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Exploring Clinician Attitudes Towards Treating Eating Disorders: Bridging Counselor Training Gaps

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Abstract

Eating disorder (ED) clinicians may face various challenges in practice, including burnout and feelings of incompetence. Several deficits may contribute to these challenges, such as graduate education and treatment gaps. In this study, 109 interdisciplinary clinicians were surveyed regarding their personal attitudes, experiences, and challenges in treating EDs. Among the various results, quantitative and qualitative findings highlighted the lack of graduate education as the primary challenge to effectively treating EDs, as well as the need for more ED research and culturally responsive care. Recommendations to enhance ED education and counselor training are provided, including managing countertransference and advocating for specialized coursework. Lastly, critical directions for future research are discussed.

Keywords

eating disorders, clinician attitudes, counselor education, graduate training, clinical practice

Eating disorders (EDs) adversely affect millions of individuals worldwide (Galmiche et al., 2019), irrespective of demographic or socio-cultural background (Kazdin et al., 2017; Schaumberg et al., 2017), and are a leading cause of mental health-related deaths, second only to opioid overdoses (Arcelus et al., 2011). The recent coronavirus (COVID-19) pandemic has only added to this concern, with ED diagnosis incidence increasing by roughly 15% during this time (Taquet et al., 2021). Not only are EDs highly prevalent, but they also demonstrate comorbidity with other mental disorders (e.g., anxiety, depression, and post-traumatic stress disorder) and are associated with premature death and elevated suicide attempts (Schaumberg et al., 2017; Tagay et al., 2014; Ulfvebrand et al., 2015). Millions of individuals do not receive help for their EDs despite the demonstrated effectiveness of early interventions (Kazdin et al., 2017). According to Kazdin et al. (2017), among the reasons for this are ongoing research gaps in the literature and a lack of studies on evidence-based treatments for EDs. Moreover, ED research remains underfunded, and treatment costs continue to rise (Murray et al., 2017), emphasizing the urgent need for enhanced ED training and practice.

When EDs are undetected and untreated, counselors may face ethical concerns in practice. The American Counseling Association (ACA) *Code of Ethics* (2014) is grounded in the values of nonmaleficence and beneficence, encouraging counselors to work within the boundaries of their competence (Code C.2.a). As such, counselors must be equipped with the necessary knowledge and skills crucial to assessing and detecting this prevalent concern. Although ED treatment is considered a specialty area, counselors should be aware of the severity and deficits in ED treatment to make appropriate referrals and provide ethical, culturally responsive care as the first point of contact for clients.

Recognizing the interdisciplinary nature of ED treatment, the researchers utilize the term "clinician" throughout this manuscript when referring to diverse helping professionals, including but not limited to counselors, marriage and family therapists, social workers, and psychologists. Scholars purport that interdisciplinary care and collaboration is "a best practice strategy for addressing some of the nation's critical social problems," including mental health care (Mellin et al., 2011, p. 410). However, counselors have historically struggled with establishing a collective professional identity, particularly since counseling is a newer helping profession (Hrovat et al., 2013). In this manuscript, the researchers advocate for enhanced counselor training on EDs to meaningfully address the evident gaps and strengthen counselors' professional identities amongst interdisciplinary ED treatment teams. The following section provides an overview of the extant literature on ED education in counselor education programs.

Eating Disorder Education in Counselor Education Programs

Given the serious nature of EDs, counselor education programs must adequately address EDs throughout the curricula to prevent harm before counselors-in-training (CITs) engage in clinical work (Levitt, 2006). In a survey of graduate counselor education programs, Levitt (2006) found that 94.7% of respondents (primarily program directors) believed that CITs would likely work with ED clients at some point in their practice, and 55.4% believed ED issues are highly relevant to clinical training. However, Thompson-Brenner et al.'s (2012) literature review discovered that ED clinicians partly attributed their lack of perceived confidence to their limited education and training in EDs. Thus, the discrepancy between program directors' reports and clinicians' challenges in practice points to the need for ED education and training early in graduate programs. Due to the dearth of ED research within counseling journals, the researchers also explored existing literature across disciplines to identify clinician challenges in ED treatment.

Clinician Challenges in the Treatment of Eating Disorders

In the treatment of EDs, clinicians face many difficulties in their clinical practice, such as treatment resistance, relapse rates, and health complications (Warren et al., 2013a). Further, EDs continue to pose a significant risk to clients' well-being, ranking as one of the most lethal mental health conditions to date (Arcelus et al., 2011; Edakubo & Fushimi, 2020). Despite these serious consequences, Peyser et al. (2021) noted that "a gap remains between effective clinical interventions developed in research studies and their application in routine clinical practice" (p. 2121). This issue is compounded by the lack of available education and knowledge of effective ED treatment among practicing clinicians and healthcare professionals, resulting in unethical and incompetent treatment practices. For instance, a recent meta-ethnographic study discovered a key theme underlying healthcare professionals' experiences working with ED clients: "Coping with caring without curing" (Graham et al., 2020, p. 426). Essentially, ED professionals' challenges contributed to a sense of dissonance or a discrepancy between their intentions to help and the reality of treatment being inadequate or unwanted at times. This study highlighted ED professionals' perceived limitations in their ability to help and treat clients suffering from an ED, thus creating a "painful dissonance that can impact enjoyment on the job, perceptions of service users, and working alliances" (p. 435).

