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# THE EXPERIENCE AND MANAGEMENT OF COUNTERTRANSFERENCE AMONG THERAPISTS WORKING WITH ANOREXIA NERVOSA: AN EXPLORATORY STUDY

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The Experience and Management of Countertransference among Therapists Working with Anorexia Nervosa: An Exploratory Study

Anoreksiya Nervoza ile çalışan Terapistlerin Karşıaktarım Deneyimleri ve Yönetimi: Nitel Araştırma

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## ABSTRACT

This study provides an extensive examination of the personal experiences of psychodynamically oriented psychotherapists who work with patients who struggle with Anorexia Nervosa. It specifically looks at how these psychotherapists view Anorexia Nervosa, how they describe and understand their own internal process during the treatment and how they manage and use their feelings of countertransference to enhance the therapeutic process. Following a comprehensive literature review, in-depth interviews were conducted with five psychotherapists who have experience in the area. Interpretative Phenomenological Analysis was used to extract themes on psychotherapist's perspectives on their work, and the following main themes emerged: the concept of "the anorexic state of mind"; the therapist hypervigilant state during the therapeutic process; the therapist's maternal, starvation and abuse related feelings within the therapy relationship; countertransference as a tool that can enhance empathic attunement and awareness for both the therapist and client; and the important role of support resources and self-care as it applies to countertransference. These results were discussed in the context of the contemporary literature and clinical implications, and recommendations were made regarding future research.



**Key words:** Anorexia Nervosa; Countertransference; Countertransference management; Therapist's experience; Interpretative phenomenological analysis.

# ÖZET

Bu çalışma Anoreksiya Nervoza tanısı almış bireylerle psikodinamik yönelimle çalışan psikoterapistlerin deneyimlerini derinlemesine incelemeyi amaçlamaktadır. Anoreksiya Nervoza'yı nasıl kavramsallaştırdıkları, bu hasta grubuyla terapi sürecinde öne çıkan unsurlar, karşıaktarım duyguları ve özellikle bu duyguların seanslarda terapötik çalışmayı destekleyecek şekilde kullanımı araştırılmak istenmiştir. Giriş kısmında Anoreksiya Nervoza konusu ve bu hasta grubuyla çalışan terapistlerin olası karşıaktarım deneyimleri geniş bir çerçevede ele alınmıştır. Psikoterapistlerin kendi bakış açılarını ifade edebilmeleri amacıyla beş tane psikoterapistle derinlemesine görüşmeler yapılmıştır. Ulaşılan kalitatif datanın Yorumlayıcı Fenomenolojik Analizi sonucunda ortaya farklı temalar çıkmıştır. Özellikle Anoreksiya Nervoza, anoreksik zihin ile kavramlaştırılmıştır. Terapi süreciyle ilgili tetikte olmak teması, deneyimlenen karşıaktarım duyguları ile ilgili annelik, açlık/mahrumiyet ve suistimal temaları ön plandadır. Son olarak bu duyguların terapötik olarak yönetilmesiyle ilgili seanslar arasında ve sırasında farkındalığa yönelik çalışmalar, destek kaynakları, terapistin kendi duygularından yola çıkarak hastayla empatik bir ilişki kurabilmesi ve hastanın farkındalığı üzerinde çalışmak beliren temalardır. Sonuçlar literatürle ilişkilendirilerek tartışılmış ve klinik uygulamaya yönelik öneriler sunulmuştur.



**Anahtar kelimeler:** Anoreksiya Nevroza, Karşıaktarım, Karşıaktarım yönetimi, Terapistin deneyimi, Yorumlayıcı fenomenolojik analiz.

# CHAPTER I
# INTRODUCTION

Today there is a general acceptance that it is part of the therapeutic process for therapists, novice or experienced, to experience countertransference (Gelso, 2013; as cited in Cartwright, Rhodes, King, and Shrines, 2014). In line with this, a recent meta-analytic review of countertransference research suggested that the therapist's countertransference reactions have an inverse relationship to therapy outcomes while successfully addressing countertransference responses corresponds to positive changes in therapy (Hayes, Gelso, and Hummel, 2011). Therefore, how a therapist manages countertransference is considered crucial to the therapeutic relationship and outcome (Fatter and Hayes, 2013; as cited in Cartwright et al., 2014).

Reports on successful psychotherapy with clients presenting with Anorexia Nervosa are especially discouraging due to the egosyntonic aspect of the illness (malnourished conditions seem to be unrecognized by the patient) and the reluctance of the patients to contain any attempt to accept help from therapist (Strober, 2004). Furthermore, treating Anorexia Nervosa is especially confusing and challenging because the condition violates our basic assumptions about life and death (Satir, 2013). The individual with Anorexia Nervosa exhibits a severe paradox: she sacrifices the self in an attempt to shape her own life. In essence, she is trying to do the undoable: survive *without* sustenance (Charles, 2006).

Interesting, given the complexities of treatment, and despite the acknowledgement of the countertransference challenges associated with treating individuals with Anorexia Nervosa, there is a scarcity of research that focuses specifically on the countertransference experience and management in the context of Anorexia Nervosa.

The current study is a qualitative examination of therapists' subjective experiences with regard to countertransference as well as countertransference management over the course of psychotherapy with individuals with Anorexia Nervosa. The scope will focus on the therapists who have adopted a

psychodynamic approach. It is suggested that this type of psychotherapy requires an intensive experience over a relatively longer period of time during which the therapist observes, understands, and manages his or her feelings through a persistent and conscious analysis of countertransference (Tobin, 2012). In this study it is believed that interviewing therapists with a psychodynamic mindset will offer the deepest insight into countertransference reactions. Since most clients with Anorexia Nervosa and/or Bulimia Nervosa are female (Bachar, 1998; Hamburg and Herzog, 1989; Tosca, Ritchie, and Balfour, 2011), this study will refer to the client in the feminine form. Additionally, the term "countertransference" will be used to refer to all of the therapist's reactions to the client independent of its sources (Satir, Thompson, Brenner, Boisseau, and Crisafulli, 2009). This comprehensive definition considering several sources (e.g., patient, therapist, therapy modality, or process dimensions) is expected to keep the researcher and the participant awake to and aware of unexpected themes that may surface during the interviews.

The introduction to this study has five parts. The first part contains a description of Anorexia Nervosa from psychodynamic theory as well as presents the diagnostic criteria for Anorexia Nervosa according to the DSM-V. The second part reviews the etiology of Anorexia Nervosa, which includes sociocultural, genetic, and family related factors as well as the psychodynamic models that explain the etiology of the disorder. The third part consists of treatment modalities developed for Anorexia Nervosa: CBT, integrative approaches, novel therapies, and interpersonal and psychodynamic psychotherapy. The fourth part begins with a focus on countertransference and its management in general: the concept's historical evolution, theorists who have contributed to the body of work on countertransference up to contemporary views, and key concepts for a better understanding of the phenomenon. This is followed by a more narrow focus on countertransference literature with regard specifically to Anorexia Nervosa. Finally, the fifth part describes the objectives of this study.

It was determined that this study should be a qualitative one in order to grasp and absorb therapists experiences since the focal point is the subjective

experiences of each participant and to gain insight applicable to the clinical setting. The choice of qualitative method for a study with this kind of intention is also supported by the literature. It is suggested that for clinically oriented research especially with regard to eating disorders, qualitative methods provide the most useful findings (Jarman, Smith, and Walsh, 1997; Gilgun, 2005). Hill (2011) also argues that research about countertransference has moved into a qualitative paradigm.

## 1.1. DIAGNOSTIC CRITERIA FOR ANOREXIA NERVOSA

The first criterion of the DSM-V diagnosis for Anorexia Nervosa is low weight. Accordingly, this weight loss, which leads to a significant drop in body weight, is intentionally manifested by conscious food restriction as would be expected for the patient's age, sex, and developmental stage as well as overall physical well-being. The definition of "significantly low weight" is calculated as an amount that is well below what is considered minimum normal weight for the person's age (Hebebrand and Bulik, 2011). Hebebrand and Bulik (2011), in their alternative proposal for the DSM-V, argue that the term "expected weight "may be misleading because what is considered expected weight is calculated from research of the general population. Additionally, among healthy individuals there is often fluctuation of weight for the same age and height. This may lead therapists as well as their clients to fixate and be preoccupied specifically with weight, which is only one of the symptomology of AN. In line with this, Föcker, Knoll, and Hebebrand (2013) argue that weight criterion needs some clarifications such as a standard or references. In their opinion, the term "restriction of energy intake relative to requirements" is also difficult to verify.

The second criterion is the persistent and deep fear of weight gain and purposeful behavior that inhibits weight gain despite the presence of weight loss and low weight. It is argued that including the additional term "persistent behavior that interferes with weight gain" next to "fear of weight gain" is a good step since the weight phobia may depends on illness stage or culture (Föcker, Knoll, and

Hebebrand, 2013; Hebebrand and Bulik, 2011). It is reported that there is are many clients who experience symptoms of Anorexia Nervosa, and whose body mass index is between the definition of moderate to severe thinness (17.0 kg/m) and what defines the lower limit of normal weight (18.5 kg/m), yet who do not fear weight gain (Brown, Holland, and Keel, 2013). It is argued, however, that even if such an individual does not admit or adhere to the desire to intentionally lose weight and restrict food, they still may be at risk for all of the complications of Anorexia Nervosa (Mannix, 2012). Accordingly, this fulfillment in the DSM-V provides a detectable clinical symptom independent of weight phobia for Anorexia Nervosa.

The third criterion reflects the individual's distorted body image, excessive focus on body weight, image, and shape, and an inability to see the gravity of low body weight. It is argued that the lack of explanation about how to judge "seriousness" diminishes the diagnostic sensitivity. Hebebrand and Bulik (2011) comment that the term "seriousness" is not a concrete concept since there is a grey zone of body mass indexes that lie between 15 and 18 kg/m and even doctors cannot agree on what constitutes being seriously underweight. It is also added that the discussion about the seriousness of low body weight may become more problematic if parents, or friends become the judge of it (Hebebrand and Bulik, 2011).

The DSM-V maintains subtypes of the disorder: the restricting type, which means that the individual is not binge eating and purging repeatedly or overly using diuretic aids for a period over three months and the binge eating/purging type, which means that the individual is binge eating and purging repeatedly or overly using diuretic aids for a period over three months.

## 1.2. ETIOLOGY OF ANOREXIA NERVOSA

To date, much is still undiscovered about Anorexia Nervosa's causative mechanisms and interactive effects (Woerwag-Mehta and Treasure, 2008). Recent findings report that Anorexia Nervosa emerges in individuals with specific

genetic predisposition and characteristic personality traits, such as significant anxiety, obsessive behavior and perfectionism, inflexibility, and poor social cognitive functioning that would have been observed prior to the onset of Anorexia Nervosa. Some sociocultural values, slimness, starvation induced brain and hormonal deficits may lead to the onset of Anorexia Nervosa (Herpertz-Dahlmann, Seitz, and Konrad, 2011). Some family types (Jurma, Morariu, Albulescu, and Velea, 2015) and developmental deficits are also identified to lead to Anorexia Nervosa (Schmidt, 2003). Especially between 60's and 70's an "anorexogenic family environment" was thought to be necessary for Anorexia Nervosa to emerge (Schimdt, Humfress, and Treasure, 1997; as cited in Schmidt, 2003 p.30). All in all, risks factors for Anorexia Nervosa can be conceptualized in 3 groups: sociocultural, genetic, and familial. In addition, there are several psychodynamic models, which attempt to capture the causative mechanisms of the disorder.

