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Article 22

Ethical Issues in Eating Disorders Treatment: Four Illustrative Scenarios

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There are complex issues to address in the treatment of clients with eating disorders (EDs) such as health concerns, rendering a diagnosis, trauma, co-morbidity, and relapse (Brewerton, 2007; Mond, Myers, Crosby, Hay, & Mitchell, 2010; Simmons, Milnes, & Anderson; 2008; Warren, Crowley, Olivardia, & Schoen, 2009; Wonderlich, Joiner, Keel, Williamson, & Crosby, 2007). Persons struggling with EDs are reported to be at a higher risk of suicidal ideation, non-trusting, emotionally avoidant, and self-stigmatizing (Hackler, Vogel, & Wade, 2010; Merwin, Zucker, Lacy, & Elliott, 2010; Warren et al., 2009). Counselors can lack awareness when working clinically with ED related interventions (Williams & Haverkamp, 2010). And, with increased clinical concerns, ethical challenges are more numerous. One way to identify ethical issues in ED work may be through reviewing the American Counseling Association's (ACA) *Code of Ethics* (Kocet, 2006). Ethical guidelines do not provide a clear answer to every challenge in counseling (Cottone & Claus, 2000; Moleski & Kiselica, 2005); however, they can provide a structure from which to guide decisions and interventions.

The primary objective of this article is to demonstrate how the ACA *Code of Ethics* (2005) can be used to proactively review ethical issues in ED interventions. First, we provide a brief overview of eating disorders followed by a general discussion of ethics in counseling. We identify four ethical challenges: confidentiality, informed consent, counselor awareness, and counselor wellness. Each challenge is followed by a real-life scenario related to working with EDs and is intended to illustrate the ethical issue. Each scenario is followed with a brief discussion regarding the ethical issues. All four scenarios are adapted for this article to protect the identity of each of the involved individuals. Our hope is that practitioners will use this approach to proactively review potential ethical challenges they may face in ED work.

Brief Overview of Eating Disorders

The formal diagnostic categories of EDs are found in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*; American Psychiatric Association, 1994). The formal diagnostic categories include Anorexia (AN); Bulimia Nervosa (BN); and Eating Disorder Not Otherwise Specified (EDNOS). Common diagnostic symptoms include the following: (a) AN—refusal to maintain a healthy body weight, intense fear of gaining weight or becoming fat, disturbance of body image, and loss of menstrual cycles; (b) BN—recurrent episodes of binge eating an amount of food larger than considered normal, sense of lack of control over eating, recurrent compensatory behavior to prevent weight gain (e.g., vomiting, laxatives, etc.), eating episodes at least twice a week, and self-evaluation dependent upon body shape; and (c) EDNOS—eating problems that do not meet the anorexia or bulimia criteria. Restricting, binge-eating, and purging are behavioral sub-types of the three diagnostic categories.

Although it is not currently identified as one of the *DSM-IV* diagnostic categories (APA, 1994), obesity needs to be mentioned. Obesity typically refers to an excessive amount of fat tissue in the body based on certain body indices. Current findings indicate that most obese individuals do not follow clear eating patterns to fit into a distinct diagnostic category (Stunkard, 2011). There are complex issues to address in obesity-related issues such as sleep disturbances, chronic pain, musculoskeletal and cardiovascular complications, respiratory challenges, self-esteem problems, and treatment compliance (Mauro, Taylor, Wharton, & Sharma, 2007). In a recent survey in the United States, both children and adults who were considered obese or overweight reported high stress was related to their eating problems (American Psychological Association, 2012). For this paper, obesity may be considered an eating disorder in some cases, although not formally identified in the *DSM-IV* (APA, 1994).

The literature on the etiology and risk factors of ED problems identifies a myriad of associated factors such as drive for thinness and perfectionism, body dissatisfaction, need for approval, mood intolerance, low self-awareness, anxiety, impaired attachment, impulse regulation, ineffective ego orientation, body surveillance, trauma, low self-esteem, history of dieting, and neuroticism (Abbate-Daga, Gramaglia, Amianto, Marzola, & Fassino, 2010; Brannan, & Petrie, 2008; Briere & Scott, 2007; Brown, Smith & Craighead, 2010; Nilsson, Abrahamsson, Torbiornsson, & Hägglöf, 2007; Vohs, Heatherton, & Herrin, 2001). As early as nine years of age, girls report body dissatisfaction and dieting behaviors which are two major risk factors found with EDs (Reijonen, Pratt, Patel, & Greydanus, 2003; Thompson, Rafiroiu, & Sargent, 2003). Over 50% of adolescent girls think they are overweight and diet (Fisher et al., 1995). The majority of American college women are dissatisfied with their bodies with as many as 80% of them reportedly wishing to lose weight (Aruguete, Yates, & Edman, 2006).

