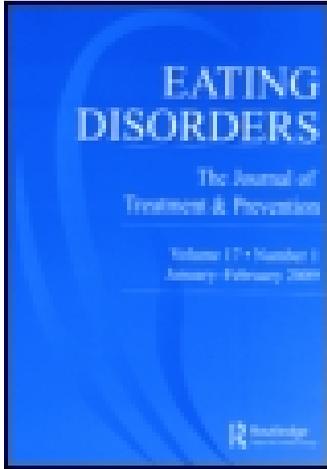


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The Influence of Clinician Emotion on Decisions in Child and Adolescent Eating Disorder Treatment: A Survey of Self and Others

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Eating disorder clinicians from various disciplines participated in one of two surveys: the “self” group (n = 143) completed a survey assessing the negative influence of emotions on their own clinical decisions, while the “other” group (n = 145) completed a parallel version of the survey that assessed their perceptions of the negative influence of emotion in their colleagues. Both groups endorsed this phenomenon to some degree, although differences in reporting were noted between groups. The perceived negative influence of emotion with regards to specific treatment decisions fell within three categories: decisions regarding food and weight, decisions regarding the involvement of the family in treatment, and decisions related to autonomy and control. Decisions regarding the involvement of the family were perceived to be the most emotionally charged, in particular the involvement of a critical or dismissive parent.

It is widely accepted that emotions play a role in the development and maintenance of eating disorders (ED; Dolhanty & Greenberg, 2007; Fox & Powers, 2009; Treasure, 2012). Furthermore, there is a growing body of literature that supports the theory that the emotions of those who care for individuals with an ED can also influence eating disorder etiology and maintenance (Goddard et al., 2011; Lafrance Robinson, Dolhanty, & Greenberg, 2013; Schmidt & Treasure, 2006; Treasure et al., 2008). For example, the Cognitive-Interpersonal Maintenance model of ED suggests that carers can

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experience emotional arousal as a result of their loved one's illness, which then can lead them to engage in behaviors that may inadvertently contribute to its maintenance (Goddard et al., 2011; Treasure et al., 2008). Similarly, the Emotion-focused Family Therapy model of ED posits that carers can experience emotional "blocks" when implementing the tasks of recovery (i.e., fears, anxiety, past emotional trauma), which can interfere with their ability to be effective in their helping role (Lafrance Robinson et al., 2013).

Building on this literature, recent theoretical models have emerged that highlight the importance of clinician emotion in the treatment of ED. Two theoretical models, the Iatrogenic Maintenance Model for ED (Treasure, Crane, McKnight, Buchanan, & Wolfe, 2011) and the Therapist Drift Model (Waller, 2009), identify factors related to emotion that can negatively influence ED treatment practices. Just as carers' emotions are hypothesized to lead to unhelpful behaviors that have the potential to maintain ED symptoms, these models suggest that some emotionally-driven practices in clinicians may also unintentionally contribute to ED maintenance and hinder treatment progress.

Developed on the basis of anecdotal evidence and reports, the Iatrogenic Maintenance Model (Treasure et al., 2011) proposes that four clinician-factors; *emotional style*, *interpersonal factors*, *pro-eating disorder beliefs*, and *thinking styles*, can negatively affect ED treatment. In terms of emotional style specifically, it is proposed that clinician anxiety, for example, can foster unhelpful practices. For example, faced with a client whose condition is declining, a clinician may feel anxious and be more inclined to avoid the discussion of difficult topics (i.e., food and weight) in an effort to neutralize their own anxiety as well as possible negative reactions from the client.

Like Treasure and colleagues (2011), Waller (2009) suggests that clinicians can be led to engage in unfavorable practices as a result of the emotions they experience in delivering treatment for ED. The Therapist Drift model (Waller, 2009) introduces three clinician-factors that can actively interfere with clinical decisions and practices: *clinician emotion*, *clinician cognition*, and *clinician behavior*. With respect to *clinician emotion*, clinicians may engage in avoidant practices to reduce their experience of negative emotions like anxiety, fear, shame, and guilt. Similarly, both positive and negative emotions can shape a clinician's judgment, as they may mislead and distract from important clinical information and cues.