### 1.2.1. Sociocultural Factors

Sociocultural factors are also known to have an impact on the development and pervasiveness of eating disorders. In western countries, slimness is equivalent to beauty and attractiveness (Herpertz-Dahlmann et al., 2011). Stice, Gau, Rohde, and Shaw (2017) suggest that pursuit of the culturally desirable thin ideal and body dissatisfaction, dieting and maladaptive weight control behaviors as its results increase risk for eating disorders. This study found that sociocultural factors have a more potent role in the attitudinal portion of especially anorexia nervosa compared to other eating disorders of DSM-5.

In 2004, Hawkins, Richards, Granley, and Stein wrote that exposure to the media, which perpetuates an idealization of thinness, has an influence on an individual's ways of eating and self-image. In the same manner, pressure from family members is argued to increase body satisfaction resulting in restrictive and bulimic behaviors increase, also peer pressure regarding weight is also found to be directly related to dietary restraint (Nilsson, Abrahamsson, Torbiornsson, and

Hagglöf, 2007). Likewise, Woerwag-Mehta and Treasure (2008) stated that unhappiness with the body and attempts to diet can be predicted by peer influences. Researchers also add that dieting may become a trigger for binging and purging in AN.

Furthermore, it is reported that individuals with certain occupations (e.g., athletes, models, and ballet dancers) are more susceptible to develop eating disorders (Woerwag-Mehta and Treasure, 2008).

### 1.2.2. Genetic Factors and Biology

Regarding genetic factors, in eating disorders, twin studies suggest a heritability of between 58% and 74% (Woerwag-Mehta and Treasure, 2008). Woerwag-Mehta and Treasure (2008) also report that symptoms of eating disorders such as dietary restraint, self-induced vomiting, eating, weight preoccupation, and body dissatisfaction have a heritability of 32 to 72. Linkage analyses suggest the involvement of chromosome 1 for AN (Woerwag-Mehta and Traesure, 2008; Herpertz-Dahlmann, Seitz, and Konrad, 2011). In line with this, Herpertz-Dahlmann et al. (2011) suggest that there are familial factors associated with Anorexia Nervosa. Those who are one generation away from a relative with Anorexia Nervosa or Bulimia Nervosa are 7 to 12 times more likely to develop a disorder than the control group. A close familial presence of anxiety as it manifests through obsessive-compulsive and affective disorder makes the chances even higher.

Concerning biologic factors, it has been shown that degenerations in hypothalamic function, which is known for its important role on the regulation of eating, appetite, food intake, and nutrition, exist in patients with AN (Clarke, Weiss, and Berrettini, 2012). However, there remains uncertainty in the determination of the exact cause-effect. Biological imbalances may be the cause of the disorder or may be the physical results of the disorder. In line with this, again Clarke et al., (2012) report that diet can alter gene expression as a result of

undernutrition. In any case, the presence of some biological factors in eating disorders is clear.

Strober (2014) emphasizes that temperament also plays a role in the development of the Anorexia Nervosa. Temperament can be described as including biological constitution and enduring patterns of behaviour that regulate interactions with the environment and consequently shapes one's identity, self-concept, personality, and psychopathology. In a very consistent manner, people with Anorexia Nervosa exhibit traits that were noticeable in childhood such as vigilant control of behavior, tendency to avoid feelings and new experiences, rigidity perfectionism, compared to people who are not diagnosed with the disorder (Vitousek and Manke, 1994; Herpertz-Dahlmann, et al., 2011). Hilde Bruch (1985; as cited in Herpertz-Dahlmann, et al., 2011) noted that early childhood histories of individuals with Anorexia Nervosa reveal some peculiarities. She suggests that Anorexia Nervosa appears in unusually good and successful children who aim to please others. Separation anxiety disorder and social phobias are the most common anxiety disorders that are found in childhood histories of patients with Anorexia Nervosa (Herpertz-Dahlmann, et al., 2011). Adolescents and adults with Anorexia Nervosa usually strongly exhibit rigid, obsessive and perfectionist behaviors, thus suggesting that when these traits appear in childhood they can be predictors or risk factors for the emergence of Anorexia Nervosa later in life (Herpertz-Dahlmann et al., 2011). These personality traits not only constitute psychological risks for Anorexia Nervosa, but are associated with its core diagnostic phenomenology (Kaye & Strober, 2004; as cited in Strober, 2004). Hayes, Wilson, Gifford, Follette, and Strosahl (1996; as cited in Wollburg, Meyer, Osen, and Löwe, 2013) described a particular type of emotional avoidance: the desire to avoid particular personal experiences that arise through sensation, feelings, thoughts, memories and behavioural predispositions. Furthermore, trying to change the actual experiences themselves: how they occur, how often, and in what context. Schmidt & Treasure (2006; as cited in Wollburg et al. 2013) comment that this emotional avoidance is a core problem in Anorexia Nervosa pathology. Being emotionally avoidant includes

rigidity that affects cognition and leads to perfectionism, therefore facilitating behaviors typical for Anorexia Nervosa, such as self-starvation, or specific dietary restrictions (Wollburg et. al, 2013). Once starvation occurs, one's temperamental characteristics give shape to Anorexia Nervosa's fingerprint that is obsession-like restraint eating to numb the psyche (Strober, 2004). In turn starvation may generate a biological vicious circle for the chronicity of Anorexia Nervosa. The long-standing malnutrition may provoke neurochemical abnormalities maintaining and reinforcing the disorder (Herpertz-Dahlmann, et al., 2011).

### 1.2.3. Family Factors

Hilde Bruch (1985; as cited in Herpertz-Dahlmann et al., 2011) who conceptualizes Anorexia Nervosa from a psychodynamic perspective suggested that the disorder appear primarily in girls who are seen by family and teachers as exceptionally good and successful; indeed perfectly fulfilling their roles as expected. According to her, overinvestment and over control are the ways that the families treat the future anorexic child (Bruch, 1982). She adds that expression of emotions, especially negative emotions, is not allowed in these families. Consequently, the family environment is not conducive to children learning how to identify and express feelings. Instead they monitor others' feelings and conform them.

Previously, in 1963, Mara Selvini (as cited in Jurma, Morariu, Albulescu, and Velea, 2015) claimed that Anorexia Nervosa is rooted in the mother-daughter relationship. She suggests that mother in these cases is unsatisfied, intrusive, dominating, and controlling while the father is silent, conforming to his wife's character, and not defending himself or his daughter.

In line with previous studies, Salvador Minuchin (1998; as cited in Jurma et al., 2015), one of the premier family therapist's of his time, believed that extreme emeshment was recognizable in families where there was an individual diagnosed with Anorexia Nervosa (interpersonal differences are poorly delineated, family members invade each other's thoughts and feelings, and family

interactions are very close and intense), overprotective (seemingly positive yet overly preoccupied and attentive to the other's well being), rigid (the boundaries between the family and the rest of the world are solid and maintained by the family members but reinforce isolation from others; meanwhile the opposite is true for the nuclear and family of origin leading to very loose boundaries), conflict-avoiding and refractory to self-expression (these families tend to avoid conflict, their capacities to tolerate differences are very low and this way, the problems and the distress remain unresolved and unreleased). It is also reported that particularly the family encouragement of leisure time is appeared as a discriminative marker for Anorexia Nervosa (Latzer, Hochdorf, Bachar, and Canetti, 2002) preventing the ego to develop efficiently and creatively without constraint (Erickson, 1968; as cited in Latzer et al., 2002).

To conclude, Anorexia Nervosa is often seen in individuals with certain characteristic traits that were present before the emergence of the disorder (e.g., perfectionism, rigidity, obsessiveness). Culturally placed high value on slimness together with some family characteristics (enmeshment, rigidity, overprotectiveness, insufficient conflict resolution skills) and may influence individuals who genetically are predisposed for eating disorders. Once starvation itself begins, this may induce hormonal deficits, which reinforce and worsen the symptomatic behaviors. Anorexia Nervosa is conceptualized as a neuropsychiatric disorder requiring various treatment strategies (Herpertz-Dahlmann, et al., 2011). Furthermore, studies have enquired into the relational aspects of the disorder, providing more psychodynamic and relational theories as to why certain family constellations are more likely to give rise to the incidence of Anorexia Nervosa. Following in the next section is a review of approaches to treatment that appear in the literature.

### 1.2.4. Psychodynamic Models of Anorexia Nervosa

Anorexia Nervosa was seen by early psychodynamic theorists as arising as a defensive response to conflictual drives such as sexual or aggressive. However a shift happened from conflict-based views toward deficit-based views

due to the complexity of the disorder as well as to the distorted self-image and heightened self-regulation (Steiger and Israel, 1999). In other words, according to Goodsitt (1977) and Sours (1980) contemporary psychodynamic theory from the self-psychology and object relations perspectives understand Anorexia Nervosa as a result of immaturity of the self (as cited in Steiger and Israel, 1999). Those views highlight developmental deficits in autonomy, self-regulation, and identity as predisposing factors to maladaptive eating. Anorexia Nervosa is conceptualized as a way for the individual to assert her individuality and separateness with the family because of the overinvolved and intrusive dynamics that often do not end up meeting the individual's needs (Steiger and Israel, 1999). When looking at Anorexia Nervosa this way, it can be conceptualized that the anorexic syndrome creates a false feeling of self-control with regard to the body instead of relationships; in other words, the body is used as a tool for an assertion of independence.

From the perspective of self-psychology, the habitual failure of caretakers to empathize with the child is fundamental to the development of eating disorders (Bachar, 1998). The parent thus is unable to meet the child's self-object needs while he or she fulfills his/her own needs through the child. Consequently, these self-object needs are addressed through distorted eating patterns that act as objects that would otherwise be human beings (Bachar, 1998). Sands (1991; as cited in Bachar, 1998) explains that food is the first pathway through which caregivers communicate and the child receives comfort and care that should lead to an individual's incorporation of positive self-care objects. The one with Anorexia Nervosa, through avoiding food (the first symbol of relationship with the world) avoids the self-object needs thus this system provides some defense against total fragmentation and disintegration.

Based on her clinical experience, Bachar (1998) states that a basic theoretical assumption is that if the therapist provides an empathic environment and analyzes the fear of retraumatization in relationships, the archaic needs will be mobilized into the transference and will indirectly be addressed. Bachar (1998) warns that in eating disorders this process is slow (because archaic needs have

been detoured into disturbed eating patterns and are not readily available to move self-object transferences) and requires special patience and efforts.

Another prominent contemporary work toward a psychodynamic conceptualization of eating disorders is the perspective of object relations (Heesacker and Neimeyer, 1990). From this viewpoint, a failure within the relationship between the primary caregiver and the infant is what leads to psychopathology. From this perspective, disrupted object relations patterns that are the result of early parenting are a reasonable cause of an eating disorder. It is explained that if the primary object of nurturance and support is unresponsive (absent, ambivalent, repudiative, hostile), then this makes it difficult for the child to internalize a sustainable maternal object and his or her self becomes fragmented, overwhelmed, helpless, and ineffective.

It is argued that early communication patterns characterized by a tendency to deny problems, to avoid expressions of emotions and points of views result in insecure (ambiguous or indefinite) attachment styles, which can be cause for an ambiguous sense of indivuation. In the eating disorder context, this leads to rigid eating patterns as an attempt to gain some power and control that otherwise would be created from the outside (Guidano and Liotti, 1983; as cited in Heesacker et al., 1990). Likewise, Friedlander and Siegal (1990; as cited in Heesacker et al., 1990) state that by focusing on these aspects of the body and body function, the eating disordered patient can hold onto her thoughts, behaviors, and consequently her anxiety.

