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RESEARCH ARTICLE

"It's a very tricky area": Exploring the use of experiential knowledge of recovered eating disorder professionals in eating disorder treatment

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Abstract
Objective: A substantial number of therapists in the eating disorder (ED) field have experienced an ED themselves, yet research on professionals using their personal ED experience as a therapeutic tool is scarce. This study explores the perspectives of recovered ED professionals (REDPs) who intentionally employ their experiential knowledge in ED treatment, examining its use, advantages, and challenges.
Method: Semi-structured interviews were conducted with 20 REDPs using a topic list with open-ended questions based on our research aim and a previous literature review (Bijkerk et al., 2024).
Results: REDPs play a key role in treatment, with self-disclosure occurring in various forms. Experiential knowledge of REDPs offers benefits like motivation, hope, and understanding, but also challenges such as potential client burden or misguidance. Successful implementation of experiential knowledge requires organizational adjustments (supervision, work guidance and adequate training) and the REDPs' responsibility to create the right conditions for using their experiential knowledge efficiently.
Conclusion: Applying lived experience in practice by REDPs requires additional competence as it places these professionals into a difficult position of having to balance self-disclosure with ethical risks to clients and the risks to one's personal and professional self. Moreover, beneficial use of experiential knowledge in practice requires organizational support.

Clinical or methodological significance of this article: Within the field of eating disorders (ED) a substantial number of therapists (30% to 80%) have experienced a history of an ED themselves (Barbarich, 2002; Bloomgarden et al., 2003; Costin, 2002). Increasingly, mental health care professionals like nurses, social workers, psychologists, and psychiatrists share their personal experiences during mental health treatment (Karbouniaris, 2020). Research indicates that contributions from lived experience can be especially valuable when professionals possess a deep personal understanding of these experiences, as it provides them with the ability to be more empathetic and non-judgmental during care provision (Bachner-Melman et al., 2021; Johnston et al., 2005; Warren et al., 2013). Similarly, the concept of the wounded healer suggests that the ability to heal rises, in part, from the healer's own psychological wounds. In addition, research indicates that the wounded healer's countertransference can have a positive influence on therapy (Fauth, 2006; Gelso & Hayes, 2007; Sedgwick, 1994, as cited in Zerubavel & Wright, 2012). A recent systematic review on self-disclosure (defined as the willingness to share personal and emotional experiences with the client) from therapists in ED treatment found that therapists' self-disclosure is viewed as a beneficial factor by clients in various aspects of the therapeutic process, resulting in a stronger therapeutic alliance, greater client satisfaction, enhanced recovery from EDs and increased treatment adherence and engagement (Albano et al., 2024).

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However, limited research has been conducted on professionals with a history of an ED who deliberately apply their lived experience as a therapeutic tool with clients. Additionally, we lack understanding on why and how these recovered ED professionals (REDPs) use their experience during therapy. It is crucial to have a comprehensive knowledge of this matter because the motives of REDPs might not be entirely unbiased. For instance, REDPs may be more vulnerable mentally, pursuing personal interests or withholding an overly involved relationship towards their client due to their own experience (Bachner-Melman et al., 2021; Bijkerk et al., 2024). Therefore, this study aims to explore the perspectives of REDPs who intentionally use their experiential knowledge in ED treatment, focusing on the way experiential knowledge is used in ED treatment and its perceived advantages and challenges.

While the value of involving experts by expertise in regular care is increasingly being recognized, healthcare professionals using experiential knowledge in their practice is a recent development. According to a systematic review, using "experiential expertise" affects the personal-professional identity, the mental health care system, and the recovery of service users (Karbouniaris, 2020). A recent systematic review focusing on professionals with a history of an ED treating ED clients emphasized the relevance of expanding the research on this specific topic (Bijkerk et al., 2024). It was stated that professionals who share similar experiences as their ED clients may face several potential advantages and challenges for treatment, impacting the professional's self and the organization and work setting of the professionals (Bijkerk et al., 2024).

Objective

A few studies focus on the perspectives of professionals who have a personal history of an ED and subsequently work in ED treatment (Rance et al., 2010; Dayal et al., 2015; Wasil et al., 2019). In one study, the counselors' awareness of the socially and/or professionally stigmatized nature of their history and how they manage this stigma was highlighted (Rance et al., 2010). Another study demonstrated that counselors were dealing with feelings of shame due to their (past) eating problems, which created complications in both personal and professional areas (Dayal et al., 2015). Finally, Wasil et al. (2019) found that self-disclosure by recovered ED therapists regarding their own recovery experiences can serve as a motivational tool for clients, particularly those who experience difficulty finding motivation to pursue recovery.

However, the organizations in these studies do not specifically encourage these professionals to use their experiential knowledge in treatment. Other studies on REDPs reported several advantages of applying experiential knowledge, including offering clients deeper insights into the recovery process, establishing strong treatment alliance, and enhancing hope for recovery (de Vos et al., 2016). Challenges were also found, such as the therapists being overly involved and the therapist's personal vulnerability and subjectivity (Johnston et al., 2005). Although these studies mention both advantages and challenges, we still have limited insight into the experiences and explanations for using experiential knowledge in practice from the professionals themselves. Hence, our study focuses on the experiences and opinions of REDPs who use experiential knowledge in ED treatment by addressing the following aims:

1. Explore how REDPs utilize their experiential knowledge in treating ED clients;
2. Identify the added value or advantages of using experiential knowledge by REDPs in treating ED clients;
3. Identify the challenges or risks of using experiential knowledge by REDPs in treating ED clients;
4. Examine what is needed to apply experiential knowledge by REDPs in treating ED clients.

