues if they have not identified as having experienced an ED. Ethical discernment may also involve alerting ED-historied therapists to the possibility of traumatic re-enactments they may be bringing into the therapy they deliver to ED clients (e.g., Levine, 2005; Ogden et al., 2006; Josephs & Zettl, 2010).

In my view, because active EDs may not be acknowledged (or able to be acknowledged) by those who experience them, and because serious ethical errors could occur due to insufficient therapist wellness, appropriate judgment must be exercised by instructors, trainers, and supervisors if a trainee’s active ED becomes known to them. In this case, appropriate support needs to be offered, which may include recommendations that the ED-historied practitioner develop self-knowledge about her ED history and its influence on therapy delivery, access personal treatment, and/or defer training, as appropriate. This is likely to be a highly sensitive ethical issue for all involved that will require trainers and supervisors to consider any recommendations and support they might offer to struggling ED-historied practitioners in light of carefully weighing benefits/avoiding harm to such practitioners against benefits/avoiding harm to ED clients.

Certainly, what constitutes a “recovered enough” therapist (Bloomgarden et al., 2003) is a critical and as yet unresolved issue for the EDs field. As professionals, ED-historied therapists would be held to the ethical standards set out by their professional organizations and licensing bodies regarding their being “recovered enough” to provide EDs treatment, rather than to any opinions, consensus or otherwise, emerging from the EDs field (B. McGilley, personal communication, June 20, 2011). An added variable for trainers and supervisors to consider is the scrutiny and “taboo” perceived by the participants in the present study regarding their wellness, which was described by them as a hindrance to disclosing and discussing ethical challenges regarding ED history. However, I believe that if this ethical responsibility on the part of
trainers/supervisors is carried out with empathy, sensitivity, and a commitment to ethically supporting ED-historied practitioners, any supports and recommendations for those who may be struggling can be communicated in such a way as to help make these be positive ethics experiences.

Self-disclosure of ED history held a significant position among participants’ ethics experiences in that it was used to differing degrees by all of the participants but one (who was considering the ethical pros/cons of it, thinking she might employ it in the future). Participants reported receiving negligible guidance regarding its use, which was considered by them as ethically problematic. Thus, I recommend that ED-historied trainees/therapists be informed that therapist self-disclosure of ED history will inevitably emerge as an ethical issue when working with ED clients. Thus, explicit preparation is indicated, which would involve exploring the ethical dimensions of disclosure of ED history to ED clients, including considerations of disclosure content, timing, frequency, etc. In my view, this will help equip ED-historied trainees/therapists to respond effectively to client questions, and to employ sound, in-the-moment, in-session ethical reasoning regarding this intervention.

Further to ED-historied therapist self-disclosure, I recommend that the training of ED-historied therapists be informed by the most up-to-date empirical literature on therapist self-disclosure. For example, Henretty and Levitt’s (2010) recent synthesis of empirically-based knowledge on the use of therapist self-disclosure (on which they based several recommendations) may presently serve as a helpful guideline to offer ED-historied therapists regarding self-disclosure of personal ED history until more research on this topic is specifically undertaken in the EDs field. Recommendations from this article that seemed to correspond to the ethics experiences of the present study’s participants included that therapists should consider their decisions around self-disclosing before these situations arise in therapy (i.e., being prepared), and that therapists can more confidently consider disclosure in the context of a strong
alliance/positive therapy relationship and to clients who are members of the same small community, but with the caveats that clients must have good boundaries and be comfortable with such disclosures. Furthermore, appropriate disclosure content may include the therapist’s relevant, resolved past struggles and client-therapy similarities, but with the strong caution that such disclosures could interfere with treatment (e.g., clients may self-censor for fear of affecting the therapist negatively, or feelings of client-therapist competition may arise). In addition, the authors recommended: that there be a clear rationale for the disclosure to further therapeutic process; responsiveness to clients before, during and after therapist self-disclosure; therapist self-knowledge about their motives for using self-disclosure, and a sound deliberation process; an appropriate level of intimacy of the disclosure; infrequent use; and returning the focus to the client immediately following the self-disclosure (Henretty & Levitt, 2010). These are the most current and empirically-based recommendations relevant to therapist self-disclosure of ED history to clients, and they resonate with many of the ethics experiences described by the participants in the present study.

In terms of more general recommendations for trainers and supervisors of ED-historied therapists, based on my interpretation of participant anxieties, I encourage trainers and supervisors to help ED-historied trainees/therapists’ observe and attend to their anxieties about professional ethics in general (as well as to its intersection with personal ED history), and to utilize any feelings of ‘ethical unease’ or ‘ethical distress’ as indicators of issues potentially requiring ethical attention. Moreover, the findings suggested that, to bring vividness to the topics and expose ED-historied therapists and trainees to ‘real’ ethical issues and concerns (thus increasing their confidence to deal with such issues and concerns in actual practice), incorporating scenarios and cases that accurately reflect everyday work with ED clients may be helpful, particularly those representing ethical “grey” or “fuzzy” areas that may elicit ethical unease and uncertainty.
A range of teaching approaches (e.g., class discussion, one-to-one supervision, self-study resources as appropriate) could be employed by instructors, trainers, and supervisors to offer opportunities to ED-historied therapists’ to consider and explore the full range of ethical issues likely to be relevant to them in their daily work with ED clients. However, all such approaches would need to be sensitive to such practitioners’ vulnerability, professional risk, and/or privacy issues involved in disclosure and discussion of their ED histories in relation to professional ethics. The interview process findings indicated that engaging with uncomfortable ethical topics prompted ethical self-reflection and practice-enhancing changes. Thus, there may be much to be gained by engaging with this material under favourable conditions.

Furthermore, in my view, any opportunities to learn about ethical issues relevant to ED-historied therapists likely need to occur at professionally-developmentally appropriate levels. For example, at a basic level, an initial dedicated, graduate-level ethics course might include general information and discussion on self-disclosure, and perhaps self-disclosure specifically related to any personal experience including mental health history. Ethics cases/scenarios incorporating topics such as self-disclosure and therapist wellness would also alert students to these issues at an early stage. Instructors’ ethical responsibility to preserve trainee privacy would be key during this early instruction (e.g., no essays assigned on students’ personal mental health histories, or group work where students are expected to disclose this type of information), when trainees might tend to over-disclose due to lack of awareness regarding future implications for them and/or the meaning of boundaries. At the same time, the high ethical stakes involved when working with vulnerable ED clients and the possibility that younger graduate students may have had very recent ED histories (or may be experiencing active ED symptoms) suggest that instructors also have an ethical responsibility to stimulate students’ thinking about the ethical implications of a personal mental health history, and to help students consider that disclosing such a history in appropriate settings (e.g., to clinical supervisors, when doing practica or
internships in EDs treatment) is likely to ultimately serve clients’ best interests.