Additional studies have identified emotional exhaustion, burnout, cynicism, frustration, incompetence, and limited knowledge as some common challenges and reactions that clinicians experience in their work with ED clients (Seah et al., 2017; Thompson-Brenner et al., 2012; Warren et al., 2013a). For example, Warren et al. (2013a) discovered that more than half of ED professionals in their sample experienced a moderate to high range of emotional exhaustion. Interestingly, Warren et al. (2013a) also found that clinicians with personal ED histories were less

likely to report cynicism, instead noting feelings of personal accomplishment, which may reflect their unique position in understanding clients' experiences (de Vos et al., 2016). Collectively, these findings point to the importance of managing countertransference and practicing self-care as a clinician working with ED clients. In addition to limited ED education, pervasive ED treatment gaps may also contribute to clinician challenges.

Eating Disorder Treatment Gaps

Research on evidence-based interventions often occurs in highly controlled clinical settings, calling cross-cultural generalizability into question (Kazdin et al., 2017; Sonneville & Lipson, 2018). Therefore, there remains a need to enhance intervention efforts to reach marginalized populations, or those with historically minoritized identities, such as Black, Indigenous, People of Color (BIPOC), Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) individuals, and people of size. Across the board, marginalized communities struggle with EDs at considerable rates but are often overlooked by clinicians, thus decreasing the likelihood of being accurately diagnosed and receiving treatment (Kazdin et al., 2017; Sonneville & Lipson, 2018). From a social justice lens, these gaps emphasize clinicians' roles as advocates to increase treatment accessibility, necessitating culturally responsive research that informs clinical practices and mental health policies to promote change within the ED field.

Current Study

Thompson-Brenner et al. (2012) highlighted the need for trained and competent clinicians to treat the increasing prevalence of individuals impacted by EDs. However, the lack of adequate ED research and training may also result in clinicians' perceived lack of knowledge and expertise. Due to the shortage of research on ED training and education, there remains a need to reexamine clinicians' experiences treating EDs and explore current challenges and deficits in graduate

education, training standards, and research. Since there is a lack of assessment tools that measure clinicians' attitudes, experiences, and preparedness with treating EDs, we developed the *Clinician Attitudes towards Treating Eating Disorders* (CATTED) survey for the present study. The first and second authors, who are both licensed mental health counselors with clinical experience treating clients with EDs, developed the items based on existing literature to explore deficits in more depth (e.g., de Vos et al., 2016; Graham et al., 2020; Seah et al., 2017; Sonneville & Lipson, 2018; Thompson-Brenner et al., 2012; Warren et al., 2013a). The items were then reviewed by the third researcher, who has expertise in assessment development and quantitative research, prior to data collection. Table 2 provides the items within the CATTED survey, which assess the respondent's graduate education on EDs, self-perceived levels of preparedness, comfort, and confidence, current challenges in treatment, perceptions on what may improve existing deficits, and other related questions. Our overarching goal was to contribute to this body of research by probing clinicians across disciplines about their current personal and professional experiences with EDs.

Building upon previous research, the following research questions guided the present survey: (1) What are the relationships between level of comfort, preparedness, effectiveness, and confidence in an interdisciplinary sample of ED clinicians? (2) Do differences exist between counselors and other helping professionals in level of comfort, preparedness, effectiveness, and confidence in treating EDs? (3) Does degree level impact clinicians' perceived level of comfort, preparedness, effectiveness, and confidence in treating EDs? (4) Do clinicians' personal histories with EDs impact their perceived level of comfort, preparedness, effectiveness, and confidence in treating EDs? (5) What challenges do clinicians face when treating EDs today? And (6) What are clinicians' perceptions on current ED research and training standards? In this article, the

researchers (a) outline and critically review quantitative and qualitative findings from this survey, (b) examine implications for counselor training programs, and (c) offer directions for future research.

Method

Participants

The researchers collected survey data between October 2020 and June 2021 from a voluntary response sample of 147 clinicians from various helping professions (counseling, psychology, marriage and family therapy, social work, psychiatry, etc.) with prior experience treating EDs. Specifically, eligibility criteria to participate in this survey entailed anyone that (a) was 18 years or older, (b) provided therapeutic services to a client for an ED at some point during their career or training, (c) was willing to answer questions concerning their clinical and personal experiences with EDs, and (d) was an English speaker. Missing cases were removed before the final data analysis, leaving 109 surveys that were completed in their entirety. The final sample consisted of 23 cisgender men, 81 cisgender women, and five non-binary/non-conforming individuals. Participants were mainly between the age bracket of 26 and 33 (n= 63). The sample predominantly consisted of Non-Hispanic White participants (n= 73), with the remaining participants identifying as Latinx (n= 25), African American (n= 10), and preferred not to say (n= 1). All respondents were from North America.

