

Professionals with Eating Disorders

Dr Shelagh Wright, Independent, U.K

Andrew O'Toole-Hampshire Partnership Trust, U.K.

Introduction.

There is a lack of formal attention regarding the role for clinicians who have personal recovery from Eating Disorders, in the treatment of the eating disordered patient population. There are many implications for investigating this particular area including human resource management laws and counter-transference regarding the use of self-disclosure in psychotherapy. Many advantages as well as disadvantages are involved in employing clinicians with personal recovery in the treatment of Eating Disorders. The main aim of this paper is to highlight the issues and ultimately through further research to eventually offer guidelines to Eating Disorder organizations, and treatment programs regarding clinicians with personal recovery, treating Eating Disorder patients.

In the United Kingdom (UK) between 15% and 30% of employees will experience mental health problems in any one year. This breaks down to 1 in 6 women and 1 in 9 men who are likely to require treatment in a psychiatric unit during their lifetime (Department Of Health DOH 2002). Only a minority of these will suffer a long-term disability. In England the context for this is the modernisation of the National Health Service (NHS) with the underpinning values of valuing diversity, social inclusion, reducing stigma and tackling discrimination and inequality. We know that employment is central to a person's independence and participation in society. We also know that people with mental health problems have some of the highest rates of unemployment among the disabled

In this paper we will describe and discuss, within the context of eating disorders, what is known about the laws relating to this issue; the people affected by this issue; review the literature addressing this issue; and highlight the key issues as we see them for both employers and those seeking employment, paying particular attention to how these issues are relevant to those with a personal experience of an eating disorder. We will also present the results from a small survey with eating disorder professionals.

The Legal Context.

The Disability Discrimination Act, (DDA), 1995, Looking Beyond Labels 2000, the Management of Health, Safety and Welfare issues for NHS staff 2000 and Mental Health and Employment in the NHS 2002, The Clothier Report, and Professional Codes of Conduct, are the main legal documents that cover this issue. The DDA was the first attempt to legislate against discrimination. It became unlawful to treat a disabled person less favourably because of their disability, or fail to comply with the duty on them to make reasonable adjustments. In Looking Beyond Labels from the NHS Executive Equal Opportunities Unit, there was an emphasis on Managers creating a culture of openness - encouraging help when needed, fair treatment and a self-awareness amongst staff. Other initiatives have included the Disability Symbol and the New Deal for Job Seekers with Disabilities, the focus being on 'decision on merit' and suitability not prejudice. As the largest public sector employer, the NHS needs to make a significant country-wide contribution to delivery of these objectives. With the introduction of the implementation of the human rights act there has been several dilemmas both for professionals and sufferers in ensuring that an individuals rights are not restricted (article 18) whilst at the same time preserving the right to life (article 2). (Human Rights)

The Clothier Report which followed the investigation into a series of child deaths in hospitals, made a number of recommendations regarding recruitment to training and employment of nurses to work with children. Allit, a paediatric nurse working at the hospital where the children died, was charged with these deaths. She was diagnosed as having a personality disorder. The report recommends not employing persons to nursing posts who have evidence of a personality disorder. No mention is made of anorexia nervosa, however, because Allitt had developed anorexia nervosa whilst in prison awaiting trial, the links between eating disorders and nursing were made and acted upon. The Clothier Report recommended that: references be taken up prior to acceptance, and one must be from the most recent work or study place; that sickness records be sought; that someone with a personality disorder is not suitable for nursing; that formal health screening take place at entry to training, post study, pre first post and every post change thereafter; that the availability of occupational health records be reviewed; that the suitability of the person for the post be ascertained. Nothing was said about anorexia nervosa.