At more advanced levels, such as during clinical coursework and practica/internships/fellowships where ED-historied trainees would be providing therapy to ED clients, it may be helpful in clinical supervision to address the topic of practitioner ‘ethical isolation’ and the curtailed helpful guidance associated with therapist non-disclosure of significant personal issues to supervisors (such as an ED history). Again, conveying this without intruding on trainees’ privacy, and at a degree of depth appropriate to supervision, would be key. If trainees do disclose a personal ED history to a supervisor, supervision can more confidently proceed to address a range of ethical issues, ideally with particular attention to therapist wellness and self-disclosure, two areas of potentially heightened therapist ethical vulnerability. At this stage, supervision could also help trainees develop certain skills (e.g., handling difficult situations regarding self-disclosure, ethical discernment) and self-knowledge (e.g., regarding wellness from the personal ED) regarding their ED history, again to a degree appropriate for the supervision context. This more in-depth and personalized type of supervision and/or consultation could continue to be beneficial in EDs treatment workplaces, after trainees have obtained their degrees and are licensed to practice independently.

At every level in education/training, I recommend (based on comments made by participants in the present study) that the following be conveyed to trainees/therapists: that all mental health practitioners are “human” and have had experiences that can impact service delivery for better or for worse; that developing self-knowledge as a practitioner about one’s personal experiences is important, so as to understand their influence on service delivery; and that seeking out personal therapy when necessary is a good thing. This could serve to facilitate ED-historied trainees’ recognition of their ED history as ethically relevant, engage them early in thinking about associated potential ethical implications, and encourage them to seek assistance if they require it. Such statements might be especially critical in early professional-developmental
stages when trainees are likely to believe they should be ‘completely healthy’ individuals who are impervious to personal difficulties. Such a stance could serve to de-stigmatize mental health issues, while at the same time emphasizing the ethical importance of practitioners’ not leaving their own mental health issues unexamined. Thus, I recommend that an ethos of ethical straightforwardness be established in training programs regarding the potential ethical impacts of any personal experiences, which could prime trainees for non-defensive, career-long ethical engagement around these issues.

In general, I recommend that instructors, trainers, and supervisors of ED-historied practitioners utilize the above recommendations in their efforts to foster positive ethics experiences for their students/trainees/supervisees. I contend that all the approaches and processes recommended above are consistent with the positive ethics experiences identified by my interpretation that will encourage and facilitate ED-historied practitioners’ nondefensive, diligent, and ongoing engagement with the ethical issues relevant to them, particularly those concerning their personal ED histories. An important component of positive ethics is that ethics engagement, particularly with topics about which practitioners feel vulnerable, occurs in an atmosphere of openness rather than fearfulness (Handelsman et al., 2009), so that practitioners feel encouraged to “aspire to their highest ethical potential” (p. 731). Thus, in my view (and consistent with Rossiter et al., [2000]), the EDs field has an ethical responsibility to reduce fear and promote respect that can foster unconstrained dialogue and therefore support its ED-historied therapists to maximize their safe and ethical practice with ED clients. I elaborate on this subject in the next section.

5.3.1.3 The EDs field. A key finding in this study was that, for ED-historied therapists, exploring and discussing the ethical issues relevant to them (particularly those related to their personal ED histories) involved significant perceived and perhaps actual professional risks. When interpersonal and workplace environments felt unsafe, participants refrained from
disclosing or discussing in any depth their ED histories with supervisors or colleagues and/or “cut off” their ED histories while at work. Furthermore, participants expressed feelings of embarrassment and/or shame when recounting gaps in awareness and ethical errors that were related to their personal ED histories. Together, these factors (workplaces intentionally or unintentionally conveying a ‘don’t talk about it’ message and therapists feeling ashamed about how their ED history might be influencing their work) could serve to compound ‘silence’ in the field concerning the ED-historied therapists in its midst, and the ethical issues relevant to them. Certainly, these factors were seen by participants to be contributing to the limiting (or prevention) of dialogue regarding important ethical issues for ED-historied therapists. Given that the ethics codes place professional responsibility upon the individual practitioner, unsafe environments may put ED-historied practitioners in the difficult position of needing to carry out certain ethical obligations within contexts that do not support them in doing so. Participants commented that some of their most profound self-learning had occurred through dialogue (e.g., supervision, the interview process itself), and some maintained long-distance mentorship or supervisory relationships in which they were able to discuss their ED history and its impact on their service delivery. In my view, if EDs field does not make efforts to offer safe environments for dialogue regarding the ethical issues relevant to ED-historied therapists, it risks contributing to potential harms to ED clients resulting from inadequately supervised and ethically under-supported ED-historied therapists.

Thus, I recommend that ‘safe climates,’ offering opportunities for safe dialogue regarding the ethical issues relevant to ED-historied therapists, be fostered at every level in the EDs field. I have selected the term ‘safe climate’ to represent the conditions conducive for facilitating ED-historied trainees/therapists engagement with the ethical issues pertinent to them, which can support them in maximizing their safe and ethical practice with ED clients. The term resembles both the “safe space” identified by Rossiter et al. (2000) and the concept of “ethical
climate” appearing primarily in the business ethics literature (e.g., Martin & Cullen, 2006). However, in my view, it is more encompassing than “safe spaces” because it connotes broader environments (e.g., institutional, field-wide), and is inclusive of the concepts of relational safety and trustworthiness.

In my view, safe climates are more likely able to promote ED-historied therapists’ positive ethics experiences than unsafe climates. Furthermore, in safe climates, because fear is diminished, open dialogue is more possible about ethics topics that might make ED-historied therapists feel vulnerable, whether related or unrelated to personal ED history. Thus, difficult ethical topics are not shied away from and left unexamined. Instead, discomfort or anxiety can be productively harnessed to identify ethical ‘red flags,’ and discuss ethical “grey areas” and other concerns. Such dialogue would decrease practitioner ethical isolation, and increase ethical clarity. Bloomgarden and colleagues (2003) previously called for increased openness and discussion regarding ED-historied therapists in order to improve ethical decision-making.