Negative body images and eating problems affect all racial groups and genders. Talpade (2006) identified increasing health and diet-related problems such as obesity and diabetes in African American children. “Given the prevalence of obesity in ethnically diverse children, it is imperative that counselors consider eating concerns that affect children of all racial and ethnic groups...” (Talleyrand, 2010, p. 319). Although much of the research in EDs is with women, men struggle with various aspects of eating and body image challenges (Baird & Grieve, 2006). Understanding the pervasiveness and

complexities of EDs reinforces the importance of addressing ethical challenges in treatment. Advancing the understanding of EDs is a public health priority (Chavez & Insel, 2007).

Ethics in Counseling

Ethical codes can assist with ethical quandaries, guide best practice, and enhance ethical self-reflection (ACA, 2005; Herlihy & Corey, 2006). A code of ethics is established to protect consumers, provide guidelines for practitioners, and clarify the standards of the organization (Corey, Corey, & Callanan, 2007; Ponton & Duba, 2009). Although this article cannot identify every ethical challenge in counseling with EDs, working with any ethical situation is challenging experience (Welfel, 2005). An effective decision-making model promotes awareness and contextual understanding, and it needs to be an automatic part of a counselor's practice (Calley, 2009; Wheeler & Bertram, 2012). The ACA *Code of Ethics* clearly supports using a model when encountering an ethical dilemma (Corey et al., 2007). Five principles that can add depth to any decision-making model are respecting the rights of clients (autonomy—*informed consent*), not causing harm (nonmaleficence—*correct diagnosis*), doing good (beneficence—*client's welfare*), treating clients equally (justice—*not having gender biases*), and abiding by the codes (fidelity—*maintaining confidentiality*; Herlihy & Corey, 2006; Kitchener, 1984).

Working with ED interventions can present unique and universal ethical challenges. Through the use of standards from the 2005 ACA *Code of Ethics*, four ethical issues (confidentiality, informed consent, counselor awareness, and counselor wellness) are presented and illustrated with case scenarios from ED-related interventions. The scenarios for this article represent real-life situations; however, to protect the confidentiality of those involved, each scenario combines elements from many cases (Sperry & Pies, 2010).

Ethical Issue 1: Confidentiality

“Counselors do not share confidential information without client consent or without sound legal or ethical justification” (ACA, 2005, B.1.c.).

Case example 1. *Mary is a 21-year-old college student who is reporting four to five binge-purge episodes per day for the last six months while living in the sorority house. Mary reported that the other women in the house all seemed thin and pretty causing Mary to begin to perceive herself as overweight. Her sorority peers had encouraged her to attend counseling. Mary told her counselor how she had considerable secrecy and shame. Mary stated she wanted to include her sorority peers at some time. The counselor thought immediate contact with her sorority peers would be helpful. Consequently, without any signed releases, the counselor contacted three of Mary's peers and invited them to attend the next individual session scheduled with Mary and the counselor. The counselor believed it would be helpful and supportive. She thought the open dialogue could help the client to realize how many young women struggle with similar body image issues and how they wanted her “to get better.” The counselor left a phone message for Mary indicating her peers would be attending the next session. Mary did not show for the next appointment. The counselor tried to contact Mary to schedule an appointment, receiving no response.*

Discussion: Confidentiality. Approximately 20% of claims made against counselors in the last few years have been due to confidentiality and privacy issues (Wheeler & Bertram, 2012). Although a counselor has the ethical duty to protect private client communications, the practitioner can enthusiastically engage the support of others in a way that confidentiality is unintentionally violated; consequently, ethical errors occur. Involvement with others in counseling work requires careful consideration of confidentiality issues.

There can be unintended violations of ethical and training standards in real-world practice (Linton, 2012). For example, involving real-world significant others can facilitate recovery and treatment (Choate, 2010; Escobar-Koch et al., 2010). Attachment insecurities and interpersonal difficulties may reduce abilities to form and maintain trusting relationships which are particularly important to recovery from ED-related problems (Abbate-Daga et al., 2010). Although counselors in practice may consider a network support system in treatment planning (ACA, 2005, A. 1. d.) and evaluate the positive supports as well as the negative ones (Longabaugh, Wirtz, Zywiak, & O'Malley, 2010), contact with any person other than the client needs to be established only after the client has signed an appropriate release (ACA, 2005, Section B).