Method

The present study is part of a research project on the use of experiential knowledge by REDPs. The overall aim of the study is to identify benefits and challenges, and to develop guidelines on how best to work with lived experience within ED treatment for both therapists and organizations. The Medical Ethics Review Board of the Leiden University Medical Center judged that the research is not subject to the Medical Research Involving Human Subject Act (non-WMO approval number N.21.092) and complies with the Netherlands Code of Conduct for Research Integrity. The study is conducted under the Consolidated Criteria for Reporting Qualitative Research guidelines (COREQ; Tong et al., 2007).

Setting

This study focuses on REDPs who work in a specialized ED treatment center (Human Concern Foundation) in the Netherlands. This ED treatment center developed an ED therapy program based on evidence-based interventions in which the primary therapists have lived experience with an ED themselves (Human Concern, n.d.). These REDPs are

actively recruited based on having been recovered from their ED for at least 3 years and are trained to use their experiential knowledge in treatment before entering their job (Human Concern, n.d.). Recovery, as defined by Human Concern, involves the absence of active ED thoughts and behaviors. The professional is considered fully recovered when they have addressed their own ED issues and disruptive triggers in all areas of their life and can apply their lived experience as a therapeutic tool in treatment. The use of personal ED experience as a therapeutic tool is taught in the accompanying training provided by Human Concern of employment as a REDP. Key training components include: clarifying their narrative, understanding the risks and challenges of using experiential knowledge, and learning how to enhance its value. Self-awareness and mindful interactions are highlighted, and REDPs are guided in transforming challenges into valuable tools for engaging with clients.

The organization consists of approximately 150 employees working across 6 locations in the Netherlands, and serving an average of 800–900 clients (aged 18 years and older) at any given time. The organization complies with the standards set by the Dutch government for mental health services, and the costs of the therapy is covered by the clients' healthcare insurance. REDPs play a central role in providing psychotherapy to clients with an ED as part of a multidisciplinary team which also contains a dietitian, a family therapist, a psychiatrist, a medical doctor and two lead clinicians who coordinate and supervise the treatment.

Participants

Our study focuses on the perspectives of REDPs. We used the following inclusion criteria for REDPs:

- Holds at least a bachelor's degree in social work, or a bachelor's or master's degree in psychology or pedagogy;
- Works as a psychologist, child and adolescent psychologist (orthopedagogue) or social worker to treat ED clients at the specialized ED treatment center Human Concern;
- Has lived experience of an ED and had been recovered from the ED at least 3 years prior to enrollment in the study;
- Utilizes lived experience of an ED in treatment to support ED clients in their recovery process;
- Speaks and understands the Dutch language.

Study design

As our methodological orientation, we opted for a grounded theory in which a conceptual idea is constructed inductively in several stages (Strauss & Corbin, 1994). Given the limited knowledge on REDPs, grounded theory provides the opportunity to establish a framework that can be used to develop a theory grounded in the data.

Data-collection

Semi-structured interviews were conducted with 20 REDPs using a topic list (see appendix A) with open-ended questions based on our research aim and a previous literature review (Bijkerk et al., 2024). The topic list was developed in reflective meetings between three of the authors (CB, LN & RV) of the study. The themes that were included contained previous ED history of the REDPs, experiences and perspectives on their use of experiential knowledge in treatment, advantages and challenges of using experiential knowledge in treatment and their view on organizational conditions and terms to successfully implement their experiential knowledge in treatment.

Procedure

We aimed for the inclusion of at least 17 participants to reach inductive saturation, which according to Hennink and Kaiser (2022) is considered to reach its saturation point between 9 and 17 interviews in homogenous groups. We recruited all current working REDPs by email ($n = 60$), providing them with information about the study and an invitation to participate. Interested REDPs ($n = 26$) received the information letter and the informed consent form. Ultimately, 6 out of 26 interviews were canceled due to scheduling conflicts, logistic reasons or illness. All remaining REDPs ($n = 20$) read and signed an informed consent form prior to the interview.

Interviews lasted approximately one hour and were conducted by the first author (CB), under the supervision of an experienced qualitative researcher (LN). After the first interview, a reflection moment was scheduled to evaluate the content and duration of the interview, allowing for adjustments in subsequent interviews accordingly. Interviews took place from November 2023 to February 2024 and were conducted through face-to-face meetings ($n = 15$), either taking place at one of Human Concern's locations ($n = 6$), at the participant's home ($n = 8$) or a second workplace ($n = 1$). The remaining interviews ($n = 5$) were conducted via Google Meet; a secure digital platform within the online environment of Human Concern. Fieldnotes (e.g., memos and extra questions or subjects) were made. The

interviews were carried out in Dutch using audio recordings and were transcribed verbatim by the first author (CB) and a student assistant. The quotations used in the results section are translated from Dutch to English and might consequently be subject to translator bias. Transcripts were pseudonymized and saved on a secured domain of Human Concern. REDPs were allowed to make additions to the interview through telephone or email. These additions ($n = 2$) were content clarifications and were added to the transcripts.