The focus has been on the nursing professions despite there being some evidence to suggest a higher prevalence in other professions, (Costin 2002, Wright 1999, Drake 1989,)

All clinicians work within a specified code of conduct. Most of these codes address issues of neglect/abuse and criminal proceedings, not the mental or physical health of the clinician. The British Association for Clinical Psychology do mention the 'fitness to practice' issue but place the responsibility to monitor fitness to practice with the clinician. In Johnston et al 2005 they asked the question whether or not people with a history of eating disorders should work as eating disorders therapists, coming from a fitness to practice perspective, they suggested that individuals who had recovered might have some therapeutic advantage whereas un-recovered individuals would lack objectivity and be vulnerable. They felt that the current guidelines were unnecessarily discriminatory and stigmatizing. Whilst Johnston et al conducted a preliminary investigation of views from patient, carer and professional view point the key issue does seem to be one of how to determine recovery: Recovered versus Recovery, recovery is a process, does it ever stop, or are you continually in recovery?

Employing people with a history of an eating disorder can have advantages as well as disadvantages:

The potential advantages might enhance the quality of mental health services offered by having clinicians who had had experience in living and coping with similar issues to the client group, they could also serve as a role model for recovery, offering understanding and hope for the patient struggling with recovery. This may help to address the stigmatization of psychiatric patients as well aid in staff retention. Some services work within the context of disclosing any eating disorder history in staff members, the alcohol services are a good example of how staff disclosure can work in a healthcare setting. Others do not disclose any kind of mental illness amongst staff seeing disclosure as an unwarranted crossing of therapeutic boundary. When thinking about the disadvantages the following issues have been raised: the level of sickness and absence from work, the inability to make decisions or cope in emergency situations, seeking therapeutic relationships with colleagues, the potential risks to patients, the individual staff member being 'on a mission', the potential to collude with the patients and their illness, and that they may have less sympathy for example they may feel 'if I can recover than so can you'.

When working as a multidisciplinary team the responsibility of each team member needs to be acknowledged and understood. Having one member suffering or struggling to maintain a recovery can have a huge impact on the rest of the team

whether they are aware of the issues or not. The challenge is to provide a supportive framework for all employees to feel confident in their ability to do their job and function as a team member. This would need to be considered within a framework of non-discriminatory practice as well as the context of the work itself, encompassing individual and peer supervision.

Review of Clinical Issues from the Literature

Johnson, C.L. and Costin, C. (2002), surveyed ten established programs in the U.S. to explore their experience and current position regarding the use of staff members with personal recovery. Interestingly, none of the programs had written policies or guidelines regarding the hiring or monitoring of staff who had personal recovery. It was found that four of the programs actively embraced hiring staff with personal recovery, five programs had mixed views (personal recovery was not an influencing factor when hiring staff). One program avoided the hiring of clinicians with personal recovery altogether. Among the four programs that embraced hiring staff with personal recovery, the estimates of staff with recovery ranged from 30% to 80%. Although, no formal definitions or criteria for recovery or relapse were produced. Two of the sites informally had 2 year recovery criteria, and two had 1 year recovery criteria. Recovery was loosely defined as "normal weight and abstinence from bingeing and purging". Yet, the clinical leaders were more concerned with their overall comfort with their size and shape. All programs expressed an interest in receiving guidelines from our professional organizations.

Barbarich (2002) looked at a lifetime prevalence of eating disorders among professionals in the field. She found 29% (n.150) had an eating disorder themselves and 14% had a family member with an eating disorder. Barbarich n=399 (33.2% females: 2.3%males) found that the length of time in recovery prior to entering the field as a clinician and having an employer who was aware of the history did not predict a lower rate of relapse. The longer the duration of the eating disorder the less time spent in recovery prior to entering the field as a clinician. Those who had not received treatment had a significantly reduced rate of relapse with those who did not receive treatment. A study was carried out on members of the Academy for Eating Disorders to ascertain lifetime prevalence of Eating Disorders among professionals. The Eating Disorder Background survey was developed to assess this. Overall the lifetime prevalence of an Eating Disorder was 27.3%. The duration of the illness ranged from 4 to 372 months (mean 115 months). 64% reported having received some treatment for their illness.