Even with a signed release, there are circumstances where there can be exceptions to confidentiality; particularly in the concerns related to suicide and self-destructive behaviors. A substantial number of suicides occur with clients who are in treatment (Rudd et al., 2009). Suicidality and self-harm are terrifying for counselors; however, there are steps counselors can take, such as conducting a thorough risk assessment, being familiar with the risk management policies of the agency, identifying protective factors, documenting, and consulting (Capuzzi, 2002; Granello, 2010a, 2010b; Rudd et al., 2009; Willer, 2009).

With reliable confidentiality, trust is enhanced (ACA, 2005; Herlihy & Corey, 2006). A strong therapeutic relationship can build the foundation to collaborate with the client and focus on involvement of others. Research supports the therapeutic relationship as a core ingredient related to success in counseling outcomes (Lambert & Barley, 2001; Norcross & Lambert, 2011). The trust needed for a therapeutic relationship is further developed through a meaningful and effective informed consent process (Pomerantz & Handelsman, 2004).

Ethical Issue 2: Informed Consent

Counselors explicitly explain to clients the nature of all services provided. They inform clients about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the counselor's qualifications, credentials, and relevant experience; continuation of services upon the incapacitation or death of a counselor; and other pertinent information. (ACA, 2005, A.2.b., p. 4)

Case example 2. *Seventeen-year-old Sarah was required by her parents to attend treatment for her alleged eating disorder problem. She reported considerable fear. There were many unknowns for her regarding what would happen and what her parents would be told. She asked the intake secretary, "Will I have to eat? Will I gain weight? What if my friends find out? Can I still attend ballet lessons?" Sarah's parents were provided the*

informed consent and since the client was a teenager, the counselor decided an additional informed consent for Sarah would not be needed. The counselor figured the parents would sufficiently explain the counseling process to their daughter. In addition, the agency provided one general informed consent form which covered the required state rules for informed consents in counseling.

Discussion: Informed consent. An informed consent is essential to the work of mental health counseling throughout the entire counseling process (Rudd et al., 2009). There needs to be a frank discussion with a client about topics such as the risks of counseling, procedures regarding suicidality, and involuntary hospitalization. The informed consent can provide a means to address many questions and logistics about the counseling process to facilitate an “open and honest discussion about important issues in psychotherapy, including common contemporary issues like third-party payment, manualization, and psychopharmacology” (Pomerantz & Handelsman, 2004, p. 203).

Clients with eating-related issues are often afraid of counseling (Hackler et al., 2010; Mond et al., 2010); many may not understand what is expected and may not know that they can choose to terminate the counseling relationship. For this hypothetical client (Sarah), an informed consent could address initial fears and issues through reviewing issues such as how to work with parents, confidentiality with friends, exemptions in confidentiality, and a description of how counseling is intended to be a client-centered process (Geller & Srikameswaran, 2006).

An informed consent also provides a structure to enable a client to collaborate with goals. Empathy can be enhanced through a dialogue about the counseling process and emphasizing choices and collaboration (Tryon & Winograd, 2011). Plans that only focus on external agendas or goals such as weight control, cultural values, and medical issues, may not engage a client, focus too much on behaviors, and often establish unrealistic expectations (Escobar-Koch et al., 2010; Garner, 1985; Thompson & Sherman, 1989).

Clear dialogue about the rights and responsibilities of minors in care is an important part of creating a therapeutic relationship. The counselor needs to inform youth in a developmentally appropriate way and clarify the rights of parents. Ethical and legal issues in working with youth frequently involve confidentiality, policies of the treatment setting (e.g., school, inpatient, etc.), and dual relationships (e.g., counselor is also a coach; Cappuzzi, 2002).

Although the 2005 ACA *Code of Ethics* does try to clarify ethical responsibilities when working with youth (Herlihy & Corey, 2006), the primary question may be if a minor child’s rights to confidentiality are outweighed by the need to inform a parent or guardian. There are many factors involved in an ethical analysis such as age, maturity, potential for harm, and the relationships with the child’s parents or guardians (Wheeler & Bertram, 2012). A counselor is wise to include consultation with the client, appropriate supervision, documentation, and self-awareness (ACA, 2005). A well-designed informed consent can be developmentally and culturally appropriate, contribute to clarity in roles and confidentiality, and support a therapeutic foundation. Confidentiality and consent are common considerations; less common is the consideration of counselor awareness.