### 1.3. TREATMENT

The literature regarding the prognosis and the treatment of anorexia nervosa is somber. Anorexia Nervosa is a comprehensive psychiatric disorder that leads to health issues and comorbidity (Danielsen, Rekkedal, Frostad, and Kessler, (2016). Fassino, Piero, Tomba, and Abbate-Daga (2009) and Steinhausen (2002) suggest that successfully treating Anorexia Nervosa is challenging because of its continuous and inflexible features and high therapy dropout rates (as cited in

Danielsen et al., 2016). Rosenvinge, and Klusmeier (2000), Kaplan and Garfinkel (2009) and Fassino, Piero, Tamba, and Abbate-Daga (2009) claim that for Anorexia Nervosa treatment, there is a broad range -- 20% and 51% for the inpatient and 23% to 73% for outpatient samples – of discontinued and incompleted treatment (as cited in Abbate-Daga, Amianto, Delsedime, De-Bacco, and Fassino, 2013). Authors Fairburn, Cooper, Doll, O'Connor, Palmer, and Dalle Grave (2013) point out that Anorexia Nervosa is difficult to work with because of the client's reluctance to engage in treatment with regard mostly to issues around change, which is at the center of the struggle for well-being (Abbate-Daga et al., 2013). Thompson-Brenner, Satir, Franko, and Herzog (2012) suggest that the client's opposition to therapy is indeed the most challenging part of working with Anorexia Nervosa. Thus, this resistance combined with medical risks and psychiatric comorbidities has been concluded to render addressing Anorexia Nervosa directly very challenging.

According to Mickley (2001) malnutrition associated with Anorexia Nervosa has life-threatening effects on health and must accompany or be prioritized over therapy for safety. Infertility, miscarriages, low birth rates, osteoporosis, the loss of brain tissues, heart, arm, leg muscles, cardiac impairments, anemia (low counts of red cells that carry oxygen), leukopenia (reduced white cells counts that fight infections), thrombocytopenia (reduced platelets counts that stop bleeding), high cholesterol, diminished levels of thyroid hormone are among the health dangers for Anorexia Nervosa. The purging type of Anorexia Nervosa damages the gastrointestinal system, may rise to dental problems, to early tooth loss, enlarged salivary glands, and lymph nodes, and low levels of potassium and other electrolytes, which may cause irregular heart rhythms and sudden deaths.

Greenfeld (2001) argues that common comorbid conditions appeared often before the onset of eating symptoms, such as depression, anxiety, panic and obsessive-compulsive, and personality disorders, as well as substance abuse, all of which may complicate the psychotherapeutic work.

While empirical evidence has clearly shown the effectiveness of Cognitive Behavioral Therapy (CBT) and Interpersonal Therapy (IPT) for Bulimia Nervosa and Binge Eating Disorder (Wegner and Wegner, 2001 2nd ed., B. Kinoy editor), there is still not enough evidence to support the use of psychotherapeutic intervention over another treatments (Stein and Latzer, 2012). The American Psychiatric Association (2006; as cited in Danielsen, Rekkedal, Frostad, and Kessler, 2016) also reports the weakness of the existing evidence for treatment of adult Anorexia Nervosa patients. Herpertz-Dahlmann, Seitz, and Konrad (2011) report that up to this point no evidence-based therapy for Anorexia Nervosa has emerged. Fairburn et al. (2012) suggest that this lack of evidence to support a specific treatment strategy for the complex features of Anorexia Nervosa with regard to medical complications and long term treatment,is partly why this is so.

Besides the above claim, Garner, Vitousek, and Pike (1997; as cited in Wegner and Wegner, 2001) suggest that with modification, CBT can be successfully used in treating AN Anorexia Nervosa. Shapiro (2007; as cited in Fairburn et al., 2013) and Wegner and Wegner (2001) also assert that CBT could present a possible reliable method for outpatient treatment for Anorexia Nervosa since the disorder has similiarities to Bulimia Nervosa. Byrne, Fursland, Allen, and Warson (2011) report that Enhanced Cognitive Behavioral Therapy can be used for all eating disorders; it is an enhanced form of CBT, conceived of by Fairburn, Cooper, and Shafran (2003). Byrne et al. (2011) report that in their study, CBT-E leads to better eating patterns and mental health an outpatient clinic population. Regarding Anorexia Nervosa, 50% achieved full (28 days of no eating disorder symptoms) or some lessening of symptoms. However, since 50% of the patients with Anorexia Nervosa did not complete treatment, they conclude that CBT-E may have a lower success rate for Anorexia Nervosa, although it is still considered effective. However, recently, in 2013, Fairburn, Cooper, Doll, O'Conner, Palmer, and Dalle Grave investigated the outcome of CBT-E for Anorexia Nervosa, their data showed that for those who finished treatment there were notable improvements in weight and symtomology that were consistent are

for 60 months after treatment. Turner, Marshall, Stopa, and Waller (2015)'s study also supports these findings. Furthermore, Interpersonal Therapy provides another option for short-term therapy and has been widely investigated in the literature for all eating disorder mentioned above but not for Anorexia Nervosa (Courbasson, Shapiro, and Di Fonzo, 2012).

The body of literature on psychodynamic treatments is seldom, although the effectiveness of psychodynamic interventions is supported by current data, particularly for AN (Abbate-Daga, Marzola, Amianto, and Fassino, 2016). Zerbe (1993, as cited in Ortmeyer, 2001) claims that there is a significant number of eating disordered patients who do not respond to cognitive, psychoeducational, behavioral, and psychopharmacologic treatment with whom psychodynamic therapy must be integrated. Ortmeyer (2001) outlines her work with eating disordered patients mentioning that many of them respond to psychodynamically oriented approaches while simultaneously addressing their symptoms. She adds that lengthy and intensive psychodynamic psychotherapy keeps its importance to enable persons with eating disorders to evolve and to realize their potential as competent and integrated people.

In the following section, I will introduce some widely mentioned psychotherapies for Anorexia Nervosa, such as enhanced Cognitive Behavioral, Psychodynamic, and Integrative therapies. Psychodynamically oriented psychotherapy will be examined by further details because it is at the center of this thesis' investigation.

### 1.3.1. CBT for Anorexia Nervosa

Fairburn, Cooper, and Shafran (2003) developed Transdiagnostic CBT (CBT-E) to address the treatment of all eating disorders including Anorexia Nervosa (Byrne et al., 2011; Danielsen et al., 2016). It is expanded from the evidence-based treatment designed for BN (CBT-BN) (Hay and Touyz, 2012). CBT-E is rooted in the transdiagnostic cognitive behavioral theory of eating disorders. The assumption is that common cognitive mechanisms, such as over

evaluation of body shape, weight, and eating underlie all eating disorders (Fairburn, 2008; as cited in Danielsen et al., 2016). CBT-E addresses not only key symptoms (e.g., strict dieting, starvation, low weight, binge eating, compensatory behaviors) but also covers additional maintaining processes (e.g., clinical perfectionism, low self-esteem, difficulty in coping with intense mood states, interpersonal difficulties) to be effective for all eating disorders. Those additional maintaining processes are external to the eating psychopathology but may be significant factors that highly prevent change (Fairburn et al., 2003; as cited in Byrne et al., 2011).

Fairburn et al. (2013) define CBT-E for Anorexia Nervosa as including up to 40, one to one of 50 minutes sessions. In the focused version there are three phases. During the first phase, the patient's motivation to change is increased. In the second phase, if willing to continue the treatment, the patient is helped to regain weight while addressing concerns about shape and weight. The broad version of CBT-E covers additional methods that maintain the patient's attempt for perfection, perpetuate low self-esteem and relational problems and a lack of tolerance to moods in this phase. In the final phase, the focus is on the developing and implementing personalized strategies to notice immediately and to correct any relapse and to maintain gained benefits. Byrne et al. (2011) report that treatment manual give some flexibility for the number of sessions, while the content is the same for all eating disorders – to strengthen motivation and to positively move forward successfully through treatment.

Fairburn et al. (2013) studied 99 adult patients with Anorexia Nervosa to investigate the efficacy of CBT-E in. Accordingly, patients with Anorexia Nervosa received benefits from the treatment. The two-thirds of patients who completed the program showed meaningful weight gain and improvement of symptoms that were maintained for 60-weeks, the time of the last follow-up. This research supports other studies that demonstrated the effectiveness of CBT-E for Anorexia Nervosa treatment (Danielsen et al., 2016; Turner, Marshall, Stopa, and Waller, 2015; Byrne et al., 2011).

### 1.3.2. Integrative Approaches Towards Anorexia Nervosa

Studies and clinical interventions indicate that for Anorexia Nervosa, therapies that combine cognitive behavioral, symptom reduction, supportive as well as insight-oriented, affect regulation and a medical/psychopharmacologic perspective are more useful that using one approach (Barth, 2014). Consequently, a more blended approach seems to most efficient (Barth, 2003; Connors, 1994, 2006; Johnson, 1999; all cited in Barth, 2014; Kaplan and Garfinkel, 1999; Zerbe, 2008). Furthermore, most clinicians may in practice behave differently than the treatment model suggests (Ablon, Levy, and Katzenstein, 2006).

Literature agrees that in practice even empirically supported interventions become eclectic and are not used in their original form (Wallace and Von Ranson 2012; as cited in Danielsen et al., 2016). Wonderlich et al., 2007 (as cited in Danielsen et al., 2016) and Barth (2014) argue that due to the wide range of symptomology and comorbidity features and high relapse and chronicity rate there is a need for flexibility and for consideration of individual differences. There is consensus among clinicians that an array of primarily cognitive behavioral therapy, and/or psychodynamic therapy with supportive psychotherapy is offered to the majority of the patients with eating disorder symptoms (Le Grange, 2016).

Recen research suggests that when approaching eating disorders, clinicians come from the two basic approaches, cognitive behavioral and psychodynamic (Colli, Gentile, Tanzilli, Speranza, and Lingiardy, 2016). Colli et al.'s (2016) data show that cognitive behavioral therapists use primarily cognitive behavioral techniques but also incorporate a range of psychodynamic strategies to explore affects and to use the therapeutic relationship as a tool to explore and to heal. On the other hand, psychodynamic therapists did not augment their psychodynamic strategies with cognitive behavioral ones as much as cognitive behavioral clinicians. All therapists used conjoint inpatient or day treatment programs for the weight control of their patients to maintain rules for therapeutic engagement.

Steiger (1989) recommends that, in the case of Anorexia Nervosa, working in a directive, structured model to respond to the immediacy of problematic symptoms and characterological disturbances while never losing sight of transference and countertransference should be the favored way.

### 1.3.3. Novel Therapies for Anorexia Nervosa

Finally, at least three novel therapies for adults with Anorexia Nervosa have been introduced and reviewed (Le Grange, 2016). Le Grange (2016) also recognizes that these "novel" therapies combine aspects of the existing models of treatments into a novel form and all include adjunctive treatment such as inpatient or outpatient medical follow-ups and individual therapy.

First one of those therapies is UCAN (Uniting Couples Anorexia Nervosa). It is a couple-based treatment addressing sexual problems, relationship challenges, community difficulties, simultaneously as the eating disorder. It integrates CBT for Anorexia Nervosa and CB Couple Therapy and it is an adjunctive treatment (Bulik, Baycom, Kırby, and Pisetsky, 2011; as cited in Le Grange, 2016).