Finally, demographic data – including sex, age, profession and years of work experience – were collected from all interviewed REDPs through a questionnaire sent to them by email.

Data Analysis

Interview transcripts were transferred into ATLAS-ti version 24, a software program for qualitative analysis. Subsequently, the interviews were coded by creating "free codes" in Atlas-ti, in which segments of data were highlighted and ascribed a meaningful code. We differentiated between subcodes and (main) codes, where subcodes were grouped under one main code, here referred to as a category. When codes could be meaningfully combined, the "merge codes" function in ATLAS.ti was used, and the newly created code was, if required, given a new overarching name reflecting the merged content. Throughout the coding process, memos were created in ATLAS.ti to document reflections on the data. Although ATLAS.ti offers an artificial intelligence-based feature, this functionality was not utilized in the present study.

We analyzed the interviews by thematic coding, whereby a theory is formed from the systematic collection and grounded theory coding techniques are used to develop a set of themes from data (Braun & Clarke, 2006). First a coding framework was deductively developed based on existing literature (Bijkerk et al., 2024) and the research aim. Additionally, the transcripts were inductively explored through line-by-line coding to identify emerging ideas in the data (Bingham, 2023). The first six transcripts were coded separately by the first author (CB) and a student assistant to limit interpretation bias. Codes were discussed in terms of meaning and definition multiple times and discrepancies were discussed and resolved to reach consensus. After coding ten articles we reached a status of inductive saturation meaning that no additional codes were added to the thematic framework (Saunders et al., 2018). Then, we used axial coding to define categories that derived from the relationship between the codes developed in open coding. Finally, selected coding was performed where the resulting themes were organized into four overarching categories supported by our research aims.

Researcher-as-Instrument Statement

The primary researcher (CB) works as a research coordinator at Human Concern and has lived experience with recovery from an ED herself. Her familiarity with the organization's vision and treatment methodology and her own experience enabled her to formulate targeted questions and explore topics thoroughly. We acknowledge that there are potential risks to the role of the primary researcher as she might be subjectively biased due to working at the same organization as her participants. Because the primary researcher has a collegial relationship with the interviewees, this may have influenced the responses provided by the interviewees. No hierarchical relationship exists between the principal investigator and the participants she interviewed, ensuring the voluntary nature of participation and minimizing power imbalance. Furthermore, the primary researcher has explicitly ensured that the interviewees cannot be identified in any data, reports, or articles resulting from the research. The researcher provided and documented information regarding the guaranteed privacy of the participants through an information letter and a consent form. To minimize potential biases, independent researchers specialized in qualitative research (authors LM and RV) were part of the research team. They contributed to the design of the study and supervised its execution including data collection, analyses and interpretation of the results, for example by holding reflexive meetings and frequently discussing the positionality of the primary researcher. The primary researcher entered the interview process with a constructive and open stance, expecting to gain insights into both the advantages and potential challenges reported by the REDPs.

RV is head of the Child and Adolescent Psychiatry department at LUMC Curium, Leiden University Medical Center (The Netherlands). LN is an associate professor and head of scientific research at LUMC Curium, Leiden University Medical Center (The Netherlands). RV focuses on severe and enduring mental health problems, and the value of involving experts by experience in complex care. LN supports youth facing severe and enduring mental health problems, for example, integrated care for youth and their families. MS works as a clinical psychologist/ psychotherapist and lead clinician at Human Concern, located in The Hague (The Netherlands). She has undergone the accompanying training provided by Human Concern, focused on

the therapeutic application of one's own life experiences, and integrates this approach in accordance with the organization's guiding clinical framework.

Results

Demographics

A total of 20 participants were included in our study. All participants were employed by Human Concern and were females of Dutch ($n = 19$) and German ($n = 1$) nationality. The participants had various theoretical backgrounds, namely social work ($n = 8$), pedagogy ($n = 7$) and psychology ($n = 5$). Interviewed REDPs had a mean of 9.8 years of working experience in mental health care (range in years 2–30) and worked as REDPs for a mean of 6.6 years (range in years 0.5–12). REDPs had a history of an ED for a mean duration of 11.2 years (range in years 4–38). All demographic data are summarized in Table 1.

Table 1. Demographic data of the study sample.

(a)

	Professionals			
	N	%	Mean (median)	Range
Age (years)			38.2 (36)	26.0–58.0
Gender				
Male	0	0		
Female	20	100		
Nationality				
Dutch	19	95		
German	1	5		
Education level				
MBO	0	0		
HBO	9	45		
WO	11	55		
Theoretical background[1]				
Psychologist	5	25		
Orthopedagogue	7	35		
Social worker[2]	8	40		

[1]*N* exceeds the total number of professionals because some had multiple backgrounds or ED types
[2]Includes also social pedagogical workers and sociotherapists.