At the time of the survey, participants predominately held master's degrees (n= 66), with clinicians equally possessing a doctorate (n= 18) and medical degree (n= 18), followed by individuals with a specialist degree (n= 6) and those with a bachelor's degree (n= 1). Largely, participants worked in the field of counseling or psychotherapy (41.3%) and held their license for either a period of 0-5 years (48.6%) or 11-15 years (27.5%). Lastly, clinicians reported that they

were currently working in multiple treatment locations (26%), had seen clients from varying age groups (54%), and treated a multitude of EDs within the past year (71%). Table 1 outlines the specifics of these findings and participants' remaining demographic data.

Table 1

Demographic Characteristics of Clinician Survey Participants

Question	Item	Percentage
Age	18-25	6.4%
	26-33	57.8%
	34-42	23.9%
	43+	11.9%
Gender Identity	Male	21.1%
	Female	74.3%
	Non-Binary	4.6%
Race/Ethnicity	Non-Hispanic White or Euro American	67.0%
	Black or African American	9.2%
	Latinx or Hispanic	23.0%
	Other/Unknown	0.9%
State Primarily Practice/ See Clients [Top 5]	California	20.2%
	Florida	14.7%
	Pennsylvania	11.9%
	Massachusetts	6.4%
	Illinois	5.5%
Highest Degree Attained	Doctorate Degree	16.5%
	Medical Degree (M.D.)	16.5%
	Specialist Degree	5.5%
	Master's Degree	60.6%
	Bachelor's Degree	0.9%
Degree or License Area [Select all that apply]	Counseling or Psychotherapy	41.3%
	Marriage and Family Therapy	6.4%
	Social Work	11.9%
	Psychology	22.9%
	Psychiatry	2.8%
	Multiple Degrees/License Areas	12.9%
	Other	1.8%

Length of Time in Practice	0-5 years	48.6%
	6-10 years	16.5%
	11-15 years	27.5%
	16+ years	7.3%
Most Common Therapeutic Services	Individual Therapy	45.0%
	Group Therapy	2.8%
	Couple Therapy	0.9%
	Family Therapy	3.7%
	Residential	25.7%
	Partial-Hospitalization (PHP)	14.7%
	Intensive Outpatient (IOP)	1.8%
	Other	5.5%
Setting Currently Treating Clients [Select all that apply]	Private Practice	22.0%
	Residential	11.0%
	Intensive Outpatient (IOP)	6.4%
	Partial-Hospitalization (PHP)	6.4%
	College Counseling	18.3%
	Non-Profit/Community Mental Health	10.1%
	School Setting	0%
	Multiple Treatment Settings	25.7%

Note: *N=109*

Procedure

Before initiating recruitment, the institutional review board exempted this survey under 45 CFR 46.104 (Exempt Category). The researchers recruited participants using convenience sampling procedures, randomly distributing the survey to various professional listservs (e.g., CESNET, CounsGrad), social media sites (e.g., Facebook, Reddit), ED treatment facilities, and other professional platforms. An email encompassing the study's purpose, along with a link to the survey, was sent out. The researchers used Qualtrics to collect participants' anonymous survey responses. Participants were initially asked to complete a brief demographic questionnaire, including five questions on age, gender identity, degree, etc. (see Table 1). The CATTED survey included 18 survey questions which consisted of multiple-choice, Likert-style, and open-ended questions (see Table 2).

Table 2

CATTED Survey Questions Table

CATTED Survey Item	Responses	Percentage
1. Did your education program offer a course exclusively on EDs?	Yes	25.7%
	No	73.4%
	I'm not sure	.09%
2. Approximately how many hours did your program dedicate to ED-related instruction?	1-5	41.3%
	11-15	0.9%
	6-10	21.1%
	16+	3.7%
	I'm not sure	6.4%
	None	26.6%
3. What is your chosen theoretical orientation for ED treatment?	Acceptance & Commitment Therapy (ACT)	5.5%
	Attachment-Based	1.83%
	Cognitive Behavioral Therapy (CBT)	22.64%
	Dialectical Behavioral Therapy (DBT)	4.59%
	Eclectic/Integrative	14.68%
	Emotion-Focused Therapy (EFT)	13.21%
	Existential	13.21%
	Eye Movement Desensitization & Reprocessing Therapy (EMDR)	0.92%
	Family-Based Therapy	1.83%
	Feminist	3.67%
	Interpersonal Psychotherapy	0.92%
	Motivational Interviewing	2.75%
	Narrative Therapy	0.92%
	None	3.67%
	Person-Centered/Humanistic	6.42%
	Psychodynamic	1.83%
	Reality Therapy/Choice Theory	1.83%
	Relational-Cultural Therapy (RCT)	4.59%
	Solution-Focused Brief Therapy (SFBT)	2.75%
	Systems-Based	1.83%
4. What setting are you currently treating clients?	See Table 1	See Table 1