The second novel approach combines Cognitive Remediation Therapy (CRT) and CBT for Anorexia Nervosa (Lack, Agras, Fitzpatrick, Bryson, Jo, and Tchanturig, 2013; as cited in Le Grange, 2016). CRT suggests that many adults with severe and enduring Anorexia Nervosa have deficits in "set-shifting," relaxing one's thinking, and in control coherence (looking at the bigger picture instead of looking at details) even after weight restoration. This novel approach uses CRT in the initial phase to work on these deficits of having overly detailed focus or of being unable to set shifts that may be responsible for inhibiting the patient's willingness to engage in CBT.

The third of these novel approaches is exposure and response prevention (ERP). It is argued that ERP is a well-practiced treatment for many anxiety disorders, as well for Anorexia Nervosa that is known with the co-occurrence of an anxiety disorder as precursor or consequence. The ERP triggers food related

anxieties and prevents avoidant rituals in patients who are acutely weight restored (Steinglass, Albano, Simpson, Wang, Zou, Attia, and Walsch, 2014; as cited in Le Grange, 2016).

### 1.3.4. Interpersonal Psychotherapy (IPT) for Anorexia Nervosa

Etiological theories point out that Anorexia Nervosa develops within the interplay of the interpersonal and family conflict (McIntosh, Bulik, McKenzie, Luty, and Jordan, 1998). Furthermore, evidence suggests that relational dysfunction in the life of the person with Anorexia Nervosa contributes to the continuation of the disorder (Rieger, Van Buren, Bishop, Tanofsky-Kraff, Welch, and Wilfley, 2010). To enhance these findings, there are also studies that look at these factors (McIntosh et al., 2010) by examining the perception of family that is held by a person with and without an eating disorder (Rhodes and Kroger, 1992; Rastam and Gillberg, 1991; Waller, Slade, and Calam, 1990; Humphrey (1986),; as cited in McIntosh et al., 2010). According to those mentioned, self-reporting studies, there is a tendency the person who suffers from Anorexia Nervosa to see their families as more troubled. Females with the disorder are more likely to view their mothers as less nurturing and their families less adaptable, cohesive, empathic, more controlling, blaming, neglectful, and rejecting. In observational studies also (Goldstein, 1981; Le Grange, Eisler, Dare, and Russell, 1992; as cited in McIntosh et al., 2010), low levels of expressed emotions, high levels of tentativeness (intensely complicated and contradictory interactions) and conformity have been described as characteristics of families of individuals with Anorexia Nervosa. How much emotion is expressed is particularly important component with regard to interpersonal problems since it has been correlated with the failure to complete treatment (Le Grange et al., 1992; as cited in McIntosh et al., 2010). McIntosh et al. (2010) also bring up the question as to whether interpersonal issues are cause or consequence of the seriousness of Anorexia Nervosa. Yet IPT does not depend on the premise of causality and it addresses all

interpersonal issues whether they predate the appearance of the illness or are maintaining or consequences of the illness.

IPT was first developed to addres symptoms of depression and was later. In the 1980s, adapted to treat Anorexia Nervosa and has been evidenced to be as effective as CBT for Bulumia Nervosa and binge eating disorder but slower to achieve its results (Fairburn, Bailey-Straebler, Basden, Doll, Jones, Murphy, O'Connor, and Cooper, 2015). Some studies found support for the use of IPT in Anorexia Nervosa but to a lesser extent (Carter, Jordan, McIntosh; Luty, McKenzie, and Frampton et al. 2011; McIntosh, Jordan, Carter, Luty, McKenzie, Bulik et. al. 2005; all cited in Fairburn et al., 2015). McIntosh et al. (2010) suggest that given the success of IPT in treating Bulumia Nervosa, the overlap of the syndromes of Bulumia Nervosa and Anorexia Nervosa, and the clinical clarity of the presence of the dysfunctional interpersonal context within which Anorexia Nervosa and Bulumia Nervosa develops, there is a strong theoretical rationale for the delivery of IPT to the patient with Anorexia Nervosa. IPT focuses on the development or maintenance of Anorexia Nervosa in the patient's life.

Similar to CBT, IPT is described by some researchers as a time-limited treatment, of 12 to 20 sessions, four to six months; although less directive than behavioral therapies, IPD is itself focused on the interrelatedness of interpersonal problems and psychological problems and is not difficult for experienced therapists to conduct, (Rieger, Van Buren, Bishop, Tanofsky-Kraff, Welch, and Wilfrey, 2010). The individual's life, the history of their mood fluctuation and feelings toward themselves, as well as their relationships as they reflect social functioning as symptom reinforcement, is a focus of IPT. While IPT aims to focus on interpersonal conflict resolution, Rieger et al. (2010) point out some limitation of IPT with regard to its prolonged period of assessment that leaves less time to focus on recovery. Together with the delayed therapeutic effects of IPT relative to CBT in the treatment of Bulumia Nervosa, post-treatment follow up revealed poorer recovery rates compared to treatment that specialized specifically on Anorexia Nervosa (McIntosh, Jordan, Luty, Carter, McKenzie, and Bulik, 2006). In the face of some limitations in usage and some questions points with regard to

the outcomes of IPT, research also demonstrates that it is largely applied to the treatment of Anorexia Nervosa in routine clinical management (McIntosh et al., 2010). Specifically for Anorexia Nervosa, the literature points to the necessity of ongoing consideration of the core anorexic symptoms. Decreasing body weight may demand a return to supportive interventions in order to first address medical issues (McIntosh et al., 2010).

### 1.3.5. Psychodynamic Therapy (PD) for Anorexia Nervosa

Abbate-Daga, Marzola, Amianto, and Fassino (2016), in their meta analysis about psychodynamic methods specifically aimed at treating eating disorders (among 47 studies 15 were available for Anorexia Nervosa), define the psychodynamic method as inclusive work on human inner perspectives focusing on the patient's inter and intrapersonal relationships. The papers included in their meta-analysis acknowledge the following points as common in psychodynamic work: focus on the patient's subjectivity, emphasis on defense mechanisms, value of the therapeutic relationships, transference and countertransference, working on the unconscious meanings of symptoms, attention to the potential link between current and past interpersonal relationships and conflicts, interest on the internal representations of relationships and on the meaning that the patient attribute to her own experiences. Abbate-Daga et al. (2016) suggest that PD therapies were always of interest to clinicians because interpersonal factors and emotion regulation are two aspects of the treatment that contribute to the change especially for Anorexia Nervosa. Psychodynamic therapies do not conceptualize eating disorders just as a constellation of eating related symptoms but recognize that the patient, before getting ill, experiences loneliness, ineffectiveness, and fear of others' opinions as negative and humiliating. Such therapies embrace the idea of tailoring each treatment plan according to the unique needs of each patient concerning and addressing the adaptive value of eating symptomology. PD therapies emphasize the unique role of the therapeutic relationship as it is supported by recent studies on the neurobiology of interpersonal relationships that

show the changes in the brain that is induced by treatments (Abbate-Daga et al., 2016).

Daniel, Lunn, and Poulsen (2015) claim that Psychodynamic treatments for eating disorders do not discuss the symptoms in each session but address them in a more indirect way. Psychodynamic oriented therapists allow the space for the patient to talk as freely as possible and listen in a non-focused way to understand and empathize with client. Stern (1992) also conceptualizes psychodynamic therapy as an open, empathetic interpersonal matrix where the patient's representational world is allowed to repatterned and restructured.

Psychodynamic therapy is described as the relatively longer treatment where the therapist is non-directive and non-focused and where the emphasis is on symbolization, transference, countertransference, and unconscious motivations rather than symptoms (Tasca, 2016). It aims to facilitate insight into the patient's hidden aspects as well as to regulate and integrate them at a higher developmental level (Mc Williams, 2004; as cited in Daniel, Lunn, Poulsen, 2015).

Ortmeyer (2001) states that in psychodynamic therapy, the therapist and patient explore and analyze the patient's experiences, past and present, repetitive relational and behavioral themes, which are often reenacted in the therapeutic encounter. Her work with eating disorders is grounded on subsequent therapeutic work in recovering and restoring a healthier self. She also believes in the integration of psychodynamic therapy with other treatment methods to ensure full recovery.

Previously, Steiger and Israel (1999) also recognized polysymptomatic coloring (temperament, generalized self-definition problems, autonomy disturbances, perfectionism, preference for order and control, hypersensitivity to social approval, developmental problematic processes conductive to self-image or adjustment struggles) and multidimensional biopsychosocial causality of Anorexia Nervosa despite its largely accepted definition as eating, weight and body image preoccupations and propose the use of psychodynamically inspired techniques in an integrated psychotherapeutic approach. They recommend interpretation of eating behaviors as examples of generalized adaptive patterns to

interpersonal struggles. Their work highlights the importance of continuously addressing the patient's perceptions and emotional experiences of their therapist and the importance of the therapist's own perceptions and feelings toward their patient. In short, they highlight the importance of interpersonal transactions between patient and therapist. In their work, Anorexia Nervosa is conceptualized as a unique compensatory system in which needs usually met by human interactions are instead fulfilled by eating and bodily preoccupations. Therefore, a part of the therapeutic task should offer a relationship that provides an alternative to eating obsessions. To ensure that this occurs, it is proposed to focus on ongoing interactions in the therapeutic relationship (the use of "you and me" and "here and now"). Steiger and Israel's work is integrative because they suggest that Anorexia Nervosa requires the reestablishment of nutritional status and the control of biologic effects of malnutrition, which implies the inclusion of some behavioral management and cognitive work into the psychodynamically informed psychotherapy for Anorexia Nervosa.

Tobin (2012) comments that any clinician working with eating disorders is already using psychodynamic tools, referring to a study (Tobin, Banker, Weisberg, and Bowers, 2007) about clinicians who attend eating disorder meetings. It is found that 99% of those clinicians, regardless of their theoretical orientation, were using psychodynamic interventions with their eating disorder patients. Furthermore, 93% of clinicians reported the analysis of countertransference. Tobin (2012) suggests that most eating disorder patients do not improve with cognitive behavioral approaches. He recommends the use of a combination of cognitive behavioral and psychodynamic approaches according to a hierarchy of concerns, which are rank-ordered, starting with physical safety, emotional safety and threats to the treatment, reducing symptom maintaining behaviors, developing interpersonal skills, and developing the self.

When the scope is Anorexia Nervosa, Barth (2014), based on her 30 years of experience with eating disorders, suggests that psychodynamic exploration and understanding is seldom to change symptomatic behaviors arguing that those patients have already highly developed verbal abilities and

capacity for insight that do not help them to manage their affect. In line with this, Chessick (1984) reports a consensus among many authors that only insight into unconscious conflicts and symbolic meanings does not lead to a cure of disordered eating behaviors. Barth (2014), as part of her "psychodynamically meaningful integrative work" emphasizes the importance of recognizing previously dissociated materials, the triggers of symptoms and working on them, and the importance of the inclusion of a nutritionist or a physician to make it easier to manage physical difficulties. In sum, she emphasizes the importance of psychodynamic exploration as a powerful tool to choose appropriate directive and supportive interventions and to enhance their effectiveness. Likewise, Chessick (1984) recommends first focusing on exploring details of and solutions to everyday acute problems and when the ego strength and a rational superego are ensured then focusing on self-examination. Morais, Horizonte, and Brazil (2002) suggest as well the use of other medical or supportive techniques to promote changes in the real dimension of the body. According to the authors, the victory for the patient with Anorexia Nervosa is the loss of life. The patient with Anorexia Nervosa no longer needs to eat; therefore, she no longer depends on anyone. Together with medical and psychodynamic treatment the symptomatic conflict may be experienced at a psychic level instead of its conversion to the organic body. Abbate-Daga, Amianto, Delsedime, De-Bacco, and Fassino (2013) call attention to the corporeality of Anorexia Nervosa and they recommend that therapists be confronted and confront their patients with the dangerous material reality. In line with this, Sands (2003) suggest that the therapist should not forget the Anorexia Nervosa's life-threatening situation.