(b)

	Professionals			
	N	%	Mean (median)	Range
Years working in MHC[3]			9.8 (7.3)	2.0–30.0
Years working as REDP[4]			6.6 (6.3)	0.5–12.0
Type of ED[5]				
Anorexia nervosa	9			
Bulimia nervosa	6			
Binge eating disorder	5			
ED not otherwise specified[4]	7			
Duration of ED (years)[4]			11.2 (8.5)	4.0–38.0
Duration of recovery (years)			14.4 (13)	5.0–34.0

[3]MHC=mental health care.
[4]REDP=recovered eating disorder professional.
[5]ED=eating disorder. *N* exceeds the total nr of EDs because of multiple diagnoses of some of the REDPs.

Findings

The motivations of REDPs to engage with their personal experiences in the ED field can be categorized into intrinsic and extrinsic motives. The first group of REDPs was intrinsically driven by their lived experiences to contribute to the field. The second group identified gaps in their own prior treatment or professional practice, such as insufficient practitioner understanding or the absence of experiential knowledge integration. One REDP articulated a dual motivation: addressing her ED experiences while acknowledging ongoing ED challenges which she recovered from fully throughout her work as a REDP.

Our findings are described in the four categories aligned with our aims:

1. Attitudes and approaches on how to utilize experiential knowledge in treating ED clients;
2. Advantages or added value of using experiential knowledge in treating ED clients;
3. Challenges or risks of using experiential knowledge in treating ED clients;
4. Conditions and requirements from organizations or professionals themselves to effectively apply experiential knowledge in treating ED clients.

See appendix B and Figure 1 for a detailed overview of each category's resulting themes.

Category 1: attitudes and approaches on how to utilize experiential knowledge in treating ED clients. Various roles of the REDP emerged from the analysis, including their central role in the treatment process and the multidisciplinary team, being the primary point of contact for clients, and the one overseeing treatment (alongside a lead clinician). A minority expressed criticism regarding the high workload and the emotional load of working with one's experience in treatment. One participant described that all team members should be willing to share their personal experiences if suitable for the client's treatment.

Concerning "self-disclosure on the origins of the ED", we found that many REDPs share the origins of their ED as it provides insight into the roots and the ways their ED serves as a coping mechanism.

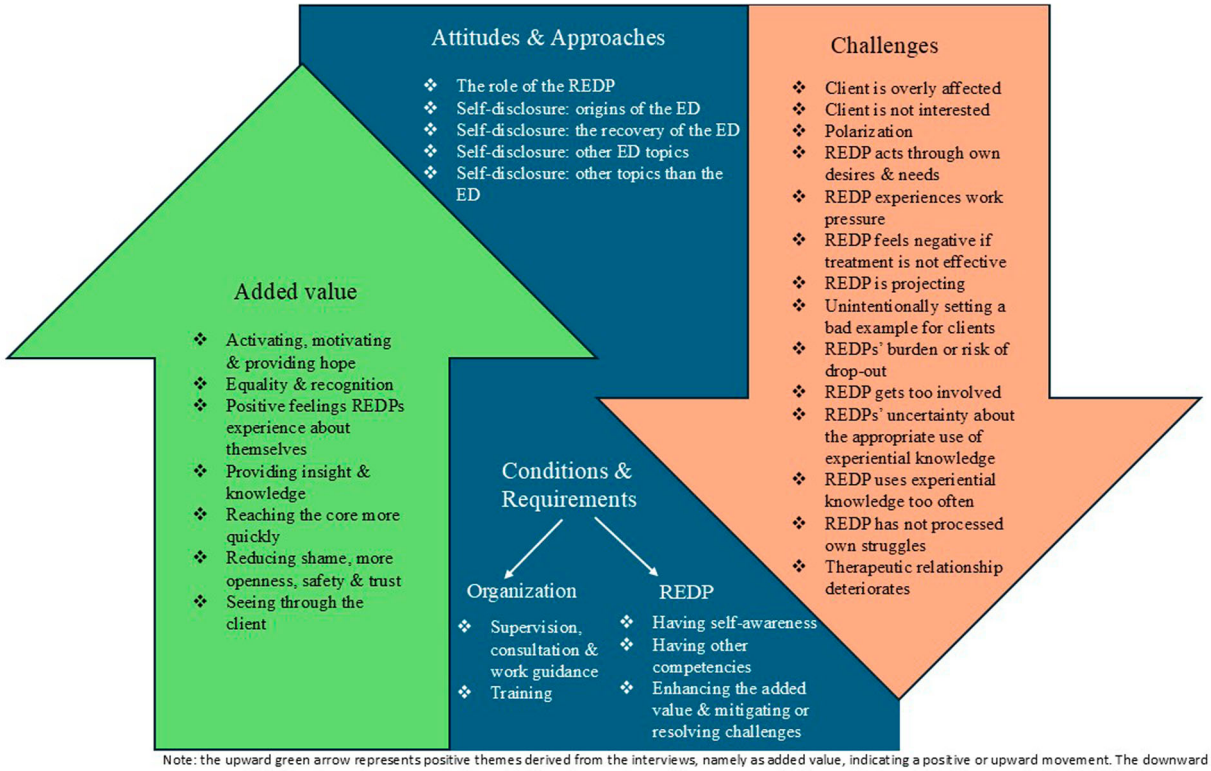

Figure 1. Overview of themes.

