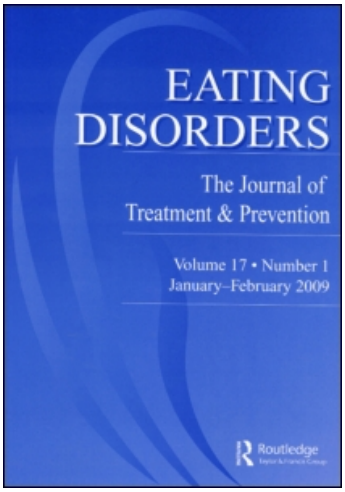

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The Therapist's Appearance and Recovery: Perspectives on Treatment, Supervision, and Ethical Implications

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HOW I PRACTICE

The Therapist's Appearance and Recovery: Perspectives on Treatment, Supervision, and Ethical Implications

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Recently, an AED listserve member requested guidance on confronting a coworker whom she and others at her eating disorder (ED) treatment facility perceived to be "dangerously thin." A spirited exchange ensued in which the vast majority of posts encouraged the writer to confront the individual. Other related issues emerged, including the impact of the therapist's body on the transference and whether recovered therapists should use self disclosure in their treatment. After all, what does our body (or weight, or previous history of an eating disorder) have to do with our professional competence? And does treating this patient population oblige candid self disclosure amongst our clinicians?

The following article was created in response to those exchanges. Eleven clinicians specializing in the treatment of eating disorders collaborated to produce this thoughtful collection. Though each has varying levels of experience, none lack passion or opinion on the subject.

THE EXPLORATION OF BODY IMAGE TRANSFERENCE AS A PATHWAY TO EATING DISORDERS RECOVERY

There are vast individual differences among clinicians with regard to self-disclosure in eating disorders treatment. Some therapists and dieticians are

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open about having a history of an eating disorder. Others feel it is both detrimental and irrelevant to discuss personal history with clients. The existing eating disorders literature currently offers no preferred position on self-disclosure, although a call for guidelines on this topic has been made (Costin & Johnson, 2002).

In addictions treatment models such as Alcoholics Anonymous, providers are characteristically open about their substance abuse histories (Urschel, 2009). They use self-disclosure as a tool to motivate and sustain hope for their clients. Moreover, they continue to attend meetings over the course of their lifetimes, and may in fact attend meetings with current patients. The boundaries between patient and therapist are diffuse and flexible.

Transference is a critical component of any treatment relationship and analysis of the transference is a core psychodynamic principle (Freud, 1912). In traditional psychoanalytic thinking, self-disclosure fundamentally dilutes the transference and distorts patient's projections and perceptions of the therapist. Regardless of orientation and attitudes toward self-disclosure, however, we argue that therapists are not "blank slates" when treating eating disordered clients. Size, appearance, weight, dress, and overall presentation of one's physical self are fundamental statements we present to our patients and can be conceived of as indirect forms of self-disclosure. Moreover, what we eat or drink in the therapeutic space is likely to be judged and scrutinized as well.

The issue may be even more salient between dietitians and their patients, as the dietitian is in the role of advising the patient about specific eating and exercise recommendations. It is likely that individuals who are body conscious may have specific concerns about whether their dietitian is "practicing what they preach," or make assumptions about a dietitian's shape and size. Dietitians as well as therapists should be aware that transferential reactions may impede the patient's recovery progress if not addressed in treatment.

Our position is that by the nature of our physical presence in the room, we communicate something important to our patients. Willingness to process reactions to our physical appearance encourages an atmosphere of trust and healing. In addition, managing these perceptions prevents potential acting out and regression by allowing the patient to explore unconscious beliefs or fantasies directly in a safe context. Winnicott (1965) states that the development of the self involves "a sophisticated game of hide and seek in which it is a joy to be hidden but a disaster not to be found" (p. 186). We suggest that body image transference be invited into the therapeutic space by the therapist in a way that is exploratory, yet not necessarily disclosing. Exploration and analysis of this body image transference can foster intimacy, insight, and revelation.

Often, patients with eating disorders struggle with identity issues; they fail to have a coherent sense of who they are, what they feel, and why they are depressed or anxious. It is difficult to move beyond the superficial world

of food, diet, exercise, and body focus with these patients. A therapeutic impasse might develop when behaviors continue with little or no insight into their origin or emotional meaning of eating disorder symptoms.