It was found that a longer duration of illness was associated with an increased likelihood of receiving treatment. The duration of the Eating Disorder, a history of Anorexia, a history of more than one Eating Disorder, and having received treatment, all predicted a greater rate of relapse among professionals. The length of time spent in recovery prior to entering the field as a clinician and having an employer who was aware of the Eating Disorder history, did not predict a lower rate of relapse. The longer the duration of the Eating Disorder, the greater the rate of relapse.

Norring and Sohlberg (1993) reported that major relapses in a group of 48 Eating Disordered patients occurred mainly in the first four years after initial presentation. Johnson (2000) argued that the risk of relapse is highly correlated with the length of time in recovery, and the level of training of the clinician.

Given the possible impact that disclosure of a clinician's personal experiences may have on patients, research is needed to determine the potential consequences of self-disclosure on the therapeutic relationship and treatment outcome. It must be emphasized that a history of an Eating Disorder is only one among many personal and technical factors that determine the suitability and competence of the individual as a clinician.

At the Juniper Centre in Southampton, a Community Eating Disorders service with a catchment area of approximately ¾ million, 20% of referrals were for nurses/counsellors. EDE generated diagnoses were used and out of 200 open cases 12% were nurses, 4% were doctors and 2% were paramedics.

Bloomgarden, A., Gerstein, F. and Moss, C. (2003), conducted a survey on staff members at an Eating Disorder unit, regarding any Eating Disorder histories, and how they feel the issue is dealt with at work. Results revealed that 24% of the staff admitted to having had an Eating Disorder averaging 12 years ago. These figures were probably an underestimate of the true figure as some staff members were too guarded to complete the survey. Some recovered clinicians thought they could be fired if it were discovered, although the American Disabilities Act reassured them that recovered clinicians can not be discriminated against. The survey also revealed that many clinicians (67%) used self disclosure in their treatment approach.

Several studies have been conducted which measure the occurrence of symptoms of Anorexia and Bulimia among college students studying dietetics, and the

findings are quite diverse. Crocket and Littrell (1985) found that some degree of vomiting after eating was reported in a group of dietetic students. Larson (1989) suggests that emphasis on body weight, image, food and diet may place dieticians at greater risk for bulimic behaviour. Drake (1989) found that 24% of dietetic students possessed characteristics of Anorexia and indicated that some students may specially choose to study this due to their personal experiences and obsessions with food. However, Johnston and Christopher (1991) and Howat (1993) did not find a high degree of Eating Disordered behaviour in female dietetic students. Fredenberg et al (1996) examined the incidence of Eating Disorders among selected female university students and found no significant differences in the EAT scores of five groups. Kinzl (1994) found that 14.4% of female students were at risk for developing Eating Disorders. Kinzl (1999) also found that dieticians who had Eating Disorders/weight problems, only 14% stated that their Eating Disorder was an important motive for choosing to train in dietetics. 22% reported that the sound knowledge of nutrition had positively influenced their Eating behaviour.

Costin (2002) who looked at multidisciplinary teams found that the prevalence was higher in the therapist counsellor group and dietician group. The issue of description has come up about recovered vs. recovering and what they actually mean. The current findings few though they are, are fairly contradictory and inconsistent. From the literature we can summarize the clinical advantages and disadvantages of having a staff member with a history of an eating disorder as follows:

Clinical advantages of staff with personal recovery

- Recovered staff members are able to become a concrete representation of the "light at the end of the tunnel", becoming an example that recovery is attainable
- Former patients consistently report that one of the most important aspects of the program is the hope and motivation they experience from staff members who have "been there".
- Staff members who have confronted and passed through this process in recovery are usually quick to disregard this issue and are less ambivalent about confronting the patients' immobilization
- When patients see recovered clinicians being valued and occupying positions of status within treatment programs, it can be extremely powerful.

- This direct or indirect message that gets communicated by the staff who have faced, dealt with and overcome their Eating Disorder is “been there, done that. If I can do it, so can you”.