Also, REDPs stated that clients often experience a significant amount of guilt, and sharing their story helps to alleviate these feelings of guilt as clients have a better understanding of their ED origins and the underlying aspects.

> You can guide a client through understanding the course of an ED, which often involves many uncertainties that the client may not fully grasp. Therefore, it can significantly aid in enhancing self-awareness of the illness, self-insight, and acceptance, such as realizing, 'You know, it's not something you choose; it's a confluence of circumstances'. – Participant 11

In choosing the content of their disclosures, REDPs described being careful, as improper disclosure can distort the relationship between the REDP and client, or the client may be too vulnerable, making it too burdensome to bear. Additionally, REDPs stated that they modified the origins of their story to the story and background of the client.

> That really depends on the client (…). For instance, when they hear my story, they might think, 'Oh, I haven't been through nearly as much, so my situation isn't that bad after all'. This highlights the importance of assessing who is in front of me and determining what adds value in terms of sharing or not sharing. It's not about being unwilling to share, but rather about recognizing when it simply isn't helpful. Participant – 4

Self-disclosure about recovery from the ED suggests that REDPs primarily share their recovery process when it serves a specific goal or purpose. This could be to support, stimulate, motivate, activate or provide hope to clients. Recovery was seen as a continuum rather than a fixed endpoint, and REDPs' stories do not have to mirror those of their clients. Again, the key is to collaboratively exploring what is effective for the client's recovery.

> Yes, especially that, and particularly the understanding that recovery involves setbacks and progress. It is not a perfect state where everything suddenly becomes ideal, but rather a realistic process in which you learn to cope with challenges. – Participant 15

REDPs also share other ED topics, such as binge eating, excessive exercise and weighing oneself. In addition, REDPs share about non-ED related topics, such as parenting, anxieties, vulnerabilities, self-care, growing up with divorced parents or trauma.

Category 2: advantages or added value of using experiential knowledge in treating ED clients. REDPs claimed that they are living proof

that recovery from an ED is possible. Therefore, they noticed that using experiential knowledge in treatment may provide hope and activate or motivate clients to take steps toward recovery. A second added value REDPs described was the use of experiential knowledge to foster an equal relationship between REDPs and clients, where clients feel recognized, validated, and understood.

> Providing words for something someone feels but may not yet have the vocabulary for can make them feel seen, understood, and validated. I believe that recognition is perhaps the most important aspect—offering acknowledgment. – Participant 1

By providing insight and knowledge into the ED, REDPs help clients in understand the nature of their condition and set realistic expectations for recovery, while also highlighting the potential for ongoing challenges. Moreover, when sharing experiences, REDPs described that in sharing experiences, there seems to be less distance between the REDP and the client, resulting in reaching the core issues more quickly.

The theme "reaching the core or essence" highlights that shared experiences reduce the distance between the REDP and client, resulting in quicker access to the core issues and deeper exploration during sessions. Also, REDPs emphasized that sharing personal experiences contributes to reducing feelings of shame and fosters openness and trust, particularly early in treatment.

> Yes, and also acting as a kind of space holder, providing a safe environment and serving as a role model—showing, without judgment, that within these walls, you are free to try anything and that there is space for vulnerability. I think that's crucial. – Participant 20

Furthermore, REDPs described that they quickly identify and address certain behaviors of their clients as they have lived through similar circumstances. REDPs mentioned they recognize the patterns their clients employ, allowing them to address, confront and challenge behaviors like manipulation, avoidance and other tactics.

> What I find really important is also confronting clients. You can see through the tricks more easily, and it's much easier to call them out because I can say: 'Been there, done that.' You recognize it faster, and it's easier to address it. This includes manipulation and all those kinds of behaviors. – Participant 1

Finally, REDPs also reported positive feelings about themselves, explaining that using experiential knowledge provides REDPs a sense of fulfillment, self-confidence and positive feedback.

Category 3: challenges or risks of using experiential knowledge in treating ED clients. REDPs indicated that most clients are quite vulnerable and often deal with trauma, making it essential not to cross their boundaries by sharing too much or triggering information from personal experiences. Most REDPs indicated they were aware of this risk, however, there are examples where sharing about the professionals' experiences triggers a trauma response in a client.

> Yes, that triggered far too much; they simply weren't ready for it due to their complex issues and severe trauma. They would quickly focus entirely on you, with little sense of their identity. But this is quite minimal though. – Participant 8

Additionally, REDPs noted that the relationship can become strained if experiential knowledge is misinterpreted or misused. For example, when a REDP expects to be idolized by the client. A deteriorated relationship might surface as a dysfunctional dynamic, such as unhealthy dependency, where the client feels the need to care for the REDP, or feelings of frustration develop.