As such, I recommend that safe climates be cultivated at all levels if the EDs field, including one-on-one (micro level), groups/teams and facilities (meso level), and at the larger institutional and ED field-wide levels (macro level). At the micro level, I recommend that ED-historied therapists have access to safe climates in the form of safe supervision, consultation, and/or mentorship with trusted others, in which the therapist’s ED history can safely be made known for the purposes of maximizing safe and ethical therapy to ED clients. In these trustworthy relationships, ED-historied therapists will be supported in their professional responsibilities to evaluate how their personal ED history influences their work, and to integrate this knowledge into their efforts to benefit and not harm their ED clients (e.g., CPA, 2000). The degree of safety established in micro level climates is likely to facilitate or limit exploration of the most risky topics for ED-historied therapists, such as the potential harm of ED clients due to therapist impairment.
At the meso level (e.g., training and work environments), I recommend developing an ethics ‘ethos’ of collegial empathy and support in place of ethical atmospheres characterized by fear, criticism, and/or judgment regarding ED-historied practitioners. Developing safe climates at the meso level could galvanize the collective responsibility of all to develop safe and respectful environments for ethically fruitful dialogue that best serves and protects ED clients. A sense of camaraderie and connection in striving towards good ethical practice might also be catalyzed. I also recommend that institutions make explicit any expectations regarding ED-historied therapists’ self-disclosure of ED history to clients, since climates in which expectations are clear are likely to be experienced as safer. This may be especially important in more intensive treatment contexts (e.g., inpatient, residential) where therapists are likely to be involved in both formal therapy and non-formal-therapy activities with clients. The findings of the present study suggested that these types of settings might offer increased opportunities for boundary crossings (including self-disclosure of ED history) due to a milieu of heightened intimacy that invites fuzzier therapist-client boundaries.

Furthermore, within any venue in which ED-historied therapists are trained or work, I recommend that individuals in leadership positions acknowledge as a statement of fact that a significant proportion (up to one-third) of practitioners working in the field have personal ED histories (e.g., Barbarich, 2002), working side-by-side with their non-ED-historied colleagues. This simple acknowledgment might begin to offset perceived professional risks associated with disclosing an ED history, reduce practitioner anxiety, shame, and self-stigma, and therefore invite such practitioners to engage in supervision, consultation and/or personal therapy regarding ethical issues pertinent to ED history.

Also at the meso level, I recommend that there be training to help sensitize individuals responsible for guiding and supporting ED-historied therapists (e.g., instructors, trainers, supervisors, managers) to the ethics experiences encountered by such therapists. Ideally, this
training would outline as much information as possible about the ethical issues known to be encountered by ED-historied therapists and highlight the professional risks for such therapists in disclosing their histories to other professionals. Furthermore, it would likely be beneficial to teach trainers and supervisors how to develop relationships characterized by a stance conducive to safe dialogue (i.e., non-judgment, trustworthiness, curiosity, skilled listening, understanding, transparency, and an agreement to strive towards good ethical practice). The results of the present study highlighting some very negative interpersonal collegial encounters suggested that such training might also include how to effectively initiate and engage in conversations when colleagues have ethical concerns about ED-historied practitioners (e.g., regarding wellness, boundaries, etc.).

Finally, at the macro level, I recommend that efforts be made by professional organizations in the EDs field (e.g., Academy for Eating Disorders; International Association of Eating Disorders Professionals) to promote safe climates by addressing any “taboo” surrounding the involvement of ED-historied practitioners in EDs treatment (e.g. policy statements on this topic). One benefit of acknowledging the existence of such practitioners in the field and pledging a commitment to ethically support all ED therapists in their work may be increased ethical engagement concerning personal ED histories, due to a perceived reduction in stigma. Moreover, macro climates characterized by more openness and acceptance may encourage respected and seasoned ED-historied therapists to step forward to mentor those less experienced and less recovered. As pointed out by one participant, addressing any such taboos conveys a message to the larger community of individuals struggling with EDs that EDs are unworthy of stigmatization (consistent with the opinions of Costin & Johnson, 2002). It is unlikely that individuals with ED histories will cease wanting to help others with whom they have shared this experience. Thus, the issue of safe climates for ED-historied therapists will continue to remain relevant in the foreseeable future.
5.3.1.4 Summary. The recommendations (for ED-historied therapists themselves, instructors/trainers/supervisors, and for multiple levels of broader EDs field) were based on my interpretation of the study’s findings. Consistent with interpretive description, each recommendation was proposed with a view to helping maximize ED-historied ED therapists’ safe and ethical practice with ED clients.

5.3.2 Recommendations for Research

The following section offers recommendations for research based on the study’s findings. Additional qualitative research could increase our understanding of the ethical issues encountered by ED-historied therapists. Future quantitative investigations will help to provide generalizable knowledge.

First, in order to generate confirming and/or disconfirming evidence regarding the ethics terrain map categories that emerged in the present study, a survey study with a large sample of ED-historied therapists could be undertaken. It would be beneficial to ascertain whether the ethics experiences revealed in the present study are generalizable to the population of ED-historied therapists working in the field. Furthermore, exploratory factor analysis could help identify variables within the ethics terrain map to uncover the underlying structure of the variables contained therein.

Second, reviewing the ethics terrain map prompted me to question which areas of the map would be identified by ED therapists (both ED-historied and non-ED historied) as being of low versus high ethical concern, and around which they have low or high awareness, and low or high feelings of uncertainty. This dimensional conceptualization, perhaps studied quantitatively, could help highlight ethical issues and concerns around which, for example, there is high concern and uncertainty but low awareness, thus identifying critical areas for self-assessment, education, training, and continuing education.

Third, the present study also suggested potential qualitative or quantitative (e.g., Delphi)
research questions regarding ‘ethical competencies’ for ED-historied therapists (e.g., What are the ethical competencies essential for ED-historied therapists? How might such therapists be assisted to develop them?). Research on ethical competencies could help develop ethics competency self-assessment tools for ED-historied therapists. Participants’ ethics experience descriptions alluded to specific areas of knowledge, skills, and therapist stances that might enhance practice with ED clients. Some competencies for ED-historied therapists could represent those necessary for minimally safe practice whereas others may reflect more aspirational knowledge, skills, and therapist characteristics.