Clinical Disadvantages of staff with personal recovery

- Risk of relapse, Johnson (99') found that the risk of relapse is highly correlated with the length of time of recovery and the level of training of the clinician. The longer the time of recovery and the more sophisticated the training, the less likely relapse will occur.
- Counter-transference issues that staff with Eating Disorder histories can experience.
- If the recovered staff member has received a specific treatment strategy, they could become quite narrow and inflexible in their beliefs about recovery, this could lead to difficulty in allowing the patient to explore the right recovery process for them.
- The clinician can often feel intense pressure to help others as they have been helped. Their dedication to help can slip into a situation where the therapist is taking more responsibility for recovery than the patient.
- Costin proposed that clinicians should have at least 2 years of being “recovered”.

The Issue of Recovery.

At what point is a clinician recovered enough to work with an Eating Disorder population? Some patients have reported that when a clinician had obvious difficulties around food for example never observed to be eating, if observed eating never seen eating certain food groups or always eating salads and vegetables or drinking large quantities of water whilst ‘on duty’, then it was counterproductive to their recovery.

Within the workplace, although guidelines are needed, it is also important for therapists to work in a culture where respectfully expressing concern about one another is the norm. Guidelines that are rigid and quantitative (although easier to devise and measure), are going to fail to capture the essence of recovery, making clinicians feel policed. Guidelines ought to be research based, flexible and not overly simplistic. In some ways having a personal interest in an issue can be positive: greater compassion, desire to make a difference due to acute awareness of the suffering.

Should clinicians self disclose these issues to clients? There has not been a study that has surveyed client's effects of such disclosure on their therapy. Many variables may determine the outcome: timing, degree of information given, how the client feels about the therapist, type of Eating Disorder, how long the client has known the therapist, and whether the client asked for the information. Also, the context in which the information is disclosed is important.

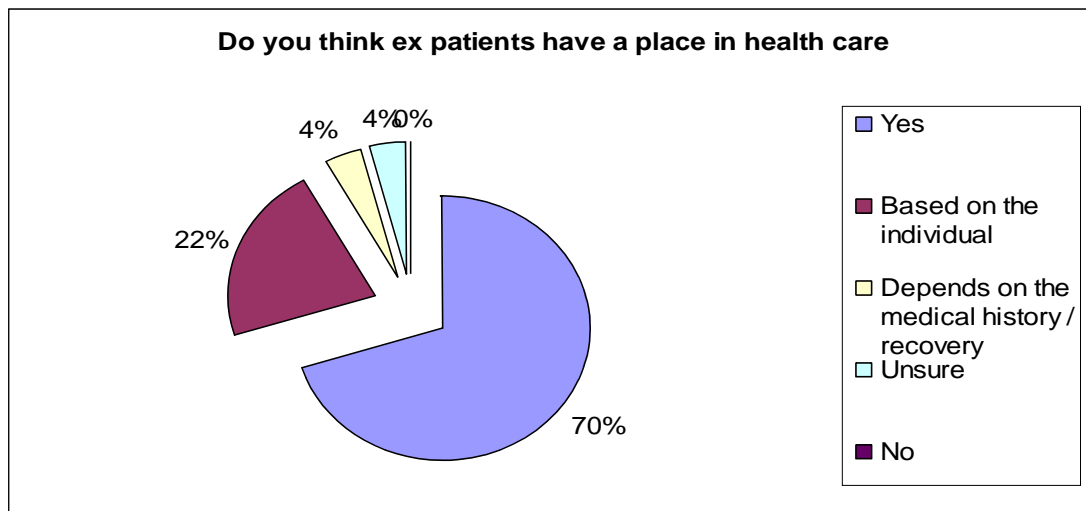
In consequence we wanted to know more about what clinicians in the field thought about the issue of people with a personal experience of an eating disorder working with eating disorder patients

Survey of Eating Disorder Clinicians.