Besides the combination of treatment modalities, all the papers included in the mega study conducted by Abbate-Daga et al. (2013) that discuss resistance and change in Anorexia Nervosa agree on the necessity of an individuated psychodynamic approach where therapeutic relationships must be used as a fundamental tool in treating treatment-resistant patients. Developmental and person-centered approach towards eating disorders are at the core of contemporary psychodynamic thinking. This is a developmental perspective to

understanding symptom development and maintenance for each patient (Tasca and Balfour, 2014), since the study illuminates that individual women diagnosed with Anorexia Nervosa each have their own inner dialogue and explanation about their own Anorexia Nervosa. This is because Anorexia Nervosa is conceptualized as a disorder of the development of the self and personality characterized by insecure attachment and mentalization impairments (Abbate-Daga et al., 2013): by a denial of need of other, by the concretization of unmet, early needs in the body, by the expression of those needs through the eating process (Sands, 2003), by avoidant and narcissistic personality traits and disadaptive management of anger (Abbate-Daga et al., 2013).

All the papers published from 1990 to 2013 included in Abbate-Daga et al.'s comprehensive work agree on the strong avoidance and high drop-out rates in the cases of Anorexia Nervosa. Patients diagnosed with Anorexia Nervosa are found to be highly resistant to treatment. In 2014, Tasca and Balfour examined attachment categories, drop-out rates and therapy outcomes in eating disorders. Patients with Anorexia Nervosa are found to have significantly lower reflective functioning and lower abilities to mentalize than those with Bulumia Nervosa and EDNOS (eating disorders not otherwise specialized). For Anorexia Nervosa, pre-treatment attachment avoidance was associated with dropping out of day treatment and pre-treatment attachment anxiety was associated with poorer outcomes in day treatment. In this study, psychodynamic therapy highlights that the relationship between patient and clinician is the fundamental tool recommended to explore and overcome resistance, Tasca (2016) suggests that since interpersonal problems and mood intolerance are found to have a primary role in developing and maintaining eating pathology across all patients with Anorexia Nervosa, only addressing dietary restraint eating concerns, and shape will not be enough for a cure. In line with this, long and difficult intensive psychodynamic psychotherapy to deal with its profound characterological depression often with core paranoid features (Chessick, 1984) and to allow for the re-engagement of arrested developmental processes is necessary (Stern, 1992). Stern (1992) states that psychodynamic psychotherapy is needed primarily for

patients with dissociative character defenses such as eating disorders. He suggests that only psychodynamic therapy can facilitate the integration of the dissociated and arrested self of the patient into her current psychic life. According to him, patients with eating disorders suffered from severe environmental failures in their early lives. As a result they have evolved character structures in which frustrated primary needs have been actively dissociated and a false-self has been adapted to maximize the connectedness with parental caregivers. He underscores the necessity of long-term psychodynamic therapy to allow the patient to tie her self-object with the therapist and gradually to weaken her reliance on pathological solutions. As Barth (2014) argues, the secure attachment provided by a psychodynamic therapist will facilitate calming, soothing, and regulating experiences for the eating disordered-patient that will be gradually internalized as techniques for self-soothing.

In sum, intensive psychodynamic work over time is accepted as necessary to translate and to symbolize the affective communication of the patient's body or soma into distinct thoughts and affects, to integrate her contradictory parts, to bring them in her conscious awareness (Sands, 2003), and finally, to enable her to realize her potential as a competent and integrated person (Ortmeyer, 2001).

## 1.4. COUNTERTRANSFERENCE

Since Freud initially mentioned the term countertransference in 1910 (Gorman-Ezell, 2009), it has been a central construct of psychoanalytic thought and practice (Arndt-Caddigan, 2013). Arndt-Caddigan (2013) asserts that even though the importance of countertransference is nearly universally accepted by analytic psychotherapists, it's meaning is not as widely agreed upon. Strean (2001 a) argues that Freud himself displayed the disputable nature of countertransference, which is visible in his 1910 and 1912 definitions of countertransference. Strean (2001 a) continues that in his paper "The Future Prospects of Psychoanalytic Therapy" (1910), Freud suggests the image of the

clinician as a surgeon, as a mirror in the therapeutic milieu but then, in 1912, Freud adds that the therapist's unconscious always influences the patient's unconscious communications. Countertransference is defined differently by various schools of psychoanalytic psychotherapy, from the single classical perspective that it is an unconscious and conflict related reaction to the client's transference as it is experienced in combination with all the therapist's emotions, thoughts and behaviors towards the client (Thisby and Wiseman, 2014). Gabbard (1995) as well states that countertransference has evolved from a narrow formulation to a comprehensive one; now it is taken as the fit between the patient's projections and the preexisting structures in the therapist's intrapsychic world.

The current part of the study will first look at the birth and the development of the notion of countertransference, second the contemporary views on the topic will be revealed, lastly key concepts related to it which are expected to be useful to get a better understanding of its progress in time.

### 1.4.1. The Birth and the Development of the Notion of Countertransference

During the last fifty years, conceptualizing countertransference has been central to psychoanalysis (Kachele et al., 2015). However, Freud had remarkably little to say about it (Gabbard, 1995). Gabbard (1995) writes that Freud viewed countertransference as an obstacle to overcome and asserts that this view is commonly mentioned as a narrow perspective. Likewise, Stefana (2015) writes that Freud viewed countertransference as something that should be kept in check in order to remain neutral towards the patient and that his view endured essentially for the rest of his life as he later stopped talking about it from the year 1915 forward. On Freud's silence Gabbard (1995) comments that this silence does not reflect his indifference to the concept rather his worries on the possible risks that may appear in the future of his young science that may result from talking about the analyst's vulnerabilities. On this silence Stefana (2015) suggests that with the purpose of preventing his new science from any judgmental critique,

Freud remained reluctant to acknowledge the possible weaknesses of the analyst that may affect the treatment. Imbasciati (2007; as cited in Stefana, 2015) comments on the silence in the overall literature of psychoanalysis on the topic of countertransference. Accordingly this silence until the 1950s reflects its embarrassing reputation gained by its belief to be the result of incomplete analysis from the very beginning. In the 1950s some thinkers began to reflect on countertransference as a useful tool instead of a problem that hinders understanding of the patient (Epstein and Feiner, 1988). For instance, Paula Heimann, in her brief paper "On Countertransference" (1950) paved the way for the concept of countertransference to gain a positive meaning such as the most important tool to reach the patient's unconscious (Gabbard, 1995). Heimann (1950) suggested that the analyst's unconscious actually can relate to the patient's unconscious and that this understanding on deep levels appears on the surface in the form of countertransference feelings and once noticed may help the therapist to create a better formulation of the therapeutic encounter (Epstein and Feiner, 1988). It is pointed out that Heimann's contribution to the development of countertransference concept was, most importantly, the idea that freeing countertransference as an obstacle for therapeutic work was vital to use it as a valuable tool toward improving the analytic work (Epstein and Feiner, 1988).

Winnicott, in his paper "Hate in Countertransference" was very courageous to discuss even hate as a countertransference feeling. Winnicott (1949) distinguished the objective and subjective components of countertransference feelings and stressed always the analyst's necessity to detoxify subjective countertransference feelings to continue to function constructively (as cited in Epstein and Feiner, 1988). He recognized objective hate as a fully human reaction towards certain patients who arouse repeadetly intense hate in the analyst as a part of their maturational process and may be used as a therapeutically useful tool with this group patient (Epstein and Feiner, 1988).

### 1.4.2. Contemporary Views on Countertransference

Contemporary perspectives depathologize the countertransference phenomenon and promote its use as a therapeutic tool by the therapist's perception and appropriate management of it. Arndt-Caddigan (2013) suggested that according to contemporary views, the therapy process includes two subjectivities that mutually influence each other. In other words, the therapeutic relationship is jointly constructed on the basis of the mutual influence of two parties. Arndt-Caddigan (2013) goes further to say that the interpersonal-relational perspective takes the therapeutic relationship as a single process that may be called cotransference (p.148) composed of the contributions that each participant brings to the relationship as well as those that stem from the encounter.

Some authors have made particularly significant contributions to the evolution of the countertransference concept from narrow toward more comprehensive contemporary perspectives. Lewis Aron (2013), for instance, argued that the patient and the analyst enact and reenact even if modulated form. In the therapeutic encounter where two inner, subjective worlds interact the impasses are inevitable. Their subjective worlds inevitably connect and likewise disconnect. Aron (2013) took those moments of impasses as full of potentiality for the progress in the analytic encounter only if the therapist has the willingness towards awareness of his or her subjective world, in other words his or her countertransference feelings contributing to the analytic experience of both his or her own experience and of the patient's experience. Aron, in 2013, remarked the importance of the role of the therapist as a witness, different than the simple observer, to reconstruct the patient's as well as her or his own psychic world. Accordingly witnessing the patient's unbearable, devastating, and dissociated experiences cause hard to carry and tolerate countertransference feelings in therapists. This suffering is required to grasp the patient's pain but must also be separated from therapist's own experiences. It can be concluded here that Aron stresses the efforts of therapist for countertransference management which will be never enough to ensure enactment free therapeutic encounter. In his words; "Even

armed with lots of good theory, clinical experience, personal analysis and continual introspection, succeeding in resolving the deadlock will never be possible" (p. 466).

Stephen Mitchell (1994) also underscored the importance of countertransference feelings as a necessary component in the therapeutic relationship for the patient's need of a new developmentally necessary object. Thus, the therapist should allow his or her countertransference feelings to be shaped by the patient for a certain period of time until the patient does not need to use this particular self-object any more. In other words, Mitchell (1994) argued that the therapist should not attempt to eliminate countertransference feelings, to the contrary, he/she should immerse but in a controlled way, in the transference-countertransference dyad until the patient does not need any more this specific transference fantasy.

Jessica Benjamin (2006) took the ruptures, same as Aron (2013) had taken the enactments as inevitable but life-giving opportunities for the therapeutic progress. Benjamin (2013) commented that seeing the therapist's containment and formulation of her own feelings open up a new place in the patient's psyche towards healing. She called this process "the procedural level of nonverbal, mutual regulation" (p.381). To explain this process she stressed that when the patient is too dysregulated and overwhelmed, the therapist's intellectual efforts to bridge the conflictual parts through understanding does not work but simple recognition of his or her unbearable state heals (Benjamin, 2006). In 2009, Benjamin referred the therapeutic dyad as a flow of dissociation and attunement similar to Aron (2003) who referred the same process; the therapeutic dyad as a continuous disconnections and connections. To work through the process, Benjamin (2009) stressed the therapist to let go of trying to fully hold the client's feelings but to examine his or her role in the breakdowns and to work for the correction. In other words, the therapist should recognize aspects of his or her own countertransference honestly, investigate moments of dissociation, misattunement, or defensiveness (p.442).