Ethical Issue 3: Counselor Awareness

“Counselors are aware of their own values, attitudes, beliefs, and behaviors and avoid imposing values inconsistent with counseling goals” (ACA, 2005, A.4.b., pp. 4-5).

Case example 3. *Bill came into supervision reporting he had struggles with several clients with ED-related issues. He explained that a client had failed to show for session after he requested she follow a food plan. He reported that he felt a client who is very overweight and now on diabetes medication would do better if she would just exercise a little and reduce her fast food intake. He shared that a third client reported that she learned to cut while in inpatient treatment, causing him to have to worry about self-harm. Overall, Bill reported feeling frustrated and judgmental.*

Discussion: Counselor awareness. In the counseling profession, competence includes awareness of self and attitudes (ACA, 2005; Williams & Haverkamp, 2010). Providers need to recognize their biases and understand their own attitudes or they can act on negative bias and impair effective treatment (Boysen, 2010). Koch, Sneed, Davis, and Benshoff (2007) described an attitude as a predisposition that prompts an individual to react to events and people in biased ways. These attitudes can be neutral, negative, or positive. Working with ED concerns, personal biases are often evoked. In ED work particular issues such as over identification, control, secrecy, helplessness, avoidance of affect, conflict, need for approval, and insecure attachment can arise in both clients and counselors (Abbatte-Daga et al., 2010; Warren et al., 2009; Zerbe, 1992).

Franko and Rolfe (1996) found that therapists felt significantly less connected, less engaged, and more frustrated with clients with ED problems versus those with depression issues. Bessenoff and Sherman (2000) reported counselors having more negative reactions toward overweight women when compared to thin women. More than 25 years ago, Garner (1985) reported negative attitudes toward anorexia when the disorder was referred to as a sin. Implicit attitudes can result in behavioral and attitudinal discrimination and stigmas (Gowers & Shore, 1999; Hackler et al., 2010). “If counselors are not aware of the impact of culture on their beliefs about self-worth, body image, and attractiveness, they may inadvertently communicate or reinforce... unrealistic beliefs and values to their clients” (Delucia-Waack, 1999, p. 380). Counselors working with clients with ED challenges need to be exceptionally self-aware (Delucia-Waack, 1999).

Personal frustrations can contribute to feeling fear and anger (Franko & Rolfe, 1996). For example, the client may not want to keep a food journal and suggest that the counselor does not really understand, then not show up for a session leaving a voice mail indicating suicidal thinking. Before taking a referral, a counselor needs to assess competence, values, potential impairment issues, and his or her ability to establish a therapeutic relationship (ACA, 2005). Research indicates that counselors can be negatively affected from work with ED issues (Johnston, Smethurst, & Gowers, 2005; Warren et al., 2009). Self-awareness can aid a counselor in understanding oneself and monitoring self-reactivity (La Torre, 2005; Lum, 2002). While individual self-awareness is required, effective supervision can greatly increase self-awareness.

In her review of supervision, Borders (2005) suggested that effective supervision includes discussion of difficult relationship issues with clients and with supervisors. Counseling supervisors need to be aware of numerous counselor issues. These include a counselor’s feelings toward clients, personal impairment, and conflict with a supervisor. When issues are avoided, supervision may not be as effective (Nelson, Barnes, Evans, &

Triggiano, 2008). Counselors were asked to identify what helped them to cope with personal feelings arising from work with EDs; nearly all (98%) cited supervision or consultation with colleagues as most helpful (Franko & Rolfe, 1996).

Particular complexities in ED work require unique areas of self-awareness, competencies, and supervision (Thompson & Sherman, 1989; Williams & Haverkamp, 2010). For example, in supervision of ED groups, it is essential to address counselor issues such as body image, food, and weight. Delucia-Waack (1999) presented a comprehensive model for supervision for counselors leading outpatient eating disorder groups. In this program she identified the parallel processes between the issues for group counselors and group members such as trust, beliefs about body-image, attitudes toward food and weight, and use of guided imagery to simulate experience of the life of a person with an ED-related problem.