We asked eating disorders clinicians attending an international eating disorder conference workshop what they thought about this subject. 56 workshop participants completed a 5-question questionnaire. We conducted a thematic analysis of their responses.

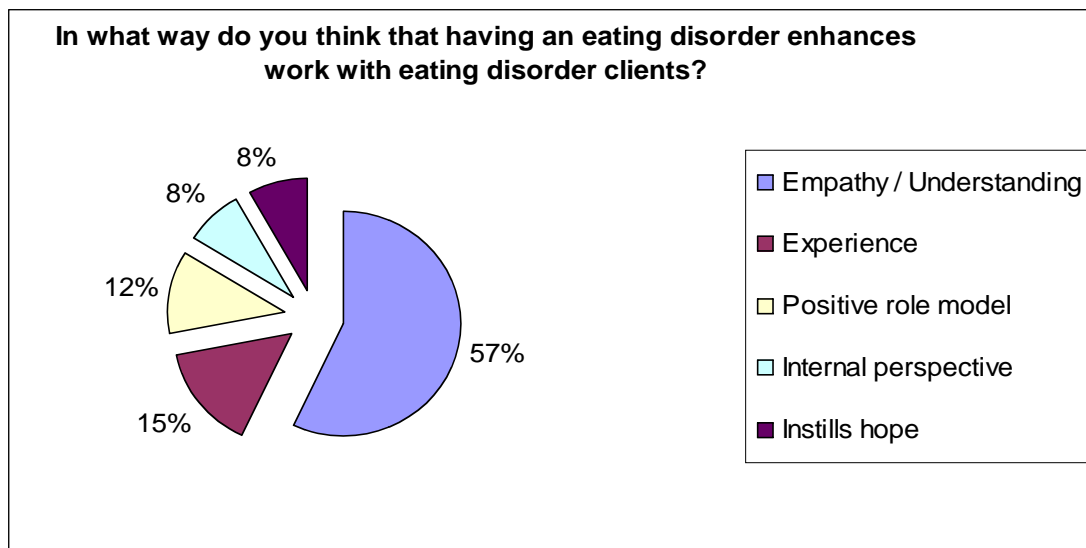
Results.

Chart 1



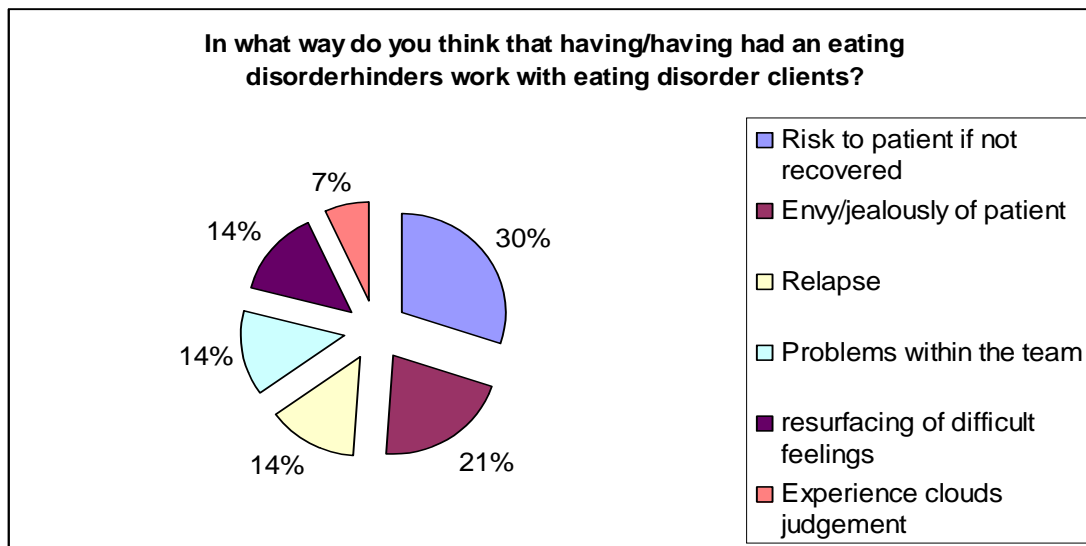
Interestingly when asked if people thought that ex-patients had a place in healthcare, no-one said an outright 'no'; 70 % said 'yes' with the remaining 30% saying it was dependant on either the individual or the medical history or were unsure.