> This is of course not conducive to the therapeutic relationship, for the client, right? Because then the client might think, 'Oh, I have to take care of you', or 'I have to … '. Then you are dealing with countertransference. So, I would say these are the pitfalls of not using your experience properly. – Participant 16

A dysfunctional dynamic can also be the result of REDPs becoming too involved or personally affected by clients' issues, making it difficult to disengage and increasing the chance of potentially prolonging the treatment unnecessarily.

> I find it particularly challenging toward the end of treatment, because each interaction is inherently intimate. However, there remains the agreement that we are client and therapist. As someone approaches recovery, especially when there is a genuine personal connection, I sometimes find myself becoming too personal. I need to monitor this closely for myself, as I can feel when I am doing it. – Participant 2

REDPs reported they must ensure their use of experiential knowledge is focused on supporting clients and not driven by personal desires. While most REDPs described to be aware of the risk of acting through personal desires or needs and regularly self-assess, some still questioned whether their use of experiential knowledge is motivated by the

right intentions. Others reported they noticed new colleagues sharing experiences in a way that felt inappropriate.

> Yes, it's a very tricky area because, well, I can imagine that if you, as a therapist, are constantly feeding your own ego—despite your good intentions—you might end up dragging someone along with you, which can make it inauthentic, almost as if it's being performed. When I say this, I really think, 'I hope it's not like that with me.' I find it quite unsettling because it could very well be the case in some instances. It's definitely something I want to address myself. – Participant 2

Aligning with risks resulting from personal desires, REDPs reported the risk of "projecting" their own experiences onto their clients. This indicates that REDPs consider their own experience as the main truth or reality for all other cases. Most REDPs mention this as a significant risk they are consistently aware of, as illustrated by the following quote:

> (…) even though you may share a similar experience, you can only be a professional from your own perspective. It is also very important to convey this to clients. Clients often come to you in the role of someone who 'knows', as a therapist, and when you share your own experience, they might assume, 'Oh, it must be like that for me too.' (…) As an 'experiential professional', you are only representing your own experience, even if the themes are similar. – Participant 11

REDPs reported high work pressure due to demanding workloads and the personal challenge of using their own experience in therapy. Those with a history of EDs often exhibit perfectionism, setting high standards that intensify the workload. As primary therapists, they face additional pressure, especially when clients show little improvement, which can trigger feelings of insecurity or failure. This can also increase the risk of burnout, vulnerability, or drop-out, with REDPs feeling stigmatized by colleagues or clients due to their ED history. Some also noted frequent colleague drop-outs, linked to the vulnerability of sharing personal ED experiences, which may lead to burnout or relapse into disordered eating behaviors.

> Yes, there is a risk that you bring a certain vulnerability to the workplace. If there isn't sufficient guidance, it requires quite a bit of resilience. You need to stay alert, so you don't fall back into old patterns. I think that it is something that can happen in our work, and it does occur sometimes. – Participant 4.

Some REDPs claimed to be uncertain regarding the appropriate use of their experiential knowledge in practice. In these cases, REDPs question the appropriateness of their self-disclosures, leading to feelings of insecurity and frustration. This risk was more often described by more inexperienced REDPs, who are more likely to go beyond the therapeutic aim of self-disclosures and are less aware of transference and countertransference dynamics.

Furthermore, REDPs explained that they are at risk of unintentionally setting a bad example for clients, emphasizing the need to be mindful of the content and frequency of their sharing, to ensure that the information from their REDPs does not enhance clients' ED behavior.

REDPs described that they need to have processed or clarified their own struggles and not get triggered, to effectively work as a REDP and therefore be capable of sharing personal stories. Many REDPs underlined the relevance of training, work supervision, or other types of support to deal with their struggles or problems when this risk occurs.

> However, for therapists, I believe that because they are continuously engaging with their own narratives and processes, it can be challenging. When something affects their well-being or when underlying themes are brought to the surface, it can place significant demands on them. – Participant 3

The theme "polarization between REDPs and other professionals" describes the impact of the potential difference between REDPs and other professionals (specialists) in the team which results in a twofold consequence according to the participants. First, REDPs are expected to self-reflect and share vulnerabilities. At the same time, clients could also benefit from the involvement of other professionals (specialists without an ED experience), who can also draw on different personal experiences that may support clients' recovery. Second, it emphasizes the potential for unnecessary competition between the two groups, in which the experiences of REDPS with lived experience were considered superior to those of other professionals (e.g., dietitians).

REDPs may also be inclined to rely excessively on experiential knowledge, referring to the risk that when REDPs apply experiential knowledge as the primary method, any other method or treatment technique might be forgotten or lacking.

> With all the associated dangers, one may eventually forget that, wait, we can also simply create a thought record. Before you know it, you are solely focused on that, and as a result, you can become somewhat absorbed in the relationship between yourself and the other. – Participant 1

Although rare, REDPs reported that some clients may be uninterested in their REDPs' ED experience,

due to a limited window of tolerance or reluctance to engage with another's story. Managing a client who reveals less interest, particularly when a REDP has anticipated engagement, might affect a REDP personally.

Category 4: conditions and requirements for organizations or professionals themselves to effectively apply experiential knowledge in treating ED clients. The conditions and requirements necessary to effectively apply experiential knowledge in ED treatment as described by the participants involved two core aspects: organizational adjustments; and the REDPs' responsibility to create the conditions for using their experiential knowledge efficiently.