5. In the past year, what percentage of your clients have you treated for an ED?	1-15%	28.4%
	16-30%	26.6%
	31-45%	2.8%
	50%	3.7%
	More than 50%	42.0%
6. Of the clients that you treated for an ED in the past year, what was their age group? [Select as many as apply]	Child (ages 3-12)	0%
	Adolescent (ages 13-17)	20.2%
	Young Adult (age 18-30)	20.2%
	Middle Aged Adult (age 31-45)	2.75%
	Older Adult (age 46+)	2.75%
	None	0%
	Multiple Ages	54.1%
7. In the past year, what ED diagnoses have you treated? [Select as many as apply]	Anorexia Nervosa	4.59%
	Bulimia Nervosa	2.75%
	Binge Eating	18.3%
	Avoidant/Restrictive Food Intake (ARFID)	1.83%
	Pica	0%
	Rumination Disorder	0%
	Other Specified Feeding or ED	0.92%
	Unspecified Feeding or ED	0.92%
	None	0%
	Multiple Diagnoses	70.6%
8. What therapeutic services have your clients with EDs most presented for?	See Table 1	See Table 1
9. In your experience treating clients with EDs, have you or are you working with a multidisciplinary treatment team?	Yes	88.1%
	No	11.9%
10. On a scale of 1-5, please rate your level of comfortability in treating EDs.	1 (Not comfortable)	5.5%
	2	11.0%
	3	37.6%
	4	22.0%
	5 (Extremely comfortable)	23.9%
11. On a scale of 1-5, how prepared do you feel to treat EDs?	1 (Not prepared at all)	6.4%
	2	11.9%
	3	35.8%
	4	22.9%
	5 (Extremely prepared)	22.9%

12. On a scale of 1-5, please rate your perceived effectiveness in treating EDs.	1 (Not Effective)	2.8%
	2	15.6%
	3	26.6%
	4	49.5%
	5 (Extremely Effective)	5.5%
13. On a scale of 1-5, how confident do you feel treating EDs?	1 (Not Confident)	8.3%
	2	9.2%
	3	26.6%
	4	43.1%
	5 (Extremely Confident)	12.8%
14. What do you perceive as significant challenges in the treatment of EDs? [Select as many as apply]	Lack of graduate-level education and specialized training	59.6%
	Insurance issues	51.4%
	Relapse/commitment to treatment	47.7%
	Reducing stigma, myths, and misinformation	38.5%
	Addressing trauma	36.7%
	Lack of evidence-based interventions and specialized treatment models	25.7%
	Cost/access to trainings and workshops	25.7%
	Research deficit	22.0%
	Culture/religious influences	22.0%
	Other	6.42%
15. What do you believe would most help enhance clinician competency in the treatment of EDs? Rank from 1=most important to 6=least important	More training/education in graduate programs	1
	Greater access to educational/training resources	2
	Greater access to ED assessments and evidence-based treatment manuals or protocols	3
	Continuing education	4
	More research on EDs in the literature	5
	Consultation/supervision	6
16. On a scale of 1-5, how well do you think the current professional literature addresses EDs?	1 (Inadequate)	0.9%
	2	30.3%
	3	52.3%
	4	14.7%
	5 (Extremely Adequate)	1.8%
17. Do you have personal experience with an ED? [Select as many as apply]	Yes, I am in treatment	1.8%
	Yes, I am in recovery or have recovered	11.9%
	Yes, I have a family member	5.5%
	Yes, I have/have had a friend	34.9%

	Yes, my caregiver/parent	0%
	Yes, [multiple responses]	15.6%
	No	30.3%
	Other	0%
18. I have other thoughts on the treatment of EDs:	Qualitative Analysis	Qualitative Analysis

Data Analysis

Quantitative responses were entered into IBM SPSS (Version 27.0) for data analysis following the survey's termination. Several survey questions offered participants the option to select the *'other'* option and '*fill in the blank*.' In addition, a few questions instructed participants to '*select all that apply*' to reflect their experience fully. With each of these questions, we subsequently quantified the responses. Then, responses were grouped into a '*multiple'* category for participants that selected more than one option (see Table 2). At the end of data analysis, we compared this study's findings against previous studies that examined therapists' attitudes toward treating EDs to identify areas of convergence and divergence. These findings are reviewed in-depth in the discussion section.

Results

Findings from our survey seemed to be consistent with previous studies (Seah et al., 2017; Thompson-Brenner et al., 2012; Warren et al., 2013a). The online supplemental materials contain individual responses for each item on the CATTED survey. The following survey items are explored below: (a) relationship between the level of comfort, preparedness, effectiveness, and confidence, (b) comparison between counselors and other helping professionals, (c) responses by degree level, (d) personal experience of EDs, (e) perceptions of significant challenges, (f) adequacy of the current ED research and training standards, and (g) other findings.