As examples, specific competencies related to areas of knowledge associated with ED history could include an understanding of how one’s personal ED influenced one’s career choice as an ED therapist; knowledge of conceptual and research literature on practitioner self-disclosure of a mental health history similar to one’s clients; and an understanding of any lingering aspects of one’s personal ED and how these may be entering therapy. Potential skills-based competencies associated with ED history implied by participant statements were an alertness to the reappearance, and appropriate management, of ED-like phenomena (e.g., thoughts, feelings, behaviours); demonstrated ability to engage in self-reflective dialogue (i.e., supervision, consultation, and/or personal therapy) in order to address personal ED history concerns that may impact one’s delivery of therapy to ED clients; and engaging in critical thinking skills to discern the ethical implications of disclosing an aspect of one’s ED history.

Fourth, my interpretation and conclusions regarding the present study suggested it would also be helpful to generate knowledge on how climates safe for ethics dialogue relevant to ED-historied therapists are specifically operationalized (e.g., conditions identified at the micro, meso, and macro levels). Other relevant questions might include: What specific interpersonal skills might be required to generate these climates? Does participation in dialogue afforded by safe climates actually make a positive difference in therapists’ ethical practices? These research
directions are consistent with Bloomgarden et al.’s (2003) recommendation that professional culture in ED treatment settings be examined regarding recovered eating disorder practitioners.

Fifth, given the anxiety expressed by participants in the current study regarding professional ethics and/or its intersection with personal ED history, it would be useful to determine what kind of exposure to professional ethics decreases anxiety to a reasonable level such that practitioner engagement is catalyzed and ethical reasoning skills are maximized. Analog studies might be employed, in which subjects’ anxiety is activated and then ethical decision-making skills tested.

Sixth, regarding the ethical vulnerabilities of early career/early recovery ED-historied therapists, research is warranted that can further establish the veracity of these vulnerabilities, and determine what interventions might ameliorate them. One of the areas of ethical vulnerability identified in the present study, therapist wellness, will likely be difficult to operationalize, given that defining ‘recovery’ in the EDs field has been fraught with challenges (McGilley & Szablewski, 2010). And, what constitutes a “recovered enough” therapist (Bloomgarden et al., 2003) has not yet been defined in the EDs field. Regarding the other salient area of early career/in recovery therapist vulnerability – therapist self-disclosures related to ED history – it may be helpful to conduct research that is able to inform the development of decision models to assist both novice and more experienced ED-historied therapists alike in informing their ethical reasoning concerning this practice. For example, the ethnographic decision tree modeling approach (EDTM; Gladwin, 1989) could be employed to ascertain the array of “if-then” decision rules that describe the key factors or considerations that ED-historied practitioners use to make the decision to self-disclose their personal ED histories (Gladwin, 1989; Beck, 2005). EDTM could also be applied to ascertain and improve ED-historied therapists’ decision-making in a variety of other areas, including when they would cease practice due to impairment from an active ED.
Finally, it will be helpful to determine what may be actually helpful, unhelpful, and harmful to ED clients regarding an ED therapist’s personal ED history. Correlational research might be employed to identify variables related to therapists’ ED histories and their use of their histories in service delivery that predict treatment outcome. Another important angle would be to ask clients about their perceptions of being helped, not helped, and/or harmed as a result of their therapist’s ED history.

5.4 Delimitations and Limitations

5.4.1 Delimitations

The study was delimited in several ways. First, given resource constraints in the context of completing multiple interviews per participant, interviewees were restricted to the geographical area of North America’s west coast. In addition, after commencing recruitment, a decision was made to include only female participants in the interviews so as to keep this variable homogeneous in the sample. This seemed reasonable given that ED experiences for men and women can differ markedly in terms of presentation, and that the prevalence of EDs and early descriptive research suggests that the vast majority of ED therapists with personal ED histories are likely to be female (e.g., American Psychiatric Association, 1994; Barbarich, 2002).

However, heterogeneity was sought and obtained regarding participant age, type of ED personally experienced (as well as duration, recency, treatment received), years of experience as a therapist and as an ED therapist, proportion of ED clients in caseload, theoretical orientation, amount of ethics training, work setting (e.g., residential treatment, private practice, etc.), and geographical location (e.g., rural, suburban, urban). Thus, the study’s delimitations include the composition of its participant group, which may have excluded certain important variables not identified as such. Although the study’s design aimed to be emergent, no new variables of interest regarding the participant group were identified during or after the data collection period. However one participant was additionally selected after data collection commenced in order to
access the ethics experiences of therapists in small communities.

The choice to recruit participants who had at least Master’s degrees and who belonged to professional associations with a code of ethics prohibited accessing individuals without these characteristics who deliver ED therapy services. The inclusion of practitioners without these credentials might have changed the ethics terrain results due to their potential lack of professional ethical knowledge and skills, perhaps leading to the emergence of more unexpected or unusual ethics experience categories.

Another delimitation was that data were limited to what emerged in interviews and what was written in first-person published accounts, both of which were likely to have been influenced by the individuals’ ‘agendas,’ as well as, potentially, social desirability factors. No behavioural observation of ED-histored therapists’ ethics experiences occurred, which might have provided valuable information about their experiences that was less influenced by these factors. The actual feasibility of behavioural observation was questionable given resources and, more importantly, the sensitive nature of the research topic for the professionals who participated.

5.4.2 Limitations

Consistent with the constructivist-interpretivist paradigm of science, the rigor of the present study is not judged on degree of generalizability, but on other concepts such as depth of understanding (see the section on Trustworthiness in Chapter 3). As such, the non-generalizability of the knowledge produced is not considered a limitation. However, the study did demonstrate several limitations consistent with qualitative research. These included reliance on only two distinct sources of data (two first-person written accounts, and interviews with 11 participants). Useful collateral data sources might have included documents such as treatment program policy and procedure manuals, text from relevant listserv discussions, the inclusion of any pre-existing qualitative datasets (e.g., Rance et al., 2010), or participant journal entries. As
noted in the Chapter 3 (Approach to Inquiry), the plan to include mixed focus groups (i.e., with non-historied and historied practitioners), another potential data source, was set aside when interviewing began to reveal the vulnerabilities and potential professional risks involved for historied participants in discussing the subject matter, particularly in such mixed groups. The focus groups were also reconsidered because of their perceived questionable ability to answer the research question.