Chart2



57% thought that some one who had personal experience could offer a greater level of understanding and empathy to the patient. 28% thought that an ex-patient could either, offer an internal perspective, instil hope, be a positive role model whilst 15% thought that having personal experience of an eating disorder could enhance their work with people with eating disorders.

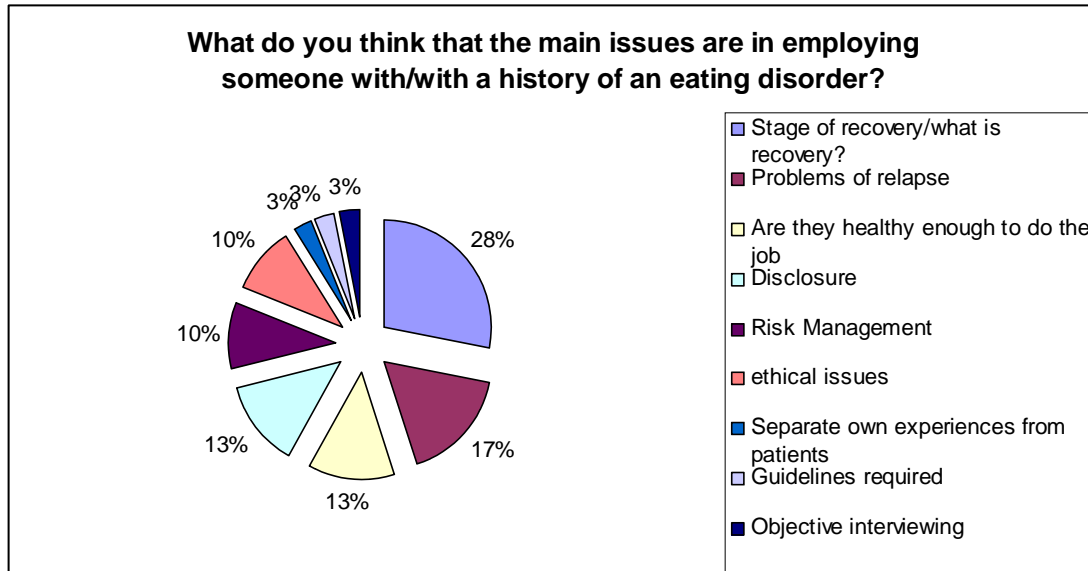
Chart 3



The main concern about ex-patient working with people with eating disorders was the potential risk to the patient if the ex-patient was not recovered: 30% thought this a concern. 21% were concerned with the ex-patient having feelings of jealousy or envy toward the patient(s). There were an equal proportion, 14%, concerned with problems within the team, the resurfacing of difficult feelings, and