Relationship between Level of Comfort, Preparedness, Effectiveness, and Confidence

We performed a Spearman's Rho correlation to assess the relationship between responding clinicians' ratings of their levels of *comfort, preparedness, effectiveness, and confidence*. The results of this analysis are presented in Table 3. Overall, there was a large, positive correlation amongst all four ratings, ranging from .621 to .860. In addition, the coefficient of determination, or the amount of variance in one variable that can be accounted for by the other, ranged from 38.5% to 74%, signifying medium to large effect sizes for these findings linking clinicians' perceptions of their comfort, preparedness, effectiveness, and confidence in treating EDs.

Table 3

Relationship Between Level of Comfort, Preparedness, Effectiveness, and Confidence

	Comfortable	Prepared	Effective	Confident
Comfortable	--			
Prepared	.860**	--		
Effective	.621**	.622**	--	
Confident	.763**	.783**	.773**	--

Note: Spearman's Rho analysis was conducted.

Comparison Between Counselors and Other Helping Professions

To investigate the differences between counselors and other helping professionals on the questions of how comfortable, prepared, effective, or confident the participants felt in treating clients with EDs, we divided the sample between counselors (n= 48) and other professions (social work, psychology, etc.; n= *51*). Ten participants identified as both counseling and another discipline, which were excluded from this analysis. A series of one-way ANOVAs were conducted, but there were no significant differences between respondents who were counselors and respondents who identified as another helping profession. Table 4 displays the means and

standard deviations for each of the questions by profession. Further, the effect sizes of each were all in the low range, suggesting that the lack of a significant finding reflects a true result.

Table 4

Comparison in Responses Between Counselors and Other Helping Professions

Variable	Profession	*M (SD)*	*F*	n^2
How comfortable do you feel?	Counselors	3.54 (1.22)	.545	.006
	Other Professions	3.37 (1.06)		
How prepared do you feel?	Counselors	3.6 (1.23)	2.042	.021
	Other Professions	3.27 (1.06)		
How effective do you feel?	Counselors	3.29 (.77)	.977	.010
	Other Professions	3.47 (1.01)		
How confident do you feel?	Counselors	3.42 (1.07)	.113	.001
	Other Professions	3.49 (1.1)		

Responses by Degree Level

We also looked at whether degree level impacted participants' ratings of their *comfortability, preparedness, effectiveness, and confidence* in treating individuals who present with an ED. While initially, categories included graduate students who had not yet attained their degree, or an educational specialist degree, we then selected the two degrees that were the largest: master's degrees ($n = 66$) and doctorate degrees ($n = 36$). A MANOVA was conducted and revealed group differences, Wilks' $\lambda = .712$, F (4, 97) = 9.822, $p < .05$, $\eta^2 = .288$, $d = 1.000$. We also conducted follow-up analyses. To account for the family-wise error rate, follow-up analyses were conducted using Univariate ANOVAs with a Bonferroni corrected alpha level ($\alpha = .05/4 = .0125$). The following questions were significantly different: *level of effectiveness* (F (1, 100) = 6.904, $p < .01$, $\eta^2 = .086$, $d = .740$), and *confidence* (F (1, 100) = 8.131, $p = .005$, $\eta^2 = .075$, $d = .806$) in treating clients with EDs. Mean differences are reported in Table 5. In each of the two significant items, therapists with a doctorate rated themselves higher in *effectiveness and confidence* than those with a master's degree in treating clients presenting with an ED. It is also noteworthy that

the effect size (partial eta squared, η^2) reported for all the significant findings were in the medium range (.065 & .075), indicating a moderate relationship between degree level and *level of effectiveness and confidence* in treating individuals with an ED.

Table 5

CATTED Responses by Degree Type (Mean Differences)

Variable	Master's vs. Doctorate	*n*	*M*	*SD*
How comfortable do you feel?	Master's Degree	66	3.50	1.256
	Doctorate Degree	36	3.44	.877
	Total	102	3.48	1.132
How prepared do you feel?	Master's Degree	66	3.42	1.229
	Doctorate Degree	36	3.39	1.022
	Total	102	3.41	1.155
How effective do you feel?	Master's Degree	66	3.20	.881
	Doctorate Degree	36	3.67	.828
	Total	102	3.36	.888
How confident do you feel?	Master's Degree	66	3.18	1.162
	Doctorate Degree	36	3.81	.822
	Total	102	3.40	1.092

Personal Experience of Eating Disorders

Participants in the survey were asked whether they had any personal experience with an ED. Responses were classified as either the individual clinician presently has or has had an ED in the past (n= 37), have had a friend or family member have an ED (n= 40), or have not had an ED, nor had any friends or family members have one (n= 32). We then looked if there were any differences in therapists' ratings of their level of *comfort, preparedness, effectiveness, and confidence* in treating individuals with an ED. Again, a MANOVA was conducted and revealed [i]group differences, Wilks' λ= .719, F (4, 104) = 4.619, p < .01, η^2 = .152, d = .997. We also conducted follow-up analyses using Univariate ANOVAs, again with similar results to other findings reported above. Only *level of confidence* (F (2, 106) = 6.64, p = .002, η^2 = .111, d = .906) was significantly different based on personal experience of an ED. *Level of effectiveness*

approached significance (F (2, 106) = 3.881, p = .024, η^2 = .068, d = .690), but was not below the .01 alpha level set. Mean differences are reported in Table 6.