To date, two studies have been conducted to empirically examine the role of clinicians' emotions during the treatment of ED. Waller, Stringer, and Meyer (2012) explored the relationship between self-reported therapist anxiety and adherence to an empirically-supported treatment protocol for ED (i.e., Cognitive-behavioral Therapy). Results indicated that clinician anxiety was related to lower levels of adherence to treatment protocol, suggesting that clinicians "drift" away from empirically-supported practices

when anxiety is high (Waller et al., 2012). A parallel investigation was conducted with clinicians who reported to use Family-based Therapy in the treatment of child and adolescent eating disorders (Kosmerly, Waller, & Lafrance Robinson, 2014). Of note, clinicians with greater levels of anxiety were less likely to weigh the client at the beginning of the session (Kosmerly et al., 2014).

Evidence for the influence of clinicians' emotions on ED treatment has also been reported qualitatively. Couturier et al.'s (2013) interviews with child and adolescent ED clinicians revealed that they can feel intimidated and anxious about certain therapeutic tasks (i.e., weighing the client and completing the family meal) related to the delivery of Family-based Therapy (Lock, Le Grange, Agras, & Dare, 2001; Lock & Le Grange, 2013). This anxiety in turn can interfere with their use of these techniques.

The Present Research Study

As part of a larger investigation, the present study examined clinicians' perceptions of the negative influence of emotions on clinical decisions when working with child and adolescent ED. More specifically, this study aimed to examine: (a) whether and to what degree clinicians perceive emotions to negatively influence clinical decisions; and (b) which specific treatment decisions encountered when working with child and adolescent ED are perceived to be the most negatively influenced by clinician emotion. Furthermore, this study examined (c) whether differences emerged when clinicians reported on the potential negative influence of emotions on their own clinical decisions versus the occurrence of this phenomenon in their colleagues.

METHOD

Participants

Three hundred and five clinicians (280 women) who reported working with children and adolescents with ED participated in the study. Participants' years of experience working with child and adolescent ED ranged from less than 1 year to 32 years, with an average of about 8 years of experience ($M = 8.44$, $SD = 6.90$). Seventy percent of participants ($n = 212$) reported using Family-based Therapy as a model of treatment for children and adolescents with ED. Participants came from diverse professions, including social work ($n = 63$, 21.0%), psychology ($n = 62$, 20.7%), psychiatry ($n = 14$, 4.7%), medicine ($n = 25$, 8.3%), nursing ($n = 49$, 16.3%), dietetics ($n = 38$, 12.7%), occupational therapy ($n = 2$, 0.7%), and other therapy professions¹ ($n = 47$, 15.7%). Seventy-six percent ($n = 228$) of those surveyed reported working within an ED program for children/adolescents, and almost all participants

($n = 265$, 90.4%) reported working as part of a multidisciplinary team. The majority of clinicians ($n = 212$, 80.6%) reported engaging in informal and/or formal clinical supervision. Frequency ranged from daily to a few times per year, with weekly supervision being the most commonly endorsed item ($n = 108$, 41.1%).

ED clinicians were recruited through a database compiled by the authors, the Academy of Eating Disorders listserv, and through in-person recruitment at federal and provincial ED conferences in Canada. Participants were invited to complete an anonymous online survey.² Participants were excluded from the analyses if they were not directly involved in the treatment of child and adolescent ED (i.e., administration staff), or if they completed less than 20% of the survey.

Measurements

A survey was designed with the goal of examining whether and to what degree clinicians perceive emotions to have a negative influence on clinical decisions when working with child and adolescent ED. Questions were based on the theoretical models developed by Treasure and colleagues (2011) and Waller (2009), and were informed by practice guidelines for the treatment of child and adolescent ED. Andres' (2012) guidelines for the development of surveys were also consulted and the survey was reviewed by the resident expert in survey design at the researchers' institution. Two versions of the survey were created in order to explore differences in responding. In the first survey, clinicians reported on their perceptions of the negative influence of emotions on their *own* decisions when working with child and adolescent ED (the *self* group). For the second version of the survey, clinicians reported on their perceptions of the negative influence of emotion on their *colleagues'* clinical decisions in the same context (the *other* group). Participants were randomly assigned to either the *self* ($n = 143$) or the *other* ($n = 145$) condition according to their year of birth (odd vs even numbers).