Second, no participants were interviewed who were not able to converse about the research topic using a professional ethical lens at least at some level, or, obviously, who were so uncomfortable with the topic that they could not imagine discussing it with a researcher. Thus, little knowledge was gleaned about the ethics experiences of ED therapists with personal ED histories who might demonstrate these characteristics. Relatedly, the interviews were unlikely to have plumbed the absolute depths of participants’ more difficult ethical experiences, given the discomfort expressed by participants in engaging with the research topic. Despite this, many participants seemed remarkably candid in describing ethical errors and negative client outcomes (e.g., a client who died, perceived as having ‘fallen through the cracks’ of the larger mental health system). Reliance on participants’ retrospective recall was also a limitation of the study, as memories may have been modified by time. As Polkinghorne (2005) points out, full access to participants’ experiences is impossible; therefore researchers must accept “partial access” (p. 139) to such data.

Third, although the sample evidenced a reasonable degree of variation on many relevant variables, there was limited variation in terms of ethnic heritage. While this is not a consideration in terms of generalizability, it is a consideration in terms of understanding the ethics experiences of ED therapists with personal ED histories who do not identify as Caucasian/European. Fourth, the inclusion criteria for the study stipulated at least 2 years of experience working in EDs. While this was intended to access participants who had at least some
knowledge and/or expertise with ED clients, the least experienced participant interviewed had completed graduate school 7 years prior, and had practiced in EDs for those 7 years. Thus, no participants who constituted true beginners in the field were included in the sample, thus limiting our understanding of the ethics experiences of such individuals and the meaning of the findings regarding early vulnerabilities.

Finally, the understandings produced by the investigation were limited by my experience level as a describer, interpreter, therapy practitioner (PhD level counselling psychology trainee), and neophyte qualitative researcher. Researchers with more depth of experience in these areas may have analyzed and interpreted the data in perhaps a different or more sophisticated fashion based on their more advanced knowledge and skills.

5.5 Chapter Summary

The discussion chapter presented the results of an interpretation process that transformed the descriptive and process-oriented findings to a next level of meaning and abstraction. This process identified further patterns, concepts, and ideas that provided a more integrative understanding of participants’ ethics experiences (Sandelowski & Barroso, 2003; Thorne, 2008), and thus better informed implications for practice and research of the knowledge generated. The interpretation included: the enumeration of the ethical issues and concerns of the participants; the complexity of their ethics experiences potential obstacles to full engagement with relevant ethical issues; early career and early-in-recovery ethical vulnerabilities; and the skill of ethical discernment. Based on this interpretation, I made recommendations for practice intended for ED-historied practitioners, their instructors/trainers/supervisors, and the broader EDs field. Implications for research were presented, and delimitations and limitations described.

5.6 Conclusions

The interpreted description produced in answer to the research question (For psychotherapists with a personal history of an ED, what are their experiences of professional
ethics in their day-to-day work with ED clients?) represents an initial step in understanding the ethics experiences encountered by such therapists, and has identified what these findings mean, why they matter, and how they might be applied responsibly to practice. The study identified common patterns and themes among the ethics experiences of this group of ED-historied therapists in their daily work with ED clients, as well as individual variations within these commonalities, including regarding what participants encountered, and how and when they encountered it. Consistent with the interpretive description approach (e.g., Thorne, 2008), the study’s practice goal was to generate knowledge that could maximize ED-historied therapists’ safe and ethical service delivery to ED clients.

Generally speaking, this study has extended our knowledge of ED-historied ED therapists’ professional practices, beliefs, and challenges – in this case, regarding professional ethics. This study is rare in its specific sampling and investigation of any aspect of this population, particularly to such a rich extent. The findings of this study extend other research regarding ED-historied therapists that previously identified “drawbacks”/“challenges” and “benefits” regarding their involvement in EDs treatment. In the present study, these concepts were conceptualized specifically as ethical issues, thus tying them to professional responsibility.

The knowledge generated, in accordance with the study’s practice goal, had several implications for informing the effective training and supervision of ED-historied therapists. The recommendations were intended to promote positive ethics experiences for ED-historied therapists that could help them increase their awareness of the ethical implications of their ED histories and apply this awareness in their efforts to benefit and not harm their ED clients, a key obligation regarding personal experiences appearing in the ethics codes (e.g., CPA, 2000). Although many questions remain about the ethics experiences of ED therapists with personal ED histories, I believe the angle of vision provided by the findings of the present study nonetheless holds considerable promise for supporting ED-historied therapists to provide maximally safe and
helpful psychotherapy services to ED clients.
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Eating Disorder Psychotherapists Who Have a Personal History of an Eating Disorder: Exploring their Experiences of Professional Ethics

There has been little literature published on the involvement of practitioners with a personal history of an eating disorder (ED) in EDs treatment.

Study’s Purpose: One way to further increase our understanding of this topic is to develop knowledge about what therapists with a personal history of an ED experience in their day-to-day work with ED clients in terms of professional ethics (e.g., ethical issues encountered, use of self-disclosure, etc.). This study has been approved by UBC’s Behavioural Research Ethics Board (study identification # H09-02828).

The study’s results will provide practical information for ED mental health practitioners, treatment program directors, and policy-developers, and facilitate ethical discourse on the topic. The results may also contribute to the content of education and training programs for ED treatment practitioners. The project aims to inform both theory and practice in the fields of both applied ethics and EDs treatment.

To participate in this study, you must:

1. Have provided counselling or therapy to ED clients for at least 2 years, and must be providing these services currently
2. Currently carry a proportion of at least 1/4 (approximately) ED clients in your caseload
3. Possess at least a Master’s degree and be a member of a professional organization with a code of ethics
4. Self-identify as having experienced an ED of diagnosable severity (i.e., either Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified)
5. Be 22 year of age or older
6. Speak English

I am also seeking counselors and therapists who do not have a personal history of an ED to participate in a focus group activity.

If you are willing to share your experiences, or for more information, please contact Meris Williams (doctoral student in Counselling Psychology at the University of British Columbia) at [Tel #], [email address], or [email address], or go to the following link: [URL]
Dear Sir/Madam,

My name is Meris Williams. I am a doctoral student in Counselling Psychology at the University of British Columbia. I am currently completing research for my dissertation under the supervision of Dr. Beth Haverkamp.