The effect size (partial eta squared, η^2) reported for *level of confidence* was in the medium-to-large range (.111), indicating a robust relationship between personal experience and *level of confidence* in treating individuals with an ED. Follow-up pairwise comparisons were conducted, and for *level of confidence,* individuals who had no experience with an ED were less confident than clinicians who either had an ED (mean difference = -.720) or had a friend or family member with an ED (mean difference = -.850). In addition, there were several significant pairwise comparisons revealing pairwise differences in *level of comfort* treating individuals with an ED between individuals with a personal history of having an ED compared to individuals with no history (mean difference = -.592). There were also significant pairwise comparisons for clinicians' level of effectiveness with individuals with a friend or family member rating their effectiveness higher than individuals with no experience (mean difference = -.588), though interestingly, there were no differences with individuals who had an ED themselves. However, these statistically significant findings should be interpreted with caution since the univariate ANOVA was not significant.

Table 6

Mean Difference by Personal Experience

Variable	Personal Experience	*M*	*SD*	*n*
How comfortable do you feel?	I have/had an ED	3.81	1.151	37
	No, I have not had an ED	3.22	1.289	32
	I have/had a friend or family member with an ED	3.38	.925	40
	Total	3.48	1.135	109
How prepared do you feel?	I have/had an ED	3.62	1.255	37
	No, I have not had an ED	3.12	1.289	32
	I have/had a friend or family member with an ED	3.53	.905	40

	Total	3.44	1.158	109
How effective do you feel?	I have/had an ED	3.41	.832	37
	No, I have not had an ED	3.06	.982	32
	I have/had a friend or family member with an ED	3.65	.864	40
	Total	3.39	.913	109
How confident do you feel?	I have/had an ED	3.59	1.117	37
	No, I have not had an ED	2.88	1.185	32
	I have/had a friend or family member with an ED	3.72	.816	40
	Total	3.43	1.092	109

Note: Due to the unequal cell sizes, non-parametric analyses were also conducted. The results were the same as the parametric analyses reported here. The results of the non-parametric tests are available upon request.

Perceptions of Significant Challenges

The present survey included a question asking clinicians to indicate what they perceived as significant challenges in treating EDs, selecting as many options as they deemed applicable. Findings from these questions were quantified by rate of occurrence and subsequently ranked in order of most to least frequently endorsed. The results of this question are presented in Table 2. Roughly 60% of participants cited a lack of graduate-level education and specialized training as the most significant challenge in treating EDs, ranking higher than insurance issues (51%) and clients' relapse or lack of commitment to treatment (48%).

Adequacy of the Current Eating Disorder Research and Training Standards

Participants were asked to rate the adequacy of the current ED research and training standards. The results of this question are presented in Table 2. Overall, approximately 52.3% of clinicians surveyed who treat EDs indicated that the literature moderately addressed these issues at best.

Other Findings

Participants were also provided with a list of options and asked what they believed would most help enhance clinicians' clinical competency in treating EDs using a rank-order system. Like

previous results, participants most frequently ranked *more training/education in graduate programs* as the primary clinical competency needed to enhance clinicians' capacity to effectively treat EDs, followed by *greater access to educational/training resources* and *greater access to ED assessments and evidence-based treatment manuals or protocols.* The remaining results of this question are presented in Table 2.

Following the survey's completion, participants were provided with an open-response question if they had other thoughts on the treatment of EDs. Of the 109 completed surveys, only 17 participants provided a written response for the open-ended item. Although we could not conduct a full qualitative data analysis due to the small sample size, a consensus coding system was developed to categorize participants' responses and quantify them by frequency. The first and second authors independently coded the responses and collectively identified common, overarching themes. The third author served as an auditor, providing an objective perspective in the review of findings. The researchers intentionally engaged in reflexivity throughout this process by discussing and bracketing their biases and assumptions about the topic.

Emergent themes related to clinicians' feedback included *lack of access to evidence-based treatments and education in graduate training and clinical settings* (41%) and the *need for more research and culturally responsive care among EDs* (29%). One participant elaborated on the first identified theme, *lack of access to evidence-based treatments and education in graduate and clinical settings*, by highlighting the systemic challenges faced by educators with addressing ED education:

> I currently teach at a university and offer a course on eating disorders periodically. However, without making it part of the curriculum, it cannot be offered very often as electives are being cut at our institution. I find this problematic as client numbers continue

> to grow, yet, I cannot provide the training and the costs of training and certification are very expensive for me as a supervisor as well as being a clinician.