Chernus (2000) portrayed Irwin Hoffman as one of the most important precursor of the contemporary psychoanalytic mainstream. Chernus (2000) argued that Hoffman posits the analyst in a social constructor role. In other words, according to Hoffman, the analyst and the patient shape their own and the other's experience including what the analyst understands about himself or herself and about the patient through a reciprocal interpersonal process. This is Hoffman's constructivist stance and goes further than the relational model, which emphasizes simply the patient's awareness of the analyst as a person (Chernus, 2000). Chernus (2000) suggested that his constructivist stance requires constant inquiry and use of countertransference feelings on the part of therapists in order to adopt an empathic mode to develop intimacy with their patients. In 2009, Hoffman talked on the therapeutic passion in the countertransference as the analyst's strong desire to make change in the patient's life. He stressed the essentiality of this passion as a powerful component in the therapeutic relationship. At this point he warned his colleagues that a simple gravitation towards passivity and the easiest path may kill this passion in therapist who has many patients under his or her care which make it understandable. Hoffman (2009) also added that many theories or techniques mask and rationalize the laziness in therapist such as the emphasis on just listening, not to interfering, avoidance of suggestion, or being the blank screen to allow the transference to develop, and on taking the account only the patient's resistance for slowness and for the lack of movement in the therapeutic process. Hoffman (2009) opposed to all those covers for failures and stood up for the therapist's continuous emotional and intellectual effort, in other words, the therapeutic passion in his or her countertransference to generate the change. In his study dating back in 2009, Hoffman also explained how to use the analytic asymmetrical relationship for the patient's need. He expressed that the relationship is asymmetrical because the analyst-patient relationship, similar to teacher-student, or parent-child relationship entails an asymmetrical distribution of power, which may be used to empower the patient or the other way around (p.626). He exemplified the therapeutic use of the asymmetrical relationship arguing that sometimes patient's hostile introjects are so destructive that their

voices may not be settled down by intellectual understandings. In those cases an opposing powerful voice that of therapist's powerful actual words may cure the destructive voices. He asserted that this kind inspirational thus therapeutical suggestions taking their power from the asymmetrical power of the therapist-patient relationship are helpful to open up the patient for richer and fuller possibilities.

Overall contemporary views agreed that countertransference, beyond any doubt is inevitable, and, if managed properly, inherits a rich potential value to understand the patient's intra and inter-world, to alleviate old pathological transference phantasies by generating new possibilities to form new configurations of relating with the world for both, the patient and the therapist himself or herself.

### 1.4.3. Key Concepts in Countertransference

Some notions or key concepts throughout the literature have been widely used to capture clinical countertransferential situations (Kachele, Erhardt, Seybert, and Buchholz, 2015). Gabbard (1995) comments that to better illustrate the contemporary understanding some several key concepts should be examined first. Those key concepts are projective identification, Bion's container/contained model of infant/mother and patient/analyst interaction, role responsiveness, countertransference enactment, and self-disclosure.

#### 1.4.3.1. Projective Identification

The concept of projective identification comes originally from Klein who refers to a fantasy in which part of the patient's self is disconnected and projected into the therapist without necessarily modifying the therapist's feelings or behaviors (Gabbard, 1995; Weiss, 2014). Moreover if the therapist is influenced by the patient's behavior, Klein would take it as a sign, in the narrow sense, for his or her need of a further analysis (Gabbard, 1995). Weiss (2014) points out that although most of Klein's followers did not find a clear differentiation between the

two concepts, projection and projective identification, Klein used the term projection to refer to attribution, but projective identification suggest that something is concretely transferred from one person to the other.

#### 1.4.3.2. Bion's Container/Contained Model of Infant/Mother and Patient/Analyst Interaction

Gabbard (1995) explains that Bion broadens Klein's ideas on projective identification into a general model of the infant's psychic development. The infant deals with many basic emotional experiences that are extremely uncomfortable by disconnecting from them completely and projecting them into the mother. In a best case scenario, the mother contains and detoxifies them to be reinternalized (Gabbard, 1995) and to be reused for further psychological development of symbol formation (Weiss, 2014). In this best case scenario, the child can reinternalize and manage those originally intolerable emotions through identification with the way the mother is able to contain and hold the child's affect (Gabbard, 1995). Gabbard (1995) emphasizes that Bion views the therapeutic situation as the infant-mother interaction, accordingly the therapist is induced to feel and behave according to the patient's behavior – as if the therapist is now a player in the patient's own story (Gabbard, 1995). Bion thus defines countertransference as a process of transformation (Weiss, 2014). At this point Gabbard (1995) warns on a common threat, he comments that although coercive pressures from a patient may have a difficult aspect to resist, a "hook," an aspect in the recipient-therapist that thus is activated by how the projector-patient behaves. So, the therapist must keep him or herself away from the pressure to enact and retain the capacity for reflective thought. In line with this Kachele et al. (2015) state that the psychoanalyst's professional role requires sensitivity to the patient's emotions and to his or her own affect but most crucially to control countertransference feelings without transforming them into action.

#### 1.4.3.3. Role responsiveness

Sandler's conceptualization of role-responsiveness means that the behaviors of the patient resulted from his or her transference needs may provoke a reaction in therapist (Kachele et al., 2015). The therapist may thus feel induced to act in a specific way or role verbally or non-verbally within the session t (Gabbard, 1995).

#### 1.4.3.4. Countertransference enactment

Gabbard (1995) states that the image of a therapist as objective, neutral and anonymous is no longer an idea that stands and that therapists very often, for significant periods of time struggle with multi-sided emotional experiences and behaviors that can not be defined and articulated consciously before an enactment occurs and creates an opportunity to recognize and to reflect on those emotions. In Gabbard (1995)'s view, enactment is often used to refer to subtle non-verbal cues such as breath changes or body movements outside of the therapist's conscious awareness, resulted by the transference-countertransference interaction. Consistent with this, according to Bion the analyst in an intimate therapeutic relationship in which he or she is recruited for particular roles by the patient, may easily fall into the enactment trap. It is stressed very strongly that the particular and continuous job of the analyst must be to recognize and to clarify the various roles into which the patient is unconsciously pushing him or her (Gabbard, 1995; Hinshelwood, 2002). Gabbard (1995) recommends reflection on particularly intense emotionally charged therapeutic interactions in supervision and in personal therapy. He also warns therapists to delay interpretive interventions on the enactments for a sufficient period of time to allow certain object relations examples become clear and the patient as well become in a more receptive and reflective state.

### 1.4.3.5. Self-Disclosure

A climate that favors openness, nondefensiveness, and a more mutual relationship between patient and therapist is reigning over in contemporary perspectives of psychotherapy. This climate implies the unrealistic nature of the therapist's anonymity (Strean, 2001 b, p.117). Gabbard (1995) also mentions that self-disclosure of countertransference feelings has became an acceptable part of psychotherapeutic technique and virtually all clinicians acknowledge that they are continuously making self-disclosure of various types. However, how to translate the therapist's feelings into useful interventions during the sessions remains an area of controversy. It is a great challenge to set a guideline on when self-disclosure is useful and when it is not (Strean, 2001 a). Yet there is a general guideline on the worthiness of restraint with regard to one's personal struggles (Gabbard, 1995). It is even recommended not to disclose certain specific feelings such as sexual or aggressive feelings (Maroda, 1994; as cited in Strean, 2001 a; Gabbard, 1995) that may be deeply disquieting to patients (Gabbard,1995). Strean (2001 a) reflects that disclosing countertransference reactions may be helpful in a state of therapeutic impasse or in situation from which there is no logical way out. He also appreciates the necessity of enactments for the awareness of countertransference that is always retrospective. Gorkin (1987; as cited in Strean, 2001 a) reviewed the literature on countertransference and emphasizes that countertransference disclosure confirms the patient's sense of reality, establishes the therapist's honesty, humaneness, and genuineness, can clarify the patient's impact on therapist, and on people in general, and may break through a negative therapeutic reaction.

### 1.4.4. Countertransference Management

Although the term countertransference has been around for more than 100 years since 1910 when first Freud mentioned it, the term remains abstract in its definition (Gorman-Ezell, 2009), operation and measurement (Rosenberger and Hayes, 2002 b). Despite the diversity of points of views on countertransference in

the literature, there is a general agreement that countertransference which is not understood and not managed properly may injure the therapeutic process and outcome. On the contrary countertransference, which is identified, controlled, and managed ameliorates and supports the therapeutic process and outcome (Gelso and Hayes, 2001).

Regardless of the lack of agreement on the definition of countertransference; there is agreement on how to manage it. Managing countertransference means coping with its negative impact and avoiding re-enactment while containing and metabolizing what the patient has transferred (Bichi, 2014). Despite the crucial importance of countertransference management for the vicissitudes of the therapeutic process there is limited amount of research focused on the management of countertransference feelings and behaviors (Gelso and Hayes, 2001; Gorman-Ezell, 2009).

Gelso and Hayes (2001) reviewed small body of empirical literature that is available on countertransference management and its effect on treatment outcomes. What is derived from this is that once countertransference is perceived and understood deeply as an internal reaction, it can be beneficial to understand the patient. However, if this internal reaction is acted out in the context of the treatment, the therapeutic alliance weakens. Gelso and Hayes (2001) comment that the first important contribution from literature to the management of countertransference comes from Reich many years ago, in 1951. They remind us that it was Reich who first addressed the fact that the therapist can have some patient identification that can lead to knowledge about the latent content of the patient's experience. The authors remark that with this comment, Reich highlighted three fundamental factors contributing to the effective management of countertransference feelings: the therapist's empathy that may be counted for partial identification, awareness of countertransference feelings, and the ability to make sense of these feelings. Authors add that empathy may also prevent countertransference behavior and help to manage therapeutic stance when facing with threatening material. According to their review of the literature on the topic they report that countertransference management is thought to include five

corresponding themes: self-insight (the awareness level of the therapist of his or her own feelings), self-integration (the recognition of ego boundaries, the capacity to differentiate the self from others), managing anxiety (the ability to feel the anxiety while having some control and understanding of what it is about so that the patient does not act it out), empathy (the capability to distinguish what the patient is feeling in order to help the patient address their needs), and finally conceptualizing ability (in order to structure the therapeutic work on a theory and comprehend the patient's relational dynamics on this theoretical basis. It is also offered that theory or conceptualizing abilities without awareness may be a hindrance for treatment as then theory can be used defensively. In another study of the same authors, but this time based on their own clinical experience, they comment that every therapist will have countertransference reactions on occasion, "No amount of self-integration, empathy, self-insight, anxiety management, or conceptualizing skills make a therapist immune to experiencing countertransference" (Hayes and Gelso, 2001 p.1047). In this study they clarify countertransference triggers and its manifestations. Regarding to its triggers, in line with previous research that report conflicted areas of therapist's life as an origin for countertransference, the authors share that when a patient reminds the therapist of someone significant in his or her life, such as a parent, a former client, the therapist him or herself, countertransference feelings are possibly aroused. Regarding countertransference manifestations they identify affective manifestations (e.g., anxiety which is a highly predictive significant of therapist's unresolved issues, anger, sadness, boredom, and nurturing feelings), cognitive manifestations (e.g., distorted perceptions of time, of what is talked about), and behavioral manifestations (e.g., avoidance, withdrawal, under or over-involvement).

Rosenberger and Hayes as well, in 2002 b, worked through the research on countertransference that has been conducted since 1977 in order to filter out some implications for counseling practice. The authors summarize that countertransference reactions are frequently negative feelings and are often triggered by the client's agenda that move the therapist's unresolved issues. It is

strongly emphasized that in the majority of cases, countertransference is triggered by some subjective perception of the therapist rather than by concrete events or stimuli (Rosenberger and Hayes, 2002 b).