Regarding organizational adjustments, REDPs often highlighted that supervision, consultation and work guidance are essential for effective work performance, as they can help address the vulnerability REDPs feel due to working with their own personal issues. While supervision, consultation and work guidance have distinct meanings, they are frequently referenced together. REDPs mentioned consultation mostly for case sharing and transparency. Supervision was often linked to work guidance and consultation, without being clearly defined. Work guidance was clarified as crucial for self-reflection, work-related issues, and personal development. Some REDPs expressed concerns about work guidance being provided by lead clinicians rather than REDPs, as lead clinicians often lack personal experience with EDs. They also worried about the lead clinicians' hierarchical role in work evaluation, which may lead to insecurity for REDPs. Frequent changes in lead clinicians were also experienced as barriers to receiving effective guidance. Many REDPs mentioned limited time allocated for guidance, supervision, or consultation, with some recalling this as a past issue and others facing this challenge currently. Another organizational requirement highlighted by REDPs involves the training provided by the organization to enable REDPs to integrate their experiential knowledge into treatment practices effectively.

> But certainly also because of the training we get here; in which you also kind of turn inward toward yourself. So when a client evokes something in you, it doesn't come as a surprise. That you know what it is; if it's really something deeper, then you also take a bit of distance or start working on it yourself. And to keep doing consultations alongside that. – Participant 10

To mitigate risks, REDPs highlighted the need of possessing self-awareness when using personal experience in treatment. Enhancing self-awareness was linked to supervision, consultation, work guidance, and training. REDPs defined self-awareness as the ability to self-reflect, observe oneself and others, and monitor dynamics. When affected by clients' stories or personal resonance, REDPs emphasized the need to discern these feelings and differentiate their narrative from their clients, adopting a broader perspective on the relationship. Finally, a key aspect of self-awareness is recognizing one's own strengths and vulnerabilities.

> If you don't reflect on what is happening within yourself and what you want—truly pausing to connect with yourself—then it becomes a very symptomatic approach that will fade away. You can't maintain it purely through discipline. It's fundamentally about understanding yourself: Why do I need this? Why do I do that? What do I truly want? What do I need for that? Everything is interconnected. – Participant 3

Having competencies beyond self-awareness was also described to be crucial for a REDP, as it involves preserving key skills needed for effective work, including communication, openness, self-confidence, expertise, analytical thinking and the ability to regulate emotions effectively.

REDPs described that they are often aware of the values and potential risks associated with applying experiential knowledge in practice. Therefore, REDPs are constantly balancing the added value with managing the potential risks related to using their experiential expertise. Enhancing the added value or advantages refers to REDPs' aim to elevate their experiential knowledge to maximize its benefit for clients. In cases where harm occurs, REDPs used strategies to manage the situation, such as redirecting the conversation to highlight the client's response, and fostering awareness.

> I had an experience just last week where I shared something, and the client became visibly shocked. So, I asked, 'Okay, what's happening right now?' Immediately, her caregiver mode kicked in, and she expressed concern for me. I recognized this as a pitfall, so I responded, 'Alright, what's going on here?' I was able to turn it around by saying, 'You see, when someone shares something sad—like what I just did—you immediately shift into caregiver mode.' I then asked, 'Look at me; do I need your care right now?' The client laughed and replied, 'No, not really, because you can handle it yourself.' I said, 'Exactly, but it's great that you're becoming aware of how, when someone shares something, you instinctively switch on that caring button.' That awareness can be very useful. – Participant 5

REDPs seek support from supervisors or colleagues when issues arise and reflect on their own triggers to avoid sharing experiences that do not serve the

client's needs. They recognized the importance of aligning with the client's needs and refraining from sharing unresolved personal issues.

Discussion

Through in-depth interviews and qualitative analyses, our study aimed to explore how REDPs utilize experiential knowledge in ED treatment, identify its potential advantages and challenges, and determine necessary conditions for its effective application. Overall, REDPs have a central role in treatment, with self-disclosure occurring in various forms. Several perceived advantages were mentioned, including activation and motivation for the client, as well as enhanced equality, recognition, acknowledgment, and understanding from the REDPs. Challenges reported in the interviews included the client being burdened or affected by REDPs narratives, or the REDP providing inappropriate inspiration which triggered the client. Additionally, REDPS must ensure their use of experiential knowledge is focused on supporting clients and not driven by personal desires. Both organizational and professional prerequisites must be established for successfully implementing experiential knowledge. Organizational conditions include supervision, consultation, work guidance and adequate training. Additionally, REDPs' involvement is key to enhancing the added value and mitigating risks or challenges.

Applying lived experience in practice by a REDP requires them to have additional competence as it places them into a difficult position of balancing self-disclosure with ethical risks to clients and the risks to one's personal and professional self (Beaton, 2020). This competence involves self-awareness, in which REDPs need to discern the feelings behind a client's words and differentiate their narrative from the client to prevent projection or generalization. As described by Costin (Costin, cited in Jacobs et al., 2010), it's about navigating a fine line with insider knowledge and working hard to remain both expert and novice with each client. REDPs understanding of each client must not be overly influenced by their own personal experience.