Another participant echoed these sentiments and stated that "education specifically about ED diagnosis and treatment is rarely more than one lecture at the master's level." Notably, these findings corresponded with the quantitative results, with 41% of participants receiving 1-5 hours of ED training in their graduate programs.

Participants also drew attention to the need for *more research and culturally responsive care*. For example, one participant provided additional suggestions for course content, specifically that:

> There should be instruction in graduate school regarding diet culture, fatphobia, and HAES® [Health at Every Size®; Association for Size Diversity and Health, n.d.; Health at Every Size and HAES are registered trademarks of the Association for Size Diversity and Health and used with permission]. This should be standard for all therapists to do less harm.

Another participant further elaborated on harmful behaviors displayed by healthcare systems and ED providers: "Weight stigma shown by insurance companies and medical providers is an extremely harmful maintaining factor of eating disorders." Overall, the qualitative findings reinforce the deficits in ED education across graduate programs and call attention to areas of need within the curriculum, including social justice-informed practice.

Discussion

The results of this study yielded crucial information about clinicians' experiences with treating EDs and the pervasive deficits in ED graduate training and research. After exploring the relationships between interdisciplinary clinicians' perceived levels of comfort, preparedness,

effectiveness, and confidence in treating EDs, the researchers further explored potential differences between clinicians by degree type (i.e., counseling versus other helping professionals) and degree level (i.e., master's versus doctoral level). First, the researchers discovered that there were no significant differences in perceived comfort, preparedness, effectiveness, and confidence between counselors and other helping professionals. These findings indicate that although evident gaps exist in ED graduate education, counselors' perceptions of their ability to treat EDs are comparable to other interdisciplinary professionals. Therefore, counselors are in a unique position to promote wellness-oriented approaches to ED treatment, further enhancing comprehensive care and challenging the prevailing pathology-oriented treatment paradigms. This is further discussed in the implications for graduate training section below.

Conversely, ANOVA analyses revealed a significant, moderate relationship between degree level and perceived effectiveness and confidence levels. Specifically, clinicians with doctoral degrees rated themselves as more effective and confident in treating EDs than clinicians with master's degrees. A possible explanation for this finding may be the differences in years of experience between groups, as doctoral programs typically require more pre-graduate clinical training than master's programs. In addition, research has shown that less experienced clinicians reported higher levels of burnout, more intense adverse reactions, and greater difficulty working with ED clients than more experienced clinicians (Thompson-Brenner et al., 2012; Warren et al., 2013a). However, more research is needed to determine whether the significant differences in perceived effectiveness and confidence between groups are related to years of experience.

The results of the fourth research question indicated that clinicians with no personal experience with an ED rated themselves as less confident than clinicians who either struggled with an ED or had a family member or friend with an ED. These findings affirm prior studies

highlighting the advantages of experiential knowledge, including enhanced insight, understanding, empathy, and the ability to serve as a positive role model (de Vos et al., 2016; Rance et al., 2010; Warren et al., 2013b). For instance, Rance et al.'s (2010) qualitative study discovered that although therapists with ED histories feared enmeshment or over-involvement with clients, they expressed that "their own experiences enabled them to believe in the possibility of recovery and to hold on to this belief even in the hardest times" (p. 388). These unique factors may increase clinical confidence for clinicians who have personal experiences with EDs.

Consistent with previous research, most participants in the study (60%) reported the lack of graduate or specialized training as the primary challenge when treating EDs. This finding underscores graduate programs' role in remedying current ED treatment deficits. Further, it illuminates the discrepancy between clinicians' experiences in practice and graduate programs' reported efforts to infuse ED education into curricula (Levitt, 2006). Additional challenges reported by participants in our study included insurance issues (51%) and client relapse or lack of commitment to treatment (45%). Thus, clinicians' awareness of how healthcare barriers (such as insurance coverage issues) contribute to inadequate support to help clients sustain long-term recovery may perpetuate the sentiment of "coping with caring without curing" (Graham et al., 2020, p. 426).

Finally, the qualitative themes from the open-response item supported the quantitative results of the CATTED survey. Participants highlighted the inaccessibility of evidence-based protocols and the cost-prohibitive nature of specialized training. Notably, these issues may serve as additional barriers to clinicians specializing in EDs despite the evident need for better-trained, culturally competent ED clinicians. Furthermore, the challenges faced by educators were also particularly salient, as they may struggle with finding ways to infuse ED education into the

curricula. Finally, our findings point to EDs as social justice issues and the prevalence of weight stigma in mental health care, perpetuating the oppression and disempowerment of clients in larger bodies (Puhl et al., 2014; Sonneville & Lipson, 2018).