Another study is conducted by the same authors, again in 2002 analyzed a single therapy dyad for 13 sessions. They examined in detail causes (predictions), consequences, and the effective ways that countertransference was managed. They used the observations of the sessions to support the previous research and observed that countertransference reactions arise when plausibly therapist and client factors interact. It is argued that in such cases, therapist tends to avoid conflictual material (Hayes and Gelso, 1991, 1993; Latts and Gelso, 1995; Peabody and Galso, 1982; Robbins and Jalkowski, 1987; Yulis and Kiesler, 1968; all cited in Rosenberger and Hayes, 2002 a). However, it is also found that in such cases the therapist becomes overinvolved or overidentified with the patient (Langs, 1977; as cited in Rosenberger and Hayes, 2002 a). In their study, authors observe the latter. Concerning the consequences of countertransference behaviors (avoidance or overinvolvement) the authors explain that in both cases the working alliance weakens. The therapist, when the patient discusses conflictual material, may feel unsettled, less of an expert, and less trustworthy. In turn, the patients may feel that the therapist less expert, less trustworthy, and less attractive. Consequently they both experience a shallow session (Rosenberger and Hayes, 2002 a).

Concerning the effective ways to manage countertransference feelings again they remain close to the previous research and echo but also emphasize the accuracy of the previous work. The therapist's level of self-integration (less fragmented personality and more stable boundaries) tends to reduce countertransference feelings as well as the levels of empathy, self-insight, anxiety management, and conceptual skills tend to ensure a better management of those feelings. In this relevant study, the authors report that the therapist's ability to manage her defensive feelings out of countertransferential issues increases her deep focus on the client.

Hayes, Gelso, and Hummel (2011) reviewed in detail the literature on countertransference in relation to therapeutic outcome. They reveal that countertransference is a universal phenomenon in therapy. Their meta-analytic findings indicate that therapist's self-care such as exercising, resting, reading for pleasure, meditating and not overscheduling patients helps to reduce countertransference feelings and enactment.

Very recently, in 2015, Hayes, Nelson and Fauth compared therapists' experiences of countertransference in nine unsuccessful and nine successful therapies. They report that successful cases of psychotherapy differ significantly in the therapist's efforts to manage, control and to prevent their countertransference manifestations. The authors note that those countertransference management efforts include reminding oneself to stay calm, objective, to be present for oneself and the patient, using self-awareness to catch up one's own reactions, distinguishing the patient from other people in one's personal life, taking care of one-self, discussing with and getting consultation from colleagues. The study, in combination with the contributions of therapist's efforts for the successful cases of psychotherapy, acknowledges that the severity, pathology of the disorder, resistance to change and social participation on behalf of the patient may lead to unsuccessful cases of psychotherapy. The countertransference manifestations in this study are similar to those previously discussed such as forgetfulness, over identification with the patient, a sense of helplessness, detachment, being overwhelmed or feeling like a parent. Once more, it is observed that countertransference reactions occur when therapy related triggers provoke the therapist's unresolved issues. In this study, Hayes and her colleagues clarify how countertransference management efforts help to work effectively. Accordingly, these efforts allow the therapist to reframe, decenter, depersonalize, and finally to attain an enlarged perspective. This new perspective and understanding, in turn, makes it possible to make adjustments and work more productively with clients (Safran, Muran, Samstag, and Stevens, 2001; as cited in Hayes et al., 2015).

To summarize, until the 1950s, countertransference was seen as a hindrance to therapy (Rosenberger and Hayes, 2002 b.). Today this is thought to be too constrictive., Now the belief that there is an informative dimension of the phenomenon that can assist the therapist in conceptualizing and treating the symptoms is largely recognized while it is still understood that unaddressed countertransference can be problematic (Singer and Luborsky, 1977; as cited in Rosenberger and Hayes, 2002 b.).

### 1.4.5. Countertransference in the context of Anorexia Nervosa

Empirical studies investigating countertransference issues while treating Anorexia Nervosa are few in number (Burkett & Sherman, 1995; Kaplan & Garfinkel, 1999: Golan et al., 2012). What stems from a literature review and research on this clinical experience is "the large spectrum of negative feelings that are likely to be evoked when treating patients with Anorexia Nervosa" (Golan et al., 2012, p.134). Patients with Anorexia Nervosa are assumed to induce intense feelings such as rage, hate, hopelessness, pity, sorrow, or love in anyone with whom they contact, as well as in their therapists (Vitousek, Watson, and Wilson, 1998; as cited in Golan et al., 2012). Among other countertransference feelings that are mostly mentioned while working with Anorexia Nervosa are: feelings of inadequacy, helplessness, love, anger, hate, rejection, being overwhelmed, anxiousness, depression, stress, frustration, jealousy, being controlled, wanting to act in a punitive, impotence, or omnipotence (Fassino, Abbate, Amianto, Leombruni, Boggio, and Rovera 2002; as cited in Golan et al., 2002).

Franco and Rolfe (1996) report that across eating disorder diagnoses, patients diagnosed with Anorexia Nervosa may evoke more intense feelings such as anger, helplessness, and stress in therapists than do patients diagnosed with Bulimia Nervosa. Mentioned possible reasons for these intense feelings in related literature are that eating disorders come with poor prognosis, considerable comorbid conditions, and treatment resistance (Burket and Sherman, 1995), the high probability of medical conditions, and suicidal behaviors surrounded by

neediness (Hamburg, Herzog, and Bortman; 1987; as cited in Golan et al., 2012). Moreover, therapy with Anorexia Nervosa is expressed to be similar to the developmental process. The therapist has to provide functions of a good-enough mother such as mirroring, tension regulation, and vitalization to a patient characterized with pathological interpersonal relational patterns while simultaneously managing her life-threatening destructiveness (Golan et al., 2012).

Based on their clinical experience and related literature, Kaplan and Garfinkel (1999) summarize the aspects of patients with Anorexia Nervosa that may contribute to the non-therapeutic reactions on the side of the therapist. They argue that patients seek treatment only after they have been ill for many years suffering from chronic, self-reinforcing symptoms. This deep-seated psychopathology makes the healing process much harder. It is mentioned that there is a paradoxical reality to the, adaptive role of the symptoms and the ego-dystonic aspect of anorexia. Patients seem to be unaware of the possible serious medical and personal burden that may result from their starvation and other symptoms. Moreover, patients with Anorexia Nervosa often suffer also from comorbid psychiatric disorders such as depressive, anxiety, personality, and substance abuse disorders (Kaplan and Garfinkel, 1999; Tasca and Ritchie, 2011). The authors argue that more than any other psychiatric disorder, patients with Anorexia Nervosa evoke intense feelings of hostility, anger, hopelessness, and stress in therapists. It is suggested that these feelings may be caused by the inability to engage in the seemingly simple act of feeding oneself. The authors indicate that countertransference feelings are also mediated by such issues as the therapist's case load and years of experience.

Warren, Crowley, Olivardia, and Schoen (2009), in their comprehensive study, investigate the reasons of the undesirable reputation of patients with Anorexia Nervosa, the ways therapists are effected in the course of treatment with this group of patients, and offer suggestions for an effective treatment process. This undesirable reputation may be because of the severity of the health consequences, the level of comorbidity, and the elevated chances of death and suicidality. They argue that the struggle of Anorexia Nervosa in sharing power

and control and their overvaluation of appearance and body while interpreting the world may challenge the therapist requiring him or her to assess symptoms within multiple contexts. Warren and colleagues report notable changes in the ways that therapists can be affected during treatment. Participants explain that as they work with Anorexia Nervosa their sensitivity to food and theirs and other's appearance becomes heightened. The majority of participants with a wide range of clinical experience indicated their conception of food was altered in these ways: an increase in food awareness, the perception of the meaning of eating as a basic need as well as their enjoyment of and their appreciation for food increased. Some participants also reported an increase in awareness/vigilance of how others appear after contact with a patient with an eating disorder. Majority of participants also reported that they became more cognizant and focused on their own appearances. Finally, some talked about intense negative feelings like anger, self-criticism and a sense of being unskilled. Participants reported that the most difficult challenges of this work were related to patient resistance to the severity of symptoms. such as body dysmorphia, rigidity, multiple diagnoses, medical complications, and confrontational personalities (domineering, demanding, abusive). The second most common theme was the poor diagnosis and relapse rates. The third most common theme was relationship issues such as the difficulty to built a therapeutic relationship, maintaining healthy boundaries, and managing countertransference reactions. The final two themes were time and resources required for the treatment process of these patients such as insurance, team collaboration and the ability to stay optimistic due to the poor prognosis. Additionally, participants responses to recommendations for those working with individuals with eating disorders was solicited. Receiving supervision, limiting the caseload, engaging in self-care while keeping in mind the chronicity of the illness and being realistic over the course and the results of the treatment were highly suggested. The complex but interesting and highly rewarding nature of the illness is also mentioned.

One of the earliest studies in the field, dating back to 1988, focuses on the possible countertransference reactions on food and body related issues such as alterations in perceptions on the physical appearance and food. Shisslak, Gray,

and Crago (1988) aim to explore therapists' reactions related to eating/exercise patterns, body image, and concerns of physical appearance in the face of treating Anorexia Nervosa and Bulimia Nervosa. They investigated 71 health care professionals who are ordinarily involved in the treatment of eating disordered patients with three years of experience on average. Twenty eight percent of the 71 participants reported that they were moderately to greatly affected by their work with patients with eating disorders. This affected group also reported a positive change in their eating habits, body image, physical conditions and appearance since the beginning of this work. Participants with a history of an eating disorder were found to be more sensitized to these issues. It was also found that the length of experience was not significantly related to the perceived affectedness.

With the interest to explore the experience of treatment providers with a personal history of eating pathology this time, Warren, Schafer, Crowley, and Olivardia (2013) asked 139 participants whether and how their history of an eating disorder influenced their treatment process with eating disordered patients. A vast majority of their participants believed that their eating disorder history positively influenced their work (e.g., increased empathy, greater understanding of disorder, more positive personal outlook). When asked to give advices to other therapists with an eating disorder history, they noted the importance of self-awareness and personal recovery that needs to occur before starting to work with this group of clients. They also highlighted the importance of avoiding overidentifying, attention to self-care, and of careful use of self-disclosure.

In the literature a few studies (e.g., Golan et al., 2012; Zerbe, 1993; Hughes, 1997) turn their scope to describe common conflictual relationship dynamics among patients with Anorexia Nervosa that may elicit intense countertransference feelings. Based on their own clinical experience and previous clinical research Golan et al. (2012) identified four conflictual areas of relationship dynamics that patients with Anorexia Nervosa create in the therapeutic dyad: Those areas are about control, unrealistic self-expectations, aggression, and true-self concepts. Patients with Anorexia Nervosa are characterized as having unrealistic self-expectations and control issues. Scully

(1983; as cited in Golan et al., 2012) states that unrealistic self-expectations together with power and control struggles is identified as the single most critical factor for the risk of therapists' burnout in working with Anorexia Nervosa. It is reported that in response to the patient resistance, the therapist may overly wish to rescue the patient or may attempt to over-control the patient's weight and meal times, or may be identified with the patient's projections of feelings of ineffectiveness, impotency, inadequacy. In the matter of the area of "aggression," it is reported that patients with Anorexia Nervosa may express their needs in self-destructive ways, and their autonomy in aggressive manners. During therapy, they may behave highly provocatively in a noncompliant, demanding, rejecting, and unpleasant way. In turn, successively therapists may feel angry, helpless, incompetent, and rejected. Regarding "true-self" issues, patients with Anorexia Nervosa do not believe that others can serve to fulfill their needs. As a result, they give up self-expression in order to secure interpersonal relationships. Therapists, in the therapeutic dyad, may find themselves in parallel process; either becoming preoccupied with the patient's demands or asserting their own needs in all costs.