Given the potential life-threatening medical dangers and complications when treating eating disorders patients, treatment often becomes mired in focus upon nutrition, behaviors, weight, and symptom management. Therapists then collude with patients' defenses to avoid examination of the emotional meaning and function of the eating disorder. We argue that analysis of the body image transference can be a critical bridge from the superficial world of defense and resistance to the rich, unconscious function of these symptoms.

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TO TELL OR NOT TO TELL: DISCLOSURE IN RECOVERED EATING DISORDER THERAPISTS

In 1978 when I saw my first eating disorder client, it did not occur to me to keep my own recovery from anorexia nervosa a secret. At the time, neither she nor I knew anyone else who had the illness. I thought it was critical for her to know that I recovered and that I knew she could too. In 1978 anyone who was recovered from anorexia was rare and finding a recovered therapist treating someone with anorexia was like finding a needle in a haystack. How could I withhold this information? In fact, she was referred to me precisely because I had suffered this same mysterious illness. For us not to have discussed my anorexia and the fact that I was "recovered" would have seemed bizarre and voyeuristic.

I did not have any guidelines to follow as to how much to reveal or how to even treat this client. Self disclosure was inevitable considering that asking her certain questions in our initial intake revealed my "insider" knowledge, as she put it, "How could you have known to ask me that? No one has ever asked me those things." In my first session and thereafter I carefully disclosed certain things to help her understand that I completely "got her," but mostly I disclosed the things I did that helped me to get better. I believe recovered clinicians should follow the same principle today. As is true for disclosure by a therapist of any kind of problem, it is not important for clients to know the details of the problem but rather how the therapist used resources to combat it.

There is very little written regarding therapists with personal histories of eating disorders treating those currently suffering with these illnesses. The few that exist are listed at the end of this article. Therefore, when I first

became a therapist I was on my own in regards to how to handle the situation. In 2002 after 24 years of dealing with this issue in my practice I co-authored an article with Craig Johnson titled, "Been There Done That, the use of Clinicians with Personal Recovery in the Treatment of Eating Disorders" (Costin & Johnson, 2002). Recovered clinicians must navigate a fine line with their "insider" knowledge and work hard to remain both "expert" and "novice" with each client. Even though they think they understand what a client means or is going through because they have "been there" it is critical that their understanding of each client is not being overly colored by their own personal experience. Each client and each situation is unique.

Clinicians have to be careful not to place treatment expectations on their client based on what the clinician was able to do or believed worked the best. For example, a recovered therapist might have found recovery with a certain kind of meal plan or medication but must be careful not to impose this on clients without good reason other than, "it worked for me." Another example is that I say I "recovered" from my eating disorder and did so without the help or even knowledge of the 12-Step program. However, there are clients who have found benefit from the 12-Step program and prefer to use the term "recovering" rather than recovered. It is important that I clarify what these terms mean to both of us and that I understand and respect what is best for each client.

Self disclosure in any form is a tricky part of our work as therapists. Disclosing personal information about one's previous eating disorder can fast become a slippery slope. If the decision is not a clear one, I always advise my interns and my staff, "When in doubt, err on the side of nondisclosure." We must each do our best to think through all of the delicate issues that may arise when and if we use our personal experiences in the treatment setting. We have to be thinking several steps ahead. Any information shared must be done wisely and prudently to impart understanding and facilitate healing in the best possible way for those entrusted in our care.

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THE TRANSFORMATIVE POWER OF SELF DISCLOSURE

Andi and I had been eating apple slices together for several weeks. One day I told her I was bored with apples. Would she consider sharing a muffin with me next session?

Andi took a deep breath. "Do you ever worry about gaining weight?" she asked me.

"Wow," I said, "I'm really proud of you for asking me this—I bet that took a lot of courage!" Andi beamed. "I notice you are beaming," I said. Andi nodded and blushed. "And you're blushing…" I said. Intentionally I focused first on our process: her risk taking and curiosity.

Now—back to her question about me. I recalled the shame I'd felt years ago when I'd innocently asked my therapist where she was going on vacation and instead of an answer was met with a frigid stare. I'd been taught to avoid these kinds of self disclosures and turn the question back to my patient, but a small voice inside encouraged me to side step this taboo and lead with my vulnerability, believing that selective self disclosure facilitates authenticity and breeds self disclosure (Rabinor, 2009).