Personal reactivity habits require effective supervision to monitor counselor counter transference (CT). Rosenberger and Hayes (2002) provided a synthesis of research on CT showing diverse definitions. Although there is not one definition, CT usually refers to a counselor's negative reactions that can negatively impact client progress. The ability to correctly interpret and integrate external information can influence "one's body image, one's body ideal, and one's level of satisfaction with one's body" (Phillips, & de Man, 2010, p. 171). Although having personal awareness is an ethical responsibility, wellness is essential in working with ED-related challenges.

Ethical Issue 4. Counselor Wellness

"Counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others" (ACA, 2005. C.2.g., p. 9).

Case Example 4. *As a recovering person following 5 years of anorexia, Sandra was committed to her counseling work with clients who struggled with ED-related issues. She carried a full case load, never refused a referral, and was proud that she would receive the largest number of referrals in her treatment team. She found herself spending most of her time alone, staying late at the office completing paperwork, and at times feeling resentful that her treatment team members did not seem to work as hard as she did. Similarly, she was noticing her own desires to lose weight, her anxiety about an upcoming licensing exam, and her inability to talk with anyone.*

Discussion: Counselor wellness. Counselor wellness can reduce negative effects of difficult counseling work (Cummins, Massey, & Jones, 2007; Jennings, Hanson, Skovholt, & Grier, 2005; Meyer & Ponton, 2006). "It is not uncommon for therapists to engross themselves so deeply in the care of others that they neglect to take care of their own mental wellbeing" (Valente & Marotta, 2005, p. 67). When a counselor over identifies with a client with ED-related issues, this impacts the professional relationship. This can be evidenced in behaviors such as avoiding conflict, being overly nurturing, and feeling in competition with clients (Delucia-Waack, 1999; Frankenburg, 1984). Warren et al. (2009) reported that counselors experienced substantial personal changes in their affect, cognitions, and behaviors when treating patients with EDs.

There is debate on whether ED recovering counselors should be treating clients with ED problems. The difference between being recovered versus being in recovery is important to identify (Costin & Johnson, 2002). Johnston et al. (2005) reported

therapeutic advantages when a counselor has a history of ED; however, “therapists with a current eating disorder... were thought to lack objectivity and to be vulnerable” (p. 301). Any counselor-in-recovery can react with their own issues manifested in behaviors such as inappropriate self-disclosure, relapse, and secrecy; similarly, they can bring empathy, shame reduction, trust, and honest feedback. These are the real issues of life and are not just evident in clients.

A counselor must monitor their well-being with awareness of personal reactivity to eating, body image, and personal self-regulation. When counselors are stressed, distressed, and impaired, they may not be able to offer their highest level of counseling services. This can lead to physical, social, emotional, and spiritual degradation (Lawson, 2007). Valente and Marotta (2005) presented a comprehensive overview of techniques to use to enhance well-being such as spirituality, meditation, and yoga which contributed to balance, acceptance, and self-awareness. In addition to wellness, counselors working with ED issues may need to manage vicarious trauma (VT).

Clients with ED problems often report trauma in their backgrounds (Briere & Scott, 2007; Levitt, 2007). Managing trauma reactions and maintaining wellness are critical to ethical practice (Warren, Morgan, Morris, & Morris, 2010). Vicarious trauma is the culminated effects of empathetically working with clients who have been traumatized; the effects can be diverse such as emotional, physical, spiritual, and/or relational, and often simulate the symptoms of the traumatized clients (Harrison & Westwood, 2009). Harrison and Westwood (2009) identified nine protective practices to manage vicarious trauma. Some of these factors are avoiding isolation, developing mindful awareness, maintaining active optimism, engaging in holistic self-care, and keeping clear boundaries. In their research, they emphasized the important ethical responsibility to address vicarious trauma and that this responsibility needs to be shared by employers, educators, professional bodies, and practitioners alike.

Summary

Steps can be taken to mindfully address complex ethical concerns in any human service work through the application of ethical codes to all phases of the counseling process (DePauw, 1986). The challenges in ED work are similar to many areas of human service work requiring confidentiality, informed consent, self-awareness, and wellness. Research indicates that counselors can be particularly affected from work with ED-related issues (Johnston et al., 2005; Phillips & de Man, 2010; Warren et al., 2009). This article identified just four of complex many scenarios in ED-related work. This is a limitation. With this in mind, this article is intended to enhance awareness of unique and common ethical concerns found in one type of specialty work and to demonstrate how ethical codes can proactively introduce and potentially frame ethical concerns.

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