The role of REDPs encompasses more than simply sharing (disruptive) lived experiences, which is becoming increasingly common in mental health treatment (Karbouniaris, 2020). This sharing is rather an element of the competencies that the REDP should possess. Being a REDP is a distinct profession in which the REDP embodies a trained and qualified professional who has personally experienced and undergone the recovery process of an ED. This personal experience is not merely used for self-disclosure but enables the professional to empathize with the client's struggles, while being aware of its challenges, and offering professional closeness instead of professional distance.

Consequently, our results indicate that REDPs should ensure that they are accessing appropriate supervision, training and support (work guidance). These three components seem to mutually reinforce each other, leading to enhanced skills, more effective treatments, and a greater sense of support. Connection with a supervisor or other REDPs may help REDPs keep their self-awareness and feel less isolated while receiving the support they need to practice ethically (Williams & Haverkamp, 2015). Our study highlights that appropriate supervision, consultation, work guidance, and training play an active role in mitigating the challenges and risks associated with REDPs' treatment practice, aligning with previous research on therapists with ED histories, which shows that supervision, training, and support can protect therapists from negative impacts such as burnout and countertransference (Warren et al., 2012; Williams & Haverkamp, 2015).

The REDPs in this study received training and support that enabled them to effectively integrate their experiential knowledge in practice. However, for "regular" therapists in other organizations this might not be the standard practice, and they lack the resources to effectively integrate their personal experiences into treatment (Karbouniaris, 2020). In fact, professionals are trained to be reserved and self-effacing (Von Peter & Schulz, 2018), while contemporary professional codes of conduct highlight the risks associated with integrating lived experiences, thus creating a barrier to utilizing experiential knowledge (Karbouniaris, 2020). Therefore, it might be beneficial if academic professions adopted a more recovery-oriented approach (which incorporates the lived experiences of people dealing with mental distress and addiction) and included training and support that recognizes experiential knowledge as a valuable asset in supporting patients' recovery.

This study constitutes a preliminary step toward the formulation of informed guidelines for the meaningful integration of lived experience within clinical practice. In this endeavor, it is crucial to account not only for the perspectives of REDPS but also for those of clients, whose insights are indispensable to a comprehensive understanding of effective implementation. Based on the existing body of knowledge, including the present study, it seems that adequate training, professional guidance, and supervision are crucial for organizations aiming to work with REDPs and to maximize the advantages while minimizing the challenges. Organizational

support should also foster the growth and development of REDPs' self-awareness, as they hold a central role in the treatment of clients, while also being exposed to high workloads and the emotional strain associated with working from personal lived experience. A high level of self-awareness enables REDPs to make informed decisions about the relevance and boundaries of self-disclosure in the therapeutic context, to understand the potential risks associated with self-disclosure, and to use their disclosure to support clients in their recovery process.

Strengths and Limitations

The qualitative nature of our study design allowed us to gain in-depth information on how REDPs utilize experiential knowledge in ED treatment, its advantages and challenges, and the conditions for its effective application. By conducting semi-structured interviews, we gained extensive insights into the perspectives of a group of professionals that has not previously been researched in this matter. The COREQ (Consolidated criteria for Reporting Qualitative research) checklist has been used to safeguard the quality of our study by describing a comprehensive and transparent description of our research (Tong et al., 2007). Our study also comes with some limitations. The research population (REDPSs) is underrepresented in mental healthcare; therefore, we were only able to recruit REDPs from one single organization in the Netherlands. In addition, our results are solely based on the perspectives of REDPs. To increase the transferability and credibility of the results, it is necessary to examine institutions abroad that have similar recovered professionals working with EDs, or institutions working with recovered professionals from other types of disorders.

It is important to consider that the observed advantages and challenges pertain to REDPs, and this does not imply that these factors directly result in better or worse treatment outcomes. Moreover, it would be valuable to also reflect on the perspectives of clients treated by REDPs for a comprehensive understanding of how experiential knowledge is utilized and how it's perceived within the treatment context.

The role of the principal investigator presents both strengths and limitations to the study. On one hand, as a colleague of the participants, the principal investigator is familiar to them, which may have made the participants feel comfortable enough to engage openly and transparently in the interview. On the other hand, being a colleague may have led to reluctance among the participants to open up or be fully candid.

Author Contributions

The contributions of the authors are as follows: The introduction and aim were written by CB under supervision and reviewed by LN, MS and RV. CB was responsible for carrying out the interviews. Formal data analysis was carried out by CB, with supervision of LN. LN, MS and RV were responsible for validating the results. The original draft was authored by CB which was reviewed by LN, MS, and RV. The final manuscript was edited by CB.

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GPT-4 model has been used for literature search and language improvement.

Disclosure Statement

No potential conflict of interest was reported by the author(s).

Informed Consent from Participants

Informed written consent to take part in the research has been obtained before the commencement of the study.

Ethical Approval

The Medical Ethics Review Board of the Leiden University Medical Centered judged that the research is not subject to the Medical Research Involving Human Subject Act (non-WMO approval number N.21.092).

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