Implications for Graduate Training

The results of our study present significant implications for clinicians and graduate training. For instance, only about 25.7% of participants indicated that their graduate programs offered a course exclusively on EDs. In comparison, roughly 41% reported receiving only 1-5 hours of ED-related instruction throughout their program curricula, while 26.6% reported receiving none. In response to the growing number of clients struggling with EDs, graduate programs and educators play crucial roles in enhancing the training CITs receive before entering the field. In Levitt's (2006) survey, counselor education programs reported that when the topic of EDs was not directly covered, it was "indirectly addressed throughout the course of the program in specific classes, clinical application, and student papers and projects in course work" (p. 99). Although these are helpful pedagogical interventions, educators must move beyond these traditional methods to approach ED treatment from a more comprehensive and culturally informed lens. Scholars have heralded deliberate practice as a means to counteract incompetency among graduate trainees, promoting highly effective clinicians as a result (Chow et al., 2015). Budesa and Barrio Minton (2022) operationally define deliberate practice as "a framework for engaging in focused, intense practice with the goal of continuous improvement and optimal performance" (p. 2). In light of this study's findings, additional strategies to strengthen ED education are proposed in the sections below, such as assisting CITs with managing countertransference and advocating for the integration of ED education.

Managing Countertransference

The inherently personal nature of food, eating, and body image may naturally contribute to countertransference in clinicians working with EDs. Even CITs without ED histories may hold attitudes and beliefs about health and wellness shaped by their life experiences, cultural identities, and worldviews. If left unchecked, clinicians may unknowingly project or impose these values onto clients. Thus, educators can encourage CITs to engage in self-reflection to increase insight around relevant issues like weight stigma and diet culture. Educators and supervisors may support CITs with ED histories to become aware of their triggers and manage common countertransference issues, such as over-involvement with clients (Rance et al., 2010). Since burnout, cynicism, and worry are common among ED providers (Seah et al., 2017; Thompson-Brenner et al., 2012; Warren et al., 2013a), educators should encourage CITs to practice self-care to manage the complexity and challenges of ED treatment. Although infusing these strategies throughout coursework is helpful, specialized coursework is another method to explore ED treatment in more depth.

Advocating for the Integration of ED Education

In our study, master's-level clinicians reported feeling less effective and confident than doctoral-level clinicians. Offering coursework on EDs may be one way to bridge the gap in ED training within counseling master's programs (Levitt, 2006). Although the ability to provide elective courses may vary depending on the program, educators can advocate for the inclusion of specialty courses to enhance CITs' comfort, preparedness, effectiveness, and confidence. Since the course content can be more intentionally focused on EDs, a wide variety of topics may be covered, such as the etiology, assessment, and treatment of EDs, relevant theories and treatment models, the continuum of care, and multicultural/social justice issues (Levitt, 2006).

If elective courses cannot be offered, educators can integrate ED education throughout the curricula in various ways. Relevant courses may include human growth and development, assessment and testing, psychopathology, social and cultural issues, research and program evaluation, and practicum and internship. Counselor educators may draw from fundamental counseling values, such as wellness and social justice, to approach ED assessment and treatment from an inclusive and strengths-based (versus pathology-based) orientation. CITs may benefit from learning about evidence-based, wellness constructs relevant to the treatment of EDs, such as self-compassion and mindfulness (Messer et al., 2021). By empowering CITs to embrace counseling values, they may feel better equipped to articulate their unique strengths, training, and counseling identities in the context of interdisciplinary ED treatment teams.

Relatedly, educators may consider inviting ED specialists, including clinicians, dieticians, medical doctors, and psychiatrists, to discuss best practices for interdisciplinary collaboration. Counseling departments can also utilize their Chi Sigma Iota chapters as a platform to host events related to ED education. Workshops or panel discussions may further educate students, practitioners, and local community agencies on the treatment of EDs. In doing so, counseling departments may develop collaborative relationships with local practitioners and treatment centers, further promoting reflective dialogue and education on ED treatment.

Limitations and Future Research

Although our findings pose important implications for the advancement of ED education, training, and research, the study is not without its limitations. Participants were recruited from professional listservs and social media pages designed for ED providers, which may have biased the sample. Also, since most of our sample identified as cisgender and non-Hispanic White, we could not fully capture the experiences of clinicians with diverse or marginalized identities. Future

studies should recruit larger and more culturally diverse samples and more professionals outside of the ED field, providing additional insights into the unique challenges that non-specialists experience. Furthermore, since the open-ended question in our survey yielded few comments, the findings did not present as rich an understanding of the phenomenon under study. Additional qualitative research on ED therapists' perceived challenges and deficits within ED education may be helpful to explore further.

Researchers should also consider reexamining the current state of ED training within counselor education programs as an update to Levitt's (2006) study. Psychology and social work programs may also conduct research to examine the depth of ED education, considering interdisciplinary differences. Additional studies examining the efficacy of pedagogical interventions may also help educators implement ED education into graduate curricula more effectively. Finally, although the CATTED survey was not specifically designed as a scale, researchers may examine its psychometric properties of the survey to determine its validity and reliability.

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