After completing demographic information, a brief introduction of the study was presented. Clinicians were then asked, "Do you feel (your/your colleagues') emotions negatively influence (your/their) clinical decision-making?" Only those participants who responded "yes" ($n = 86$, 30.5%) to this question completed the remainder of the questions presented in the subsequent analyses. Of this subset of participants, those in the *self* group indicated the percentage of the time they were negatively influenced by their emotions in their clinical decisions on an 11-point scale ranging from 1–10% to 100%.³ Participants in the *other* group indicated the percentage of their colleagues who may be negatively influenced by emotions when making clinical decisions. Next, all remaining participants were asked to rate on a scale from 1 (*not at all*) to 10 (*very much*) the degree to which they (*self*) or

their colleagues (*other*) were negatively influenced by emotion in regards to a number of treatment decisions commonly encountered in the treatment of child and adolescent ED (Table 1).

Statistical Analysis

Statistical analyses were performed using the SPSS 17.0 package. A statistical significance level of $p < .05$ was employed for all tests. Statistical tests met all assumptions. The demographic information was outlined using descriptive statistics. A Pearson chi-square test (χ^2) was used to compare conditions (*self/other*) on the question regarding whether emotions have a negative influence on decisions. Treatment decisions were ranked based on mean values. An exploratory factor analysis (using Maximum Likelihood extraction and Varimax rotation) was conducted to determine whether patterns could be observed between clinicians' perceived level of negative emotional influence in relation to ED treatment decisions. Factor loadings were considered relevant if they were equal to or above the .40 level. Subscale scores were then calculated based on the emergent factors by calculating the mean of the items that loaded onto each factor. A two-way mixed design repeated measures multivariate analysis of variance (MANOVA) examined differences between conditions and subscales and was followed up with an analysis of variance (ANOVA) and paired sample *t*-tests.

RESULTS

Clinicians' Perceptions of the Negative Influence of Emotions on Clinical Decisions

Overall, 30.5% ($n = 86$) of participants endorsed a negative influence of emotions on clinical decisions, whether their own or that of their colleagues. A Pearson chi square test revealed that clinicians in the *other* group endorsed this item more frequently (40.0%) than those in the *self* group (21.1%), $\chi^2(1) = 11.85, p = .001$. Only those participants who endorsed a negative influence of emotions were included in the subsequent analyses.

In order to assess for the perceived intensity of this phenomenon, clinicians in the *self* group ($n = 30$) reported on the frequency with which they were negatively influenced by their own emotions in making clinical decisions. Nearly all participants (96.4%) reported being negatively influenced by their emotions between 1% and 30% of the time. The most frequently reported response was 11–20% of the time (range 1–7, $M = 2.18, SD = 1.19$).

To assess clinicians' perceptions of the prevalence with which emotions negatively influence their colleagues' clinical decisions, the *other* group

TABLE 1 Means, Standard Deviations, and *t*-Tests for *Self* and *Other* Ratings of Perceived Negative Emotional Influence on Decisions Encountered in the Treatment of Child and Adolescent ED