As you may be aware, despite calls from the field, there has been scant literature published on the involvement in eating disorders (EDs) treatment of practitioners with a personal history of an ED that goes beyond basic description or opinion surveys about the potential benefits, drawbacks, and suitability of such involvement.

**Study’s Purpose:** One way to further increase our understanding of this topic is to develop knowledge about what therapists with a personal history of an ED experience in their day-to-day work with ED clients in terms of professional ethics (e.g., ethical issues encountered, use of self-disclosure, etc.).

I hope that the study’s results will provide practical information for ED mental health practitioners, treatment program directors, and policy-developers, and will facilitate ethical discourse on the topic. The results may also contribute to the content of education and training programs for ED treatment practitioners. The project aims to inform both theory and practice in the fields of both applied ethics and EDs treatment.

This study has been approved by UBC’s Behavioural Research Ethics Board (study identification # H09-02828).

I am enclosing flyers that describe the research and call for participants. I would appreciate your assistance in distributing/posting them in your workplace, and informing any other currently practicing therapist or counsellor who you think might fit the inclusion criteria. There are opportunities for currently practicing therapists or counsellors with or without a personal history of an ED to participate in the study’s data collection activities. Participant identities will be kept strictly confidential; however, in British Columbia, policies on research ethics require a few standard exceptions to confidentiality:
1. If a participant expresses an intent to harm themselves or another, I must disclose information as necessary to protect those involved.
2. If the researcher has a reasonable reason to believe that anyone under the age of 19-years-old needs to be protected from abuse (physical, sexual, or emotional) or neglect, I must disclose that information to the Ministry for Children and Families.
3. If I am served with a valid subpoena, court order, or search warrant, I must comply.

As with all research that involves the disclosure of personal information, there is a possibility that such disclosure may create temporary discomfort for participants or impact their coping abilities with other psychological issues. Possible benefits for therapist-participants who have a personal history of an ED may include an enhanced understanding of themselves regarding the intersection of their personal histories of an ED and their professional lives. For all participants, there may be an increased awareness of, and sensitivity to, professional ethics in their and their colleagues’ practices.

If you have any questions about the study please do not hesitate to contact me, and thank you for your help.

Meris Williams, M.A.
Tel#
Email: [email address] or [e-mail address]

Supervisor: Dr. Beth Haverkamp, [Tel #]
Email: [e-mail address]

Website: [URL]
Appendix B: Consent Form

THE UNIVERSITY OF BRITISH COLUMBIA

Department of Educational and Counselling Psychology, and Special Education
The University of British Columbia
Faculty of Education
2125 Main Mall
Vancouver BC Canada V6T 1Z4
Tel 604-822-0242 Fax 604-822-3302 www.ecps.educ.ubc.ca

Experiences of Professional Ethics for Psychotherapists Who Have a Personal History of an Eating Disorder

Therapist Consent Form

Principal Investigator: Dr. Beth Haverkamp, Principal Investigator & Associate Professor, Department of Educational and Counselling Psychology, and Special Education, University of British Columbia, Tel. #, e-mail address

Co-Investigator: Meris Williams, Doctoral Student, Department of Educational and Counselling Psychology, and Special Education, University of British Columbia, Tel. #, e-mail address

This research is being conducted as part of Meris Williams’s doctoral degree in Counselling Psychology, and is being supervised by Dr. Beth Haverkamp. The information collected will be included as part of a thesis, which is a public document.

Purpose: The purpose of this study is to develop knowledge about what therapists with a personal history of an ED experience in their day-to-day work with ED clients in terms of professional ethics (e.g., ethical issues encountered, use of self-disclosure, etc.).

Study Procedure: If you agree to participate, you will be asked to take part in two interviews of approximately 60-90 minutes each, over a period of 2-3 months. During the first interview, you will be asked some questions about yourself (e.g., age, gender, years of work experience, the type of eating disorder you have experienced), and your work setting (e.g., rural/urban, private practice, clinic). During both the first and second interviews, you will be asked about your experiences of professional ethics in your day-to-day work with ED clients (i.e., the various ways in which ethical issues enter your practice, for example, ethical issues encountered, use of self-disclosure, etc.). The interviews will be audio recorded and later transcribed to assist in analyzing your comments. You may be contacted after the interviews by the co-investigator to confirm her understanding of your comments or to clarify them. You may additionally be contacted, after both your interviews have been completed and once all participants have been interviewed, in order to share your feedback with the co-investigator on common themes emerging from the interviews.

Time Commitment: The total time commitment for the interviews is a minimum of 3 and a maximum of 5 hours.
Potential Risks and Benefits: There is a possibility that, in the process of sharing your experiences in the interview, uncomfortable feelings may arise. At any time, you may choose to take a break or withdraw your participation from the interview. If you choose to withdraw from the interview, no data from the interview will be entered. As per standard practice when interviewing people about potentially sensitive topics, you will be given a list of affordable counselling services. You may wish to consider accessing these services if the research activities trigger feelings or issues that you wish to explore further.

The potential benefits of your participation in the study may include an enhanced understanding of yourself regarding the intersection of your personal history of an ED and your professional life, and an increased awareness of, and sensitivity to, professional ethics in your practice. If you wish, you will receive a summary of the study’s results, which you can request at the bottom of this form.

Confidentiality: Your identity will be kept strictly confidential. Only the principal- and co-investigator will have access to your name and your interview materials. All documents and audiotapes will be kept in a locked filing cabinet when not in use, and all computer files will be encrypted with a password. In any publications resulting from this research, your name and any other identifying information will be altered. As per university policy, all information and data obtained in this research study cannot be destroyed until at least five years after the publishing of the research in a refereed academic journal.

Remuneration/Compensation: You will receive an online bookstore gift card in the amount of $20.00 for your interview participation.

Contact for information about the study: If you have any questions or wish further information about the study, you may contact Meris Williams at [Tel #] or [e-mail address], or Dr. Beth Haverkamp at [Tel#] or [e-mail address].

Contact for concerns about the rights of research subjects: If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598 or if long distance e-mail to RSIL@ors.ubc.ca

Consent: Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without any negative consequences. If you have any questions about the research study or your participation in it, please address these with the co-investigator before signing this consent form.