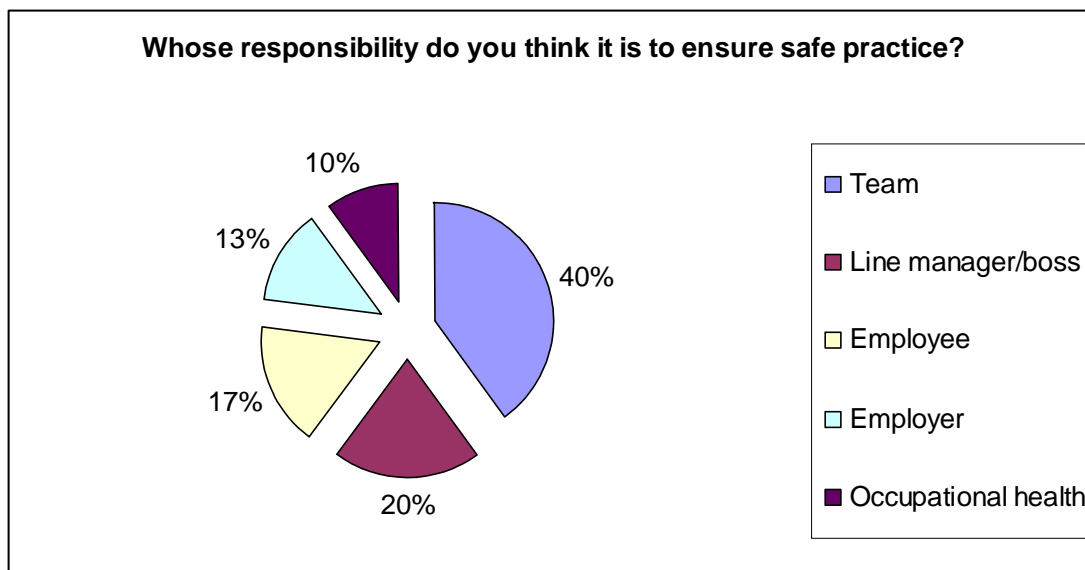
relapse, and 7% were worried about the ex-patients judgement being clouded by their own experiences.

Chart 4



The main issues around employing someone who has had an eating disorder seems to be about the stage of recovery and what is recovery, problems with relapse, being able to separate out own experiences from the patients, and self disclosure. Some minor concerns were around ethical issues e.g. one respondent was concerned with issues in the team of 'who knows best', risk management and whether or not the individual is healthy enough to do the job. In addition from a recruitment perspective, there were some thoughts about objective interviewing and the needs for guidelines e.g. one respondent felt the interviewer needed not to be prejudiced whilst another identified good supervision as an important component.

Chart 5



40% of those asked thought that it was the team’s responsibility to ensure safe practice when there is a team member with a history of an eating disorder: 20% thought the responsibility lay with the line manager: 17% saw the responsibility lying with the employee; 13% with the employer and 10% with occupational health. This is rather concerning as occupational health are the ‘gatekeepers’ when it comes to an employees health at work in the United Kingdom.

Discussion.

From these results the main issues seems to be around 1) defining recovery in such a way that can permit recovered patients to use their experiences to benefit others but without putting themselves, their colleagues, or their patients at risk from these experiences; and 2) protecting their confidentiality whilst at the same time being able to monitor their practice for early warning signs of potential relapse.

With regard to the first point the debate is ‘what is recovered’ and can anyone ever fully recover. Some people believe in absolute recovery whilst others believe one is always ‘in recovery’. Is being ‘in recovery’ just another way of holding onto residual aspects of the eating disorder? Does this sentiment suggest an ambivalence about being recovered? And if this were the case then a person ‘in recovery’ would presumably be more tempted to relapse when faced with the patient and her symptoms. As professionals working with people with anorexia nervosa particularly, we are only too aware of how plausible and convincing their beliefs can sound when they are desperate to hang on to the illness; what effect does this persistence have on some one who is not convinced that full recovery is

possible. For the other side of this debate if full recovery is not possible or not possible for all does that then mean that only people who have fully recovered should pursue work in this field. This does come back again to defining what recovery is.

With regard to the second point of confidentiality, whose rights are upper most in this consideration? Does the patient have a right to know the clinician treating her has personal experience? Does the ex-patient have the right to withhold that information from her employer, her colleagues or her patient? Are there sufficiently robust systems in place to protect both the ex-patient and the current patient? In the United Kingdom there seems to be an open mind about knowingly appointing someone to an eating disorder post who acknowledges a past history as well as someone who is in the process of recovering. This approach seems to be giving the ex-patient the benefit of any doubt, which leaves the issue of how to monitor that individuals' practice and conduct in relation to his or her own issues. From the survey it seems that people thought this was predominantly a team responsibility, which essentially means that if an employer chooses to appoint an individual with a history of an eating disorder to an eating disorder unit then the team would need to have that information shared with them. However this information could not be shared without the individuals' permission.