Decisions	Self <i>M</i> (<i>SD</i>)	Other <i>M</i> (<i>SD</i>)	<i>t</i> -test
Increasing calorie recommendations	3.39 (2.00)	4.26 (2.26)	
Introducing feared foods	3.08 (2.19)	4.82 (2.28)	$t(69) = 3.15, p = .002$
Recommending a structured meal plan (as opposed to parental instructions)	3.41 (2.09)	4.15 (2.56)	
Reintroducing meat in a child's vegetarian diet	3.27 (2.45)	4.85 (2.32)	$t(68) = 2.60, p = .011$
Determining goal or target weights	2.95 (2.54)	4.43 (2.51)	$t(68) = 2.25, p = .028$
Determining whether the ongoing weight will be shared/not shared with the family	3.87 (2.38)	4.60 (2.66)	
Determining an acceptable level of physical activity/sports activities	3.95 (2.59)	5.00 (2.51)	
Supporting the child's travel plans (e.g., overseas)	4.59 (2.72)*	5.67 (2.53)	
Determining the degree of involvement of separated parents in treatment	3.88 (2.70)	5.55 (2.78)	$t(71) = 2.48, p = .016$
Determining the degree of involvement of non-custodial/alienated parents in treatment	4.48 (2.92)*	5.62 (2.74)	
Determining the degree of involvement of critical/dismissive parents in treatment	6.08 (2.78)*	6.56 (2.47)*	
Deciding to make individual therapy with the child the primary mode of treatment	4.20 (2.66)	5.90 (2.82)*	$t(72) = 2.50, p = .015$
Determining the intensity of treatment required (outpatient, inpatient, etc.)	4.40 (2.42)	6.29 (2.36)*	

Note: Means and standard deviations were calculated based on Likert scale ratings from 1 (*not at all*) to 10 (*very much*). *represents the 3 highest ranked decisions for each group, respectively. Only significant *t*-tests ($p < .05$) are presented.

($n = 56$) reported on the proportion of their colleagues they perceived to be negatively influenced by emotions when making decisions. Results indicated a wide range of variability in responding (range 1–11, $M = 5.10$, $SD = 2.79$). The most frequently reported selection was 21–30% of colleagues.

The Negative Influence of Emotion on Specific Treatment Decisions

Clinicians ($n = 86$) rated the degree of negative influence of emotions associated with specific treatment decisions commonly encountered throughout the course of treatment when working with children, adolescents, and families with ED. The mean ratings are presented in Table 1. *t*-tests

were conducted to compare group ratings on the individual decisions, and although some differences were observed, the ratings between groups were similar for many of the decisions listed. The groups were in agreement when it came to the treatment decision they perceived to be the most negatively influenced by emotion: determining the degree of involvement of a critical or dismissive parent in treatment. Differences were noted between groups with regard to decisions perceived to be the second and third most likely to be negatively influenced by emotion. For the *self* group, supporting the child/adolescent's travel plans and the decisions around the degree of involvement of non-custodial/alienated parents in treatment rounded the top three treatment decisions perceived to be the most likely to be negatively influenced by emotions. For the *other* group, the treatment decisions perceived to be the most likely to be negatively influenced by emotions included determining the intensity of treatment required and deciding to make individual therapy with the child the primary mode of treatment.

Factor Analysis of Specific Treatment Decisions

In order to assess for underlying components, a factor analysis was conducted on the total sample (*self* and *other*).⁴ Results of the Varimax rotation are presented in Table 2. A three-factor solution provided the clearest extraction and accounted for 60.8% of the total variance.

TABLE 2 Rotated Factor Structure for Perceived Negative Emotional Influence on Decisions Encountered in the Treatment of Child and Adolescent ED

Decisions	Factors		
	1	2	3
Increasing calorie recommendations	.742*	.168	.194
Introducing feared foods	.660*	.144	.111
Recommending a structured meal plan	.651*	.219	.042
Reintroducing meat in a child's vegetarian diet	.708*	.255	.074
Determining goal or target weights	.690*	.154	.353
Determining whether the ongoing weight will be shared	.533*	.230	.436*
Determining an acceptable level of physical activity/sports activities	.237	.207	.949*
Supporting the child's travel plans (e.g., overseas)	.080	.394	.564*
Determining the degree of involvement of separated parents	.264	.912*	.144
Determining the degree of involvement of non-custodial/alienated parents	.225	.912*	.144
Determining the degree of involvement of critical/dismissive parents	.189	.697*	.237
Deciding to make individual therapy with the child the primary mode of treatment	.388	.561*	.239

*represents decisions loading onto each factor (loadings > .40).