Your signature indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

Your signature indicates that you consent to be audio recorded during the interviews.
Name (please print)

_____________________________          ____________ _______

Signature                                              Date

I am interested in participating in a focus group with other ED therapists and counselors (circle):

Yes            No

I would like to receive a summary of the study’s results (circle):    Yes    No

Please send the summary to the following address:

________________________________________________________________________
________________________________________________________________________
Appendix C: Demographic Questionnaire

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Tel 604-822-0242 Fax 604-822-3302 www.ecps.educ.ubc.ca

Experiences of Professional Ethics for Eating Disorder Psychotherapists Who Have a
Personal History of an Eating Disorder

Subject Demographic Information

We would like to collect some demographic information about the participants in this study. The
information you share here will be kept confidential, and you will not be identifiable. The
demographic information will be used to contextualize the data. Thank you for your assistance.

Participant #: __________________

Basic Information

1. Age: ________

2. Gender: (circle) Male Female

2. Ethnic Heritage:

(a) African (e) Latin/Hispanic
(b) Asian (f) South Asian
(c) Caucasian/European (g) Other (please specify) _________________
(d) First Nations

Personal History of Eating Disorder

4. What type of eating disorder (ED) did you personally experience? ______________________

4a. Was this ED diagnosed? (a) Yes (b) No

4b. If yes, by whom was the ED diagnosed? _______________________________________________________________________

5. Duration of ED: _______________________________________________________________________

6. Do you feel you are currently fully recovered from the ED? (circle)

(a) Yes (b) No (c) Unsure

If yes, when did you achieve recovery? _______________________________________________________________________

What treatment(s) did you receive for your ED?

7a. Before entering the field of EDs treatment: ______________________________________________________________________

________________________________________________________________________________________
7b. After entering the field of EDs treatment: ____________________________________________

8a. Approximate number of relapse experiences before entering the field: ______

8b. Approximate number of relapse experiences after entering the field: ______

9. Is your workplace aware of your personal history of an eating disorder?
   (a) Yes   (b) No   (3) Unsure
   Please explain: _____________________________________________

Work Experience

10. Approximate number of years providing counselling/therapy services: ____

11. Approx. number of years providing counselling/therapy services to clients with EDs: ____

12. Current caseload of ED clients (approximate proportion): __________

13. Counselling/therapy theoretical orientation: __________________________

14. Practice setting:
   (a) private practice   (b) EDs treatment program   (c) other (please specify) __________

15. Geographical context:   (a) urban   (b) suburban   (b) rural

Thank you.
Appendix D: Interview Guides
First Interview

Questions

• Can you tell me what interested you about my study?

• Tell me about your experiences of professional ethics in working with eating disordered clients.
  • Probe: Can you give me a specific example(s)?

• Have I missed anything that you wanted to tell me about your day-to-day ethics professional experiences in your work with ED clients?
Interview Guide - Second Interview

Section A Questions:

1. Tell me about any reflections you have had since our first conversation.

   Probe: Are you thinking about ethics differently, or doing anything differently since our first conversation?

2. Are there any other experiences of professional ethics in your work with eating disordered clients that you would like to tell me about, or any experiences that you would like to expand on from last time?

Section B Questions: (based on first round of interviews)

1. When you reflect on your work with ED clients, are there any residuals of the ED experience that enter into your work? (this may not be obvious)

   The way I've designed this study, whatever I come up with for the results will reflect your experiences and my understanding and interpretation of those experiences. Through our interacting, we affect each other. Related to those ideas:

2. Given my desire to understand your experiences, is there any "take home message" that you really want me to understand about your experiences of professional ethics with ED clients?

3. Regarding the idea of mutual effect we have on each other, one participant wryly disclosed that she realized she had an intense desire to prove to me that she doesn't have an ED any more. Her saying that prompted me to realize that, when I was giving my own self-disclosure statement, I also wanted to convey to you and other participants that I didn't have an ED any more. I am wondering, for you, if there is anything you have been aware of in our conversations, that you had an intense desire to convey to me (can be similar to or different from that example)?

4. My next question may be a difficult one...and before I ask it of you, you have absolute permission to give me just a 'yes' or 'no' answer if you prefer. It occurs to me that there may be some things about this topic that are unspeakable between us. Is that true for you?

5. How do you think ED therapists with personal ED histories could best be ethically supported in their work?”

Section C Questions: Additional demographic question:

6. There has been so much variation among all the participants, and training has changed so much over the years, I am wondering if you could tell me about your training in ethics?
Section D Questions: Final Question

7. Have I missed anything that you wanted to tell me about your day-to-day professional ethics experiences in your work with ED clients?
Interview Guide - Third Interview (Phone)

1. Any reflections, anything you’ve been thinking about since our conversations?

2. As a therapist with a personal history of an eating disorder, what does professional ethics mean to you?

3. Something that has come up in the interviews is the idea of "boundaries" -- as a therapist with a personal history of an ED, what do “boundaries” mean to you in your work with ED clients?

4. The idea of therapist wellness has also come up. As a therapist with a personal history of an ED, what does "wellness" mean to you in your work with ED clients?

5. Have I missed anything that you wanted to tell me about your day-to-day experiences of professional ethics in your work with ED clients?

6. Do you have any questions for me?
(b) Concept Map of Process-Oriented Findings

The Interviews as Ethics Experiences

are themes regarding

Comfot w/ Research Topic

Reflections & Changes

are aspects of

Comfort w/ Professional Ethics

are types of

Reviewing/Assessing Ethics Knowledge & Practice

Developing Self-Knowledge and/or Clarity

Increasing Comfort/Self-Assuredness

Being Triggered

Stimulating Action

are factors influencing

Ethics as Ambiguous, Abstract

Getting it Right

Negative Associations w/ Ethics
Table 1

*Ethics Experiences Categories Not Associated with ED History (Spontaneous Responses to Main Interview Question)*

<table>
<thead>
<tr>
<th>Source (participant #)</th>
<th>P1</th>
<th>P2</th>
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<th>P9</th>
<th>P10</th>
<th>P11</th>
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Table 2

*Ethics Experiences Categories Associated with ED History (Spontaneous Responses to Main Interview Question)*

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Table 3

**ED History & Boundary Issues Sub-Categories**

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<th>P10</th>
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<th>Bloom-garden</th>
<th>Goldkopf-Woodtke</th>
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<td>Making mistakes, having regrets &amp; coping with challenges</td>
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## Table 4