"I know I'm normal weight, but even knowing that, believe it or not, sometimes I do worry about eating too much—and gaining weight too." I said, hoping to de-pathologize and validate her personal struggle. She glanced up at me, smiled and as our eyes met, I thought to myself, "This seemingly insignificant tidbit of information means the world to her!"

"Now I have a question for you," I said, "What's it like for you to know your therapist—who is a normal weight person—can worry about gaining weight? Can I be just as nutty as you?" A big smile spread across her face. "Is there anything else about me you are curious about—because I really want you to ask me whatever you want to. I can't promise I'll answer every question, but speaking up, saying what's on your mind and asking hard questions is really important—in this office and outside of it too." Andi was wide eyed, and once again, I learned about the transformative power of being authentic, genuine and present with what is.

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WHEN THE THERAPIST HAS A BODY

During my 25 years of work as a psychotherapist in the disordered eating community, I have found myself more aware of my body within the therapeutic relationship. My weight has changed over time as I have matured and found life affecting my relationship with food. The loss of a parent, a divorce, a major surgery and pregnancy have all affected me, as those life events would affect anyone. Always, I have returned to my normal eating habits, which leave me looking like a maturing, evolving version of my short, curvy and generally thin self. Each change however, written on my external self, has been observed by my clients.

The strongest moments in therapy come when clients have courageously asked me about what they see, and compared their world view with my own. One study (Warren, Crowley, Olivardia, & Schoen, 2009) queried providers regarding client comments about the therapists' bodies and found that 25% of clients had something to say. Jenny, a 28-year-old client struggling with anorexia, had nothing to say at first. She had developmentally stopped her sexual growth at around age 14, and as my girth widened during my 38 week gestational period, she became visibly less comfortable in the room. Most of my clients were told of my pregnancy as I "showed" so the discussion about my maternity leave could begin. While many had guessed, or asked once they determined I was not just gaining weight, Jenny did not. She ignored my words, other than to ask about the therapist covering my practice when I was away. Her eyes would stay on mine; steadfastly ignoring what was changing me. Finally one day, she asked how I felt being fat. It was a huge turning point in therapy for her to allow me to "enter the room" and for my pregnancy to be noticed by her. "I do not feel fat," I replied. That message shocked her and led to a wonderful exploration of how other women may feel about themselves, parenting, and related bodily changes. It is a powerful process to share and be prepared to hear fantasies about your life, your work and your body that can be easily turned into fuel for client exploration and growth.

And how women feel about themselves and their bodies is always in the room. Whose responsibility is it to talk about it? Lowell and Meader (2005) report that therapists' bodies become part of the discussion as clients feel more open to self reflection about their own bodies. Some clients have asked me how I stay thin (do I have an eating disorder?); while others wonder if their hips will grow from childbirth as well (could they ever parent a child?). What about the clients who say nothing about the therapists' body? I use a lot of techniques which include movement, changing seats with a client, drawing and imagery. Often, this is when the questions begin. Finding the right space to honor and hold their courage for asking, to wonder about the possible underlying meaning in their questions, and to explore their worry about how their fears affect or contaminate us provides rich therapeutic material. There is a ripe potential in these discussions to allow ourselves to carefully, non-judgmentally, wonder with our clients about the messages women hold about themselves which they absorb from society, family and low self esteem. Fat is a feeling that emerges here, and I work with that feeling as I work with feeling sad. It is profound to share, within reason, challenges to the self that we, as women therapists, must not only teach but must live. If you have never had a fat day, you are a rare woman; and sharing just enough of this feeling can break open the myths that everyone else, including you, feels good, happy, gorgeous and brilliant all of the time. As we work to be more embodied and open in the therapeutic relationship, so will our clients.

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TAPESTRY: ENDORSING DIVERSITY AMONG EATING DISORDER THERAPISTS

I've learned that the way we view events depends largely on the depth of our experiences; that we are in a perpetual process of learning and only in hindsight will we see the many missed opportunities for kindness and cohesion. It is in this spirit that I write with heartfelt passion.

In January 2009, when the topic of therapist size and recovered therapists was discussed in detail on the Academy for Eating Disorders' listserve, I read the comments with curiosity, cynicism, and increasing fury. As the posts appeared on my screen, my computer appeared to grow warm from the heated and pointed exchanges. While the strong views we hold on the care of patients can be contradictory, the views we hold on how to support one another became utterly conflicted.