Communalities for each decision ranged from .31 to .84. Corrected-item total correlations ranged from .005 to .831. Six decisions related to food, meals, calorie recommendations, and weight loaded onto the first factor. Accordingly, Factor 1 was labelled “*Decisions Regarding Food and Weight.*” Four decisions loaded onto the second factor, all of which related to the involvement of parents/family members in the child/adolescent’s treatment. Factor 2 was therefore labelled “*Decisions Regarding the Involvement of the Family in Treatment.*” Finally, three decisions (determining whether ongoing weight will be shared and supporting the child/adolescent’s participation in sports and in travel) loaded onto the third factor, which was labelled “*Decisions Relating to Autonomy and Control.*”

Subscales

Three subscales were calculated to correspond to each of the emergent factors. Scores for the total sample were as follows: *Food and Weight* ($M = 3.96$, $SD = 1.88$), *Involvement of Family* ($M = 5.46$, $SD = 2.47$), and *Autonomy and Control* ($M = 4.75$, $SD = 2.19$). Possible scores on each of the subscales ranged from 1–10, where higher scores represented greater perceived negative emotional influence. The subscales each showed adequate internal consistency ($\alpha = 0.87$, $\alpha = .90$, and $\alpha = .78$).

Differences Between Subscales

A two-way mixed design repeated measures MANOVA was conducted to compare scores for each of the three subscales. A significant multivariate effect was observed for group, $F(1, 49) = 8.12$, $p = .06$, $Partial\ Eta^2 = 0.14$. A follow-up univariate ANOVA revealed that the *other* group reported significantly higher scores than the *self* group on each of the three subscales (Table 3). Results also revealed a significant multivariate effect for subscale, $F(2, 48) = 7.97$, $p = 0.001$, $Partial\ Eta^2 = 0.25$. According to post hoc paired sample *t*-tests, there were significant differences between all subscales (Table 4). The highest mean was found for the *Involvement of Family*

TABLE 3 ANOVA for Differences on Subscale Scores Between Groups (*Self* vs. *Other*)

	<i>F</i>	Self <i>M</i> (<i>SD</i>)	Other <i>M</i> (<i>SD</i>)	Total <i>M</i> (<i>SD</i>)
Food and weight	9.12	2.74 (1.27)	4.38 (1.93)*	3.90 (1.90)
Involvement of family	4.42	4.12 (2.40)	5.67 (2.40)*	5.22 (2.49)
Autonomy and control	4.81	3.42 (2.01)	4.86 (2.19)*	4.44 (2.22)

*Note: Univariate *df* = 1, 49.

* $p < .05$.

TABLE 4 Paired-Sample *t*-Tests Between Subscales

Family involvement	Autonomy and control	Food and weight	<i>t</i> -test
<i>M</i> = 5.22, <i>SD</i> = 2.49	–	<i>M</i> = 3.90, <i>SD</i> = 1.90	<i>t</i> (50) = –4.34, <i>p</i> < .001
<i>M</i> = 5.53, <i>SD</i> = 2.45	<i>M</i> = 4.67, <i>SD</i> = 2.26	–	<i>t</i> (61) = 3.35, <i>p</i> = .001
–	<i>M</i> = 4.56, <i>SD</i> = 2.15	<i>M</i> = 3.96, <i>SD</i> = 1.88	<i>t</i> (56) = –2.645, <i>p</i> = .011

Note: *Mean and standard deviation values differ slightly between pairings based on differences in *N* between pairings.

subscale, followed by the *Autonomy and Control* subscale, and the *Food and Weight* subscale. No significant interaction effects between group and subscale were observed.