**ED History & Therapist Wellness Sub-Categories**

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<th>P11</th>
<th>Bloom-garden</th>
<th>Goldkopf-Woodtke</th>
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</thead>
</table>

- **Experiencing an active ED**
  - P1
  - P7
- **Experiencing ED residuals**
- **“Sticky bits”**
  - P1
  - P3
  - P4
  - P9
  - P10
- **Lingering body, weight, and/or eating issues**
  - P2
  - P4
  - P5
  - P8
- **Pushing, working too hard, high expectations, perfectionism**
  - P1
  - P3
  - P4
- **Under-reacting to client risk**
  - P3
  - P4
- **Keeping on top of the work**
  - P2
- **Saving and protecting clients**
  - P1
  - P7
- **Integrating the ED**
  - P1
  - P2
- **Having Self-awareness**
  - P1
  - P2
  - P3
  - P4
  - P5
  - P7
  - P8
  - P9
  - P10
  - P11
- **Being human**
  - P1
  - P2
  - P3
  - P4
  - P5
  - P6
  - P7
  - P8
  - P9
  - P10
  - P11
- **Being congruent**
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  - P2
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<td>Plus good boundaries</td>
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Table 5

*ED History & Helpfulness of the ED Sub-Categories*

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### Table 6

*Openness Regarding Therapists’ ED Histories Sub-Categories*

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Table 7

*The Interviews as Ethics Experiences*

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Appendix G: Participant Recommendations for Ethical Support

When the therapists were asked how therapists with personal ED histories could be supported ethically in their work with ED clients, the overriding theme among their responses was that there be more open dialogue, in a number of potential venues. Sharing her perspectives on why, how, and with whom such dialogues might take place, and what might beneficially be talked about, a therapist commented:

[I] would like to see more dialogue in our field about it and would like clinicians to be able to support each other and talk about this more...If we’re all judging each other for having personal histories, that’s not helping anyone...I think, if you talk about it, then you can really see how your own experience is affecting your work...I think that when you’re isolated with anything, you don’t get the best supervision or consultation...[Dialogue] enhances your ability to conceptualize more clearly, to understand yourself, your patient, and really practice in a way that is more effective. So, if it’s something that you can’t talk about, you miss the opportunity to see, where is this coming up for me? Where is it coming up for other people? How are they handling it? (P7-1, 401-407, 411-422).

Other participants expressed that ethically helpful conversations would be possible in “good” supervision that was readily available, and in which the supervisor could serve as a “sounding board” with whom the therapist could feel comfortable talking about how her ED history might be entering therapy, for example if she was feeling “triggered” by clients.

Other potential sites for dialogue identified by participants for helping to ethically support ED-historied therapists were as follows: the therapist’s own therapy (e.g., to practice “separating” the personal and professional); training programs (e.g., training students regarding the use of self-disclosure concerning personal information, including mental health experiences); continuing education; and in the broader EDs field (e.g., symposia at conferences with practitioner-panelists who had ED histories). Each of these venues was felt to render the topic of ethics and therapists with ED histories more visible and tangible, and therefore more addressable, thus increasing accountability and potential benefits to clients. It was noted that these types
of dialogues would necessitate that therapists with ED histories have the courage to engage in them. Consider the following short excerpts:

[I]t behooves those of us who have had, and remain somewhat residually connected to, eating disorders to be willing to share their own experiences in a very honest way…[T]hose of us who have that piece of the puzzle need to be prepared [to talk about it with colleagues] in an unashamed fashion (P2-2, 625-632).

It’s worthwhile to know ourselves and be able to speak it publicly in the circles that we work in. It’s not something I should feel, in my team, I have to hide and be wary that people would find out. It’s actually good, ethical practice (P10-2, 1037-1040).

Perhaps there are people like me who aren’t letting people know (laughing). I think in terms of being able to be more forthcoming with that and authentic with that, then we can work with it more with each other and talk about all of who we are at work, both in terms of accountability, but also in what that can bring to the work as well (P1-2, 174-179).

In addition, therapists expressed the desire for environments that demonstrated an openness to, or acceptance of, these types of conversations occurring. For example, a participant who advocated for more structured training on the use of therapist self-disclosure stated that training could serve to normalize (without compelling trainees to disclose) that all therapists have past experiences of one kind or another that they must know how to manage in therapy with clients. She said:

I think if there was education about that [self-disclosure], then it would reduce the stigma in our field. [You could] examine the judgments you might have about your colleague who has a personal experience or who doesn’t have a personal experience. I think it can go both ways…thinking “Well, you don’t really know what you’re –” and “Can you work with those patients?” There can be judgments on both sides. So, fostering some opportunity to talk about that in a professionally guided way (P7-2, 483-492).

To facilitate this, she suggested, a combination of didactic and process-oriented (e.g., discussing encounters with clients who have had a similar life experience) training would be useful. She posited that new therapists might then feel less “ashamed that this is happening. [Therefore], it won’t impede your ability to move forward with it and actually address it” (P7-2, 524-525).
Participants proposed that continuing education events could offer opportunities for therapists with (and without) ED histories to explore how their histories (or lack thereof) were entering their work. For instance, a therapist stated:

[I]t would be helpful to have break-out groups and talk about it, to continue to check back in...“How is the work affecting your thoughts about your own recovery?” “You’re using your recovery in your work. Do you think that’s helpful? Let’s give that some thought. And how are you using it? How could it be used if you’re not? And how do you feel about not having had one [an ED]? Is that getting in the way?” “Do you feel that you should have had the experience? Do you do you assume that you’re better than the ones that are recovered because you don’t have any chance of damaging therapy that way?”...Maybe just some brainstorming (P6-2, 1182-1188, 1197-1199, 1220-1228).

The desire to see the topic of ED-historied practitioners more visible at conferences and other professional events was also expressed.

Finally, regarding dialogues in which a colleague approached another about a wellness concern such as a weight loss, a therapist offered a perspective on how such encounters could be engaged in effectively. She stated that it would be helpful to begin simply by inquiring “How [are] things going for you, professionally and personally?”, expressing concern in a way that invited discussion, and being trained/prepared to be comfortable with what emerges in that discussion. She remarked that a non-judgmental, safe space for this was critical.