Whilst it is acknowledged widely that personal experience of an eating disorder can enhance clinical work within an eating disorder service, can the obstacles of defining recovery and protecting confidentiality be sufficiently overcome to make openly employing ex-patients feasible?

Conclusion and Further Research

It seems clear from this small survey that some eating disorder clinicians do see ex-patients having a role to play in current treatment of individuals with eating disorders. This has been supported by the findings of the previous studies mentioned in this paper. However there are some obstacles to overcome for it to be feasible to openly recruit such individuals to eating disorders teams. Guidelines do need to be drawn up that will include those that are capable of offering something positive, but exclude those that would present too much of a risk to current patients. It seems that the issue of recovery is the crucial one: can recovery be sufficiently defined for these purposes?

Proposal for Guidelines

We propose the following points, to serve as a guideline for assessing the suitability of an individual, who has a personal experience of an eating disorder, for employment within an eating disorders team:

1. Healthy weight (defined by healthy ultrasound exam for women and healthy secondary sexual characteristics for men) and abstinence (defined by specialist interview using recognized interview measure in conjunction with self report) of eating disorder symptoms for significant and sustained period of time, (determined by individual circumstances).
2. Individual can describe and utilize alternative coping strategies.
3. Display an attitude of 'recovered' as opposed to 'in recovery'.
4. An ability to understand the functionality of their eating disorder symptoms.

References

Barbarich, N. (2002) Lifetime prevalence of Eating Disorders among professionals in the field. *Eating Disorders*, 10, 305-312.

Bloomgarden, A., Gerstein, F. & Moss, C. (2003) The Last Word: A Recovered Enough Therapist? *Eating Disorders*.11: 163 - 167.

Crockett, S. J. & Littrell, J. M. (1985) Comparison of eating patterns between dietetic and other college student. *Journal of Nutrition Education*, 17, 2, 47.

Drake, M. A. (1989). Symptoms of anorexia nervosa in female university dietetic majors. *Journal of the American dietetic Association*, 89, 97-98.

Fredenberg, J. P., Berglund, P. T. & Dieken, H. A. (1996). Incidence of Eating Disorders Among Selected Female University Students. *Journal of the American Dietetic Association*, 96, 64 - 65.

Howat, P. M., Beply, S. & Woznaik, P. (1993). Comparison of bulimic behaviour incidence by profession: dietitian, nurse, teacher. *Journal of Nutrition Education*, 25, 67-69.

Johnson, C. L. & Costin, C. (2002). Been there, done that: The use of clinicians with personal recovery in the treatment of Eating Disorders. *Eating Disorders*, 10, 293-303.

Johnston, C. S. & Christopher, F. S. (1991). Anorexic-like behaviours in dietetic majors and other student populations. *Journal of Nutrition Education*, 23, 148-153.

Johnson, C. (1999). Dysfunctional thinking in anorexia and bulimia nervosa. *Journal of Personality and Social Psychology*, 53, 734-742.

Kinzl, J. F., Traweger, C. M., Trefalt, E., Mangweth, B. & Biebl, W. (1999). Dieticians: Are they a risk group for Eating Disorders? *European Eating Disorders Review*, 7: 62-67.

Kinzl, J. F., Traweger, C., Guenther, V. & Biebl, W. (1994). Family background and sexual abuse associated with eating disorders. *American Journal of Psychiatry*, 151, 101-103.

Larson, B. J. (1989). The new epidemic: ethical implications for nutrition educators. *Nutrition Education*, 21, 101-103

Norring, C. E., & Sohlberg, S. S. (1993). Outcome, recovery, relapse and mortality across six years in patients with clinical eating disorders. *Acta Psychiatrica Scandinavica* 87, 437-44.

Wright, S. (1999). To nurse or not to nurse, *Nursing Times*, UK