Therapists recounted stories of being told by their eating disorder staff that they were "too thin," and "triggered the patients." There was also reference to overweight therapists lacking credibility. It astonished me that that there was no public outcry or call for challenge in this line of thought.

Prior to considering whether I would enter the field of eating disorders, I had the opportunity to peruse the staff photographs of numerous eating disorder facilities. I noted that there was a stark homogeneity to the staff that is not reflective of the population at large. While NEDA may have had a theme in the past of "Eating Disorders come in all shapes and sizes," staff members at eating disorders facilities usually do not.

As a person of color and size with a history of an eating disorder, I've become attuned to potential spoken and unspoken biases against size and perceived well being that has been intimidating, disrespectful and maddening. Unfortunately, as a junior clinician, rules of hierarchy and lack of authority have often prevented me from speaking out or trying to create change.

Since we are aware that at least 27% of our clinicians have had an eating disorder (Barbarich, 2002), I appreciate that we have organizations, forums and journals that allow discussions about recovered clinicians to be front and center. By contributing to this article and joining recruitment committees, we can play a proactive role in seeking out heterogeneity. Offering our clients, who are becoming more diverse on a daily basis, a more representative sample of America in their clinicians would be a welcome contrast to the homogeneity of many staff profiles. We teach our patients that self worth is not measured on a scale; hence we must practice this in our daily

lives with our colleagues and ourselves. As we continue to take on new challenges as a community, our cohesiveness is dependent on our ability to respect and support each other. These are the healthiest things we can model for our patients.

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SUPERVISION ISSUES—ENHANCING THE HEALER'S EFFECTIVENESS IN EATING DISORDER TREATMENT

As Director of the Partial Hospitalization and Intensive Outpatient Programs at Penn State Hershey Medical Center, I supervise our program therapists. Throughout my years of supervision, I have found that sometimes thoughts and behaviors which should be brought to supervision are the precise ones that are excluded. This happens either because of the therapist's inexperience (just not realizing the importance) or the desire to look more skilled.

Often I learn about issues from other team members or patients themselves. For example, one therapist discussed her own exercise regime with patients, thereby fueling their anxieties. When another therapist started limiting certain carbohydrates in her diet, she focused on this same issue with patients (despite our team dietician being responsible for nutritional guidelines). As a result, her patients felt overly criticized by her comments. As a supervisor, I couldn't allow that to continue. However because the therapist didn't bring the issue to supervision, she felt defensive when the topic was broached.

Rather than arguing about her intentions, I focused our discussion on the patients' perceptions of her comments. Even if the therapist did not intend to cause harm, if her patients experienced lowered self-esteem, body image and/or mood because of these interactions, the therapist's approach had to be reexamined. Therapists may not be aware of their influence on patients, including the significance of self-disclosure about exercise or diet. These actions can have a profound effect. Because of this, the therapist and supervisor need to work together to reexamine sessions and understand when and how comments and/or actions could have been triggering for patients.

Providing supervision can be difficult, but the tough subjects regarding therapy have to be tackled. Treatment literature describes a parallel process between supervision and therapy. Emotions in therapy often reoccur in supervision (Whitman & Jacobs, 1998). If we (therapists and supervisors)

feel discomfort, the patient may be feeling this too. We need to discuss these feelings openly—with sensitivity and care—or risk mimicking the secrecy in our patients' lives.

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WHOSE BODY? WHOSE BUSINESS?

While the AED listserve community focused their attention on the content of the initial post mentioned above, I focused on the rapid process by which our professional community reflexively interpreted the colleague's weight loss as resulting from an eating disorder (vs. medically ill, or depressed), and it raised a number of questions in my mind. How much does the focus of our field of treatment narrow our field of vision? What if the supervisor had dealt with the situation, the effects or details of which were legitimately no one else's business? Does an employee's thinness carry more worrisome weight in the eating disorder work setting than weight cycling or obesity? In other words, from an employment standpoint, are the physical, psychiatric and cognitive effects of bingeing and/or purging associated with bulimia and binge eating disorder of equal cause for alarm as those associated with anorexia nervosa? Based on what objective data?

Each question begged another, and the sociopolitical implications loomed large. Who decides and when does an eating disorder therapist's body and health legitimately become his/her colleagues business? More pointedly, what does our body or weight have to do with our professional competence?