DISCUSSION

This study examined clinicians' perceptions of the negative influence of emotion on clinical decisions when working with child and adolescent ED. Overall, a significant minority of clinicians endorsed the occurrence of this phenomenon, and in particular with respect to decisions regarding family involvement. As such, the results of this study provide preliminary support for the components of the Iatrogenic Maintenance Model for ED (Treasure et al., 2011) and the Therapist Drift Model (2009) related to clinician emotion. In light of the complexity of these illnesses and the high stakes of ED treatment, it is not surprising that some clinicians recognize this process in action (Bellon & Fernandez-Asensio, 2002); however we did not expect that such a larger number of clinicians would deny the occurrence of this phenomenon. Clinicians were also more likely to endorse this phenomenon in their colleagues than they were to report being negatively influenced themselves. There are a number of possible explanations for this discrepancy. One possibility is that the differences observed between groups may be reflective of the different ways in which each group is influenced by social biases. For example, self-evaluations are said to be more vulnerable to the influence of social desirability (Vazire & Carlson, 2011) and therefore may represent an underrepresentation of what actually occurs in clinical practice. Conversely, while the evaluations of others are less likely to be influenced by social desirability, they do tend to be based on limited information (i.e., that which is observable), including biased perceptions of others (Paunonen & O'Neill, 2010) and therefore may represent an overestimation of the occurrence of negative emotional influence (e.g., Yeager & Krosnick, 2011). Although the nature of the data prevent us from drawing firm conclusions regarding the discrepancy between groups, researchers have suggested that considering

both sources of information together (*self* and *other* evaluations) can be valuable when interpreting study findings (e.g., Atwater, Ostroff, Yammarino, & Fleenor, 1998; Vazire & Carlson, 2011). Using this approach, the results allow us to assume with some degree of confidence that about a third of clinicians in the field of child and adolescent ED perceive there to be at least some degree of negative influence of emotions on clinical decisions.

Despite differences between groups with regards to the extent to which emotions were perceived to negatively influence treatment decisions, similarities emerged with respect to the extent to which different types of decisions are negatively affected by clinician emotions in the context of child and adolescent ED. For example, clinicians reported the least discomfort with decisions related to food and weight followed by decisions regarding the autonomy and control, and regarding the involvement of the family in treatment. Since decisions about food and weight tend to be more “objective,” in that they are more often based on numerical or physiological criteria (Dempfle et al., 2013; Konrad, Carels, & Garner, 2007), they may be less susceptible to the influence of emotion. On the other hand, it was clear that decisions related to the involvement of the family in treatment were perceived to be the most emotionally charged, and in particular when this involvement related to critical or dismissive parents. At this time, very little is known about the factors that affect a clinician’s decision to involve a parent in ED treatment. It is possible that well-intentioned clinicians are sometimes cautious when determining the intensity or type of involvement of a critical or dismissive parent for fear that the parent’s style may exacerbate the child’s symptoms and hinder treatment. It is also possible that clinicians are hesitant to engage that parent in treatment in order to shield themselves from witnessing the parental criticism (which most likely is not confined to the therapist’s office). In either case, when parents present as critical or dismissive, this style is highly suggestive of a clinical marker of underlying fears, shame, or helplessness, indicating a need for the clinician to attend to the parent’s emotional experience in order to support its processing (Lafrance Robinson et al., 2013).

A number of other individual treatment decisions were identified as vulnerable to negative emotional influence. Decisions related to supporting the child’s travel plans, determining the degree of involvement of a non-custodial/alienated parent, decisions about the intensity of treatment required and whether to make individual treatment with the child the primary mode of treatment were among the top treatment decisions perceived to be negatively influenced by emotion. Given the variety of treatment decisions identified by clinicians, it is clear that the field must turn its attention to this phenomenon in order to prevent emotions from negatively interfering with clinical care. For example, in terms of decisions related to the involvement of a non-custodial parent in treatment, the general mental health literature reports that 50% of custodial parents opt to exclude non-custodial parents

from treatment (Isaacs, Montalvo, & Abelsohn, 1986), and in some instances have “an agenda to marginalize the noncustodial parent’s involvement and influence” in the child’s treatment (Ellis, 2000, p. 318). This situation can be challenging for clinicians to navigate given the importance of maintaining a therapeutic alliance with the presenting parent while also recommending family involvement (Lock & Le Grange, 2005, 2013). It is possible that in these instances, clinicians fear that including a non-custodial parent in ED treatment may result in negative reactions from the custodial parent or even disputes between ex-partners, which could then derail therapeutic efforts. In some cases, clinicians may also have legitimate fears about involving a non-custodial parent in treatment when the non-custodial parent has been reported to exhibit traits (for example, abuse, substance abuse, etc.) regarded as possibly interfering with the child’s well-being (Campbell, 1992). Given the importance of parental involvement in the treatment of children and adolescents with ED (American Psychiatric Association, 2013; Le Grange, Lock, Loeb, & Nicholls, 2009; National Collaborating Centre for Mental Health, 2004) and the fact that therapy-interfering behaviors can be conceptualized as “emotional blocks” in the parent needing to be processed (Lafrance Robinson et al., 2013), it may be useful to develop treatment guidelines when engaging with critical, dismissive, and non-custodial parents so that clinicians’ emotional reactions do not interfere with delivery of treatment. It will also be important to continue to research these phenomena in order to support clinicians to make treatment decisions that are not influenced by their own emotional reactions to family members or situations.

Overall, our findings suggest that some clinicians believe that emotions can negatively affect the treatment of ED, and in particular when making decisions regarding family involvement. Although our understanding of the ways in which emotions negatively influence clinical decisions in a day-to-day clinical setting is limited by the discrepancy between groups (*self* vs *other*), the results suggest that both clinical conversations and ongoing research are warranted. It will be important to examine the factors that influence this phenomenon, including clinician variables (i.e., level of experience, emotional drain, etc.) and team variables (i.e., specialized program, culture of acceptance around emotions, etc.). In addition, given that most clinicians surveyed were already working within specialized programs and engaging in regular supervision, it will also be necessary to examine the ways in which team dynamics, supervision, and other factors can better protect clinicians from the negative influence of emotions when making treatment decisions. For example, the potential benefit of supervision and team consultation may be curtailed when supervisors and teams are non-acceptant of clinicians’ disclosures of emotions (Figuroa & Dalack, 2013; Jacobs & Nye, 2010). As such, it will be important to ensure that teams foster an emotion-focused milieu where clinicians can process their emotions without fear of judgment. It may also be worthwhile to augment clinicians’ training with specific skills

and strategies to identify and address this phenomenon when it arises in themselves, in their colleagues and perhaps even in the parents with whom they work. For example, clinicians may choose to audiotape and/or videotape their sessions for later review (with or without supervision) as a way to increase awareness of their own emotional reactions. Given that ED are treatment-resistant (Berkman, Lohr, & Bulik, 2007; Fassino & Abbate-Daga, 2013) and can lead to irreversible medical complications (Golden et al., 2003), we as a field should explore any and all possible factors that have the potential to affect treatment outcomes, including clinician emotions.

Limitations

The present study is not without limitations. Patterns of participation associated with the recruitment methods employed have the potential to bias the results. Although the findings are interesting and worthy of follow-up, the strength of the conclusions that can be drawn from this study are limited by the nature of the instrument (self-report) as well as the differences that emerged between groups (*self* vs. *other*). Additionally, it is possible that variables not examined in the present study may have influenced survey responses. For example, follow-up studies could examine the impact of clinician-factors that may contribute to the perceived frequency of this phenomenon, such as a personality type, history of personal psychotherapy, specialized training, supervision type, level of burnout, and team factors that could play a role, such as the culture around emotions and self-care. Laboratory investigations, including the testing of clinician-responses to case vignettes using facial affect coding or physiological responses, are recommended in order to better understand these processes. These investigations could also explore whether certain eating disorder presentations (low weight anorexia for example) engender higher levels of therapist anxiety. Finally, it will be important to determine the actual impact of emotion-based decisions on treatment outcomes with child and adolescent ED populations.

NOTES

1. For example, participants who identified as being counselors, family therapists, “eating disorder clinicians,” etc.

2. Given that all clinicians were asked to forward the survey on to eligible colleagues, it was not possible to determine the survey completion rate; however the number of responses is comparable to that of similar studies (e.g., Kosmerly et al., 2014; Wallace & von Ranson, 2011).

3. The scale was as follows: 1–10%, 11–20%, 21–30%, 31–40%, 41–50%, 51–60%, 61–70%, 71–80%, 81–90%, 91–99%, 100%

4. The *self* and *other* samples were combined for the factor analysis as a reasonable means of reducing the data into manageable categories for possible interpretation.

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