My perspective is informed as a psychologist but I suspect all of the healing professions have similar ethical and legal guidelines. Psychologists are ethically required to intervene if we suspect a colleague is impaired in his/her ability to practice according to abiding standards of care (APA, 2002). It is critical, in this context, to not confuse impairment with an ethical violation—the former does not always imply the latter. Equally critical but perhaps more elusive, is the issue of defining and determining impairment when most of what we do as therapists occurs behind closed doors and under the protective cloak of confidentiality. To flesh out the inherent predicament most literally—a therapist's weight (or weight loss as noted in the listserve post), should not be the focus of a confrontation from a strictly business, ethical, or legal standpoint. A therapist's performance is rightfully a matter of objective review. In the absence of evidence of impairment in professional functioning, our colleague's bodies are really not meant to be

our business (Adamitis, 2000; Solovay, 2000). There are national organizations dedicated to protecting the rights of those facing weight discrimination (e.g., Council on Size and Weight Discrimination). Michigan is the only state to make it illegal, but with rare exception, outside of our tiny field of eating disorders, employees' weights and eating habits do not figure into their performance reviews or their colleague's consciousness—at least with regard to their professional functioning.

Returning, then, to the fundamental question: are our colleagues' bodies our business simply because we're in the business of bodies? Depending on the level of inquiry (personal, professional, ethical, legal), the answers I have definitively arrived at are yes, yes, maybe, and almost always, no! Yes and yes on the personal and professional levels, given the specific content and context of eating disorder work and especially for those of us with known personal history who are demonstrating observable signs of relapse. It is noteworthy, however, that I was unable to find a single published article addressing if, how and under what circumstances an eating disorder specialist's weight or questionable symptom status should be confronted. Nor did anyone from eating disorder treatment facilities reply to my request on the listserve for copies of their policies on this matter. It appears this is addressed on a case by case basis, informed by little, if any, data directing the process.

On the ethical front, the answer appears to be maybe and only in so far as weight changes are associated with an underlying condition which is impairing one's capacity to effectively function (i.e. weight status is thus not the primary issue, but a potential symptom of a compromised mental or physical status). Finally, and most definitively, where legalities weigh in on the dilemma, it is almost uniformly discouraged if not disallowed to address an employee's weight or appearance.

All things thus considered, confronting a clinician considered impaired related to an eating disorder is complicated at best, risky at worst. Where the personal and professional imperatives collide with the ethical and legal constraints, a critical juncture is exposed that we have not adequately addressed as a field. Decisions are likely influenced by one's professional as well as body biases, empathic regard or collegial indifference, position of power or lack thereof, and avoidance of or comfort with conflict. Seeking supervision at such times seems prudent, if not essential to determining a proper course of action. The writer on the listserve is to be commended for bravely reaching out to her colleagues, and thanked for the provocative and illuminating discourse (including this article) which it inspired.

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REFERENCES

Adamitis, E. M. (2000). Appearance matters: A proposal to prohibit appearance discrimination in the workplace. *Washington Law Review*, *75*, 195–223.

American Psychological Association. (2002). *Ethical principals of psychologists and code of conduct*. Washington, DC: Author.

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

Costin, C., & Johnson, C. L. (2002). Been there, done that: Clinicians' use of personal recovery in the treatment of eating disorders. *Eating Disorders*, *10*, 293–303.

Freud, S. (1912). *The dynamics of transference*. London: Hogarth.

Lowell, M. A., & Meder, L. L. (2005). My body, your body: Speaking the unspoken between the thin therapist and the eating-disordered patient. *Clinical Social Work Journal*, *33*, 241–257

Rabinor, J. (2009). Self disclosure as a turning point in psychotherapy. In A. Bloomgarden and J. Mennuti (Eds.), *Psychotherapy revealed* (pp. 55–70). New York: Routledge.

Solovay, S. (2000). *Tipping the scales of justice: Fighting weight-based discrimination*. Amherst, NY: Prometheus Books.

Urschel, H. (2009). *Healing the addicted brain: The revolutionary, science-based, alcoholism and addiction recovery program*. Naperville, IL: Sourcebooks, Inc.

Warren, C. S., Crowley, M. E., Olivardia, R., & Schoen, A. (2009). Treating patients with eating disorders: An examination of treatment providers' experiences. *Eating Disorders*, *17*, 27–45.

Whitman, S. & Jacobs, E. (1998). Responsibilities of the psychotherapy supervisor. *American Journal of Psychotherapy*, *52*, 166–175.

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment*. New York: International Universities Press.