Once more, regarding relationship dynamics, Zerbe (1993), based on her observations that clients with anorexia usually have traumatic pasts, identifies two core relationship patterns. The first one is the patient's masochistic tendency, which will push, in turn, the therapist to be the bad object. The second is her identification with the aggressor; in other words her tendency to be hostile which will push, in turn, the therapist to feel worthless, controlled, manipulated, and drained.

Hughes (1997), shares her experiences of countertransference in the treatment of Anorexia Nervosa based on her clinical experiences from a psychodynamic perspective. She identifies four common areas of challenge that a therapist may experiences in relation to the patient with Anorexia Nervosa: denial of the reality of sexual maturity, not really engaging in therapy and implicit refusal to take from it or from the therapist, eliciting special help only to sabotage it, and evoking acute anxiety in the therapist while remaining relatively free from it. She mentions many feelings such as frustration, inadequacy, helplessness,

hatred, fear, disappointment, over responsibility as her countertransference feelings in response to those challenging relationship dynamics. Hughes also suggests that these countertransference feelings may be used to get an idea about the patient's world. In other words, these feelings may be similar to feelings of someone from the patient's world, as well as similar to patient's feelings.

In another study, another relational dynamic is highlighted within the therapeutic dyad between a female therapist and a female patient with Anorexia Nervosa (Frankenberg, 1984; as cited in Golan et al., 2012). It is noted that the patient with Anorexia Nervosa may view the female therapist as a rival in the competition for thinness. This, in turn, may leave the therapist to bear the negative feelings if she is overly concerned with her body and weight. She may feel stuck and ineffective in connecting to the patient.

DeLucia-Waack (1999), based on her 11 years of supervising female counselors working with patients with eating disorders discusses potential countertransferences issues of which overidentification is one. In the beginning, it facilitates communication, connection, and a common base of experience but it has a risk to prevent the therapist from seeing her own competence and to truly help the patient. Regarding possible countertransference feelings about control, she recommends that therapists find an appropriate level of activity without asking all about the patient's weight or meal but simultaneously always keeping in mind that eating disorders cause many medical complications and to have a clear treatment plan. She comments that due to anorexia's slow progress and strong resistance to treatment and recovery, the therapist may realistically feel ineffective or helpless. She also notes that in response to anorexia's prominent characteristic of avoidance of affect, the therapist, as well, may exhibit concordantly avoidance of affect.

Hamburg and Herzog (1990) focus on often experienced countertransference feelings such as being secretive, intrusive, shaming, over controlling, overindulgent, or over-identified in the course of long term psychoanalytic therapy with patients with anorexia and bulimia keeping their focus on how these feelings are reflected on during the supervisory process. The

authors report that these experiences are often mirrored in the supervisory process. They indicate that exploration and addressing these issues in supervision is a valuable tool in conducting especially psychoanalytic therapy with patients with eating disorders.

In order to investigate the differences of attitudes between therapists who desire and who do not desire to treat Anorexia Nervosa and Bulimia Nervosa, Burket and Schramm (1995) investigated 90 (44 men, 46 women) therapists. They directly asked if they desire to treat patients with eating disorders or not and if not, the reasons, their experience of countertransference and the prognosis. 31% of the participants desired not to treat eating disorders. As the reasons for this reluctance, transference/countertransference issues, treatment resistance, comorbidity problems, physical problems, and excessive time demands were stated. The most frequently mentioned countertransference feelings were frustration, anger, helplessness, and anxiety as well as satisfaction and empathy. These feelings were reported to be equally common in both, the group who desired to treat eating disorders and the one that did not, except empathy was more common in the group who desired to treat patients with eating disorders. As mentioned before, the prognosis is found to be better for Bulimia Nervosa than for Anorexia Nervosa. Twenty-nine percent of the combined men and women groups believed that female therapists were better at treating eating disorders. Individual therapy was used as the sole treatment approach by 40% of those who desired to treat and by 60% of those who did not. This might signify that therapists who are flexible and receive support from adjunctive approaches experience more satisfaction with their work with patients with eating disorders. The psychodynamic approach was used as primary treatment of Anorexia Nervosa by more therapists who desired to treat such patients.

Satir, Thompson-Brenner, Boisseau, and Crisafulli (2009) in their study give a more positive reaction to working with individuals with eating disorders. Instead, they reported feelings of warmth and competence at significant level combined with negative affects such as anger, frustration, aggression, and boredom. Here the researchers looked at characteristics of both the therapist and

the patient as they may be related to countertransference feelings. They report that the patient's personality pathology and functioning level affected the clinician's reactions. As opposed to expectations it is reported that the number of years of the therapist in the field did not reflect a lower level of negative reactions; however, specialized training for working with eating disorders predicted lower level of countertransference feelings.

Regarding treatment effectiveness, Vanderlinden, Buis, Pieters, and Probst (2007) explored both patient and therapist perspectives on the necessary components of therapy. Their findings suggest that both parties hold similar opinions mentioning that together, work towards improved self-esteem and body image, problem solving, as well as increasing the impetus for change and understanding of how the eating disorder plays a role in the patient's life.

Thompson and Sherman, in 1989, discussed possible therapist mistakes while treating eating disorders based on a literature review. They discuss several common mistakes that happen in therapy such as unrealistic expectations, too much focus on the patient's actions vs. their emotional reality, and the therapist being too much in control.

In brief, it is common for therapists to have persistent countertransference during the treatment process with this population. These intense feelings are shown to arise from anorexia-related characteristics such as destructiveness in its different forms, ambiguous therapeutic success, pathological patterns of interpersonal relationship, but also from therapist characteristics such as case load, experience and education.

### 1.4.6. Countertransference management in the context of Anorexia Nervosa

The literature offers some strategies and guidances to manage countertransference reactions in the course of therapy with eating disorders. There are some recommendations such as developing the skill of empathy (Burket and Schramm, 1995), working on self-awareness (Warren et al., 2013), to getting further education about the field (Warren et al., 2009) and limiting the case load

and engaging in self-care activities, experience (Kaplan and Garfinkel, 1999). However, there is no known empirical study aimed to investigate deeply countertransference management in the context of eating disorders (Golan et al., 2012) and specifically in the context of Anorexia Nervosa. Strober's study dating to 2004, turns its focus on describing the psychopathology of Anorexia Nervosa (characterized by temperamental rigidity, deformed self-concept, fear of change, self-reinforcing nature of its symptoms) and its clinical management. He suggests that from the very beginning of the therapy with Anorexia Nervosa, the therapist's work is to make decisions of extraordinary delicacy because with patients diagnosed with Anorexia Nervosa, the slightest misstep may cause flashpoints for anger, symptom aggravation, strengthening of the already well-established resistance, or sudden termination. It is recommended to have peer supervision, individual supervision, or group supervision periodically to acknowledge, receive, and transform some reactive and possibly damaging feelings (e.g., slowness, boredom, pity, irritation, frustration, annoyance) that are very common when treating Anorexia Nervosa. Strober also states that working with Anorexia Nervosa demands for the acquisition of certain skills and qualities such as tolerance of sameness, perception of professional success that is not measured by patient progress, respect for privacy and solitude, ease of exploration of profound wounds, and acceptance of profound silence and deep-rooted sickness.

Golan and his colleagues (2012), based on literature review supported by their clinical experiences, divide the countertransference management process in three stages in order to proceed step by step and to clarify each step, eventually to clarify and to keep under control the whole therapeutic process (Golan et al., 2012). It is revealed that identifying negative dynamics in the intersubjective space is the first step of the management of countertransference. The second step is to facilitate to breakout the problematic relational pattern and to work on a healthier one. In the third step, once a countertransference enactment is identified the therapist should be able to translate this enactment and related-feelings into non-accusatory statements in order to clarify and to work on it. It is stated that the ultimate step in treatment is to transform the recurring maladaptive patterns and to

develop a stronger sense of coping self, which will be allowed only by the correct identification and handling of countertransference reactions.

## 1.5. OBJECTIVES OF CURRENT STUDY

The review of the literature reveals a number of studies that investigate therapists' feelings of countertransference while working with patients struggling with Anorexia Nervosa. The most consistent theme indicated in literature is this population of patients may bring up intense feelings in psychotherapists and they are postulated to be "difficult" to treat (Hughes, 1997; Golan et al., 2012). This opens up an important question for clinical practice: what is the experience of therapists who work with Anorexia Nervosa and in what ways do they address, clinically, the emotional challenges that they encounter? Very few studies explore these questions, and as far it is known there is no research conducted in Turkey on countertransference with Anorexia Nervosa. All in all, there seem to be some gaps in research relating to this subject, countertransference and its management. This current study can add to the current literature in terms of experiences of psychotherapists who work with this population.

This study's goal was to perform an in-depth exploration of therapists' countertransference while working with patients with Anorexia Nervosa. Therefore, in this thesis, qualitative research has been used for in-depth examination of the experiences and feelings of the participants, with a focus on understanding their experiences from their own perspectives. A combination of focused and open-ended questions were used with the intention of conducting flexible investigation with each participant. The use of open-ended questions permitted the interviewer and participant flexibility in identifying and exploring the most salient themes while the use of focused questions allows the exploration of previously defined areas of investigation.

The first objective of this study is to gain an overall sense of how therapists experience the therapy process with patients with Anorexia Nervosa. The second objective is to attain a deeper understanding of the complex and

intense countertransference reactions that may occur within the therapist in the course of therapeutic process. Finally, the third objective is at the end to achieve increased knowledge about how these countertransference reactions are best managed and, if possible, utilized in clinically useful ways. This study is also anticipated to create an opportunity for therapists and for psychotherapy trainees to learn about how colleagues in the field of eating disorders have managed their countertransference, which may provide insight into the identification and management of those experiences in their own work.

# CHAPTER II
# METHOD

## 2.1. INCLUSION CRITERIA OF THE PARTICIPANTS

Five psychotherapists were interviewed for this study based on the following criteria:

1) The participant was a licensed clinical psychologist or a psychiatrist who practices psychotherapy
2) The participant self-identifyied as psychodynamically-oriented
3) The participant was:
    a) currently working with at least one patient that fits the DSM-5 criteria for Anorexia Nervosa for at least six months, or
    b) had worked with at least three patients with Anorexia Nervosa in long term therapy, for at least six months, in the last five years, or
    c) had worked with at least ten patients with Anorexia Nervosa in long term therapy, for at least six months, throughout their entire career.

## 2.2. SETTING AND PROCEDURE

### 2.2.1. Identification and Recruitment

Potential participants were identified through referrals and word of mouth based on the criteria stated above. Following the Istanbul Bilgi University Ethic Committee's approval, the researcher contacted the potential participants by telephone, or e-mail. Once the researcher reached the potential participants she introduced herself, the study, and the criteria for participation. The researcher introduced herself and the study as follows, "I am a student in the process of earning my degree as a clinical psychologist. For my master thesis, I am investigating the phenomenon and the potential use of countertransference of psychodynamically oriented psychotherapists while working with patients with

Anorexia Nervosa according to DSM-5". They were told that the information they provided would be used anonymously in a qualitative study. They were also told that the information acquired during the interview would be kept confidential. They were asked whether they were interested in to be a participant of this master thesis. All the potential participants expressed interest in participating in this study. A 45-minute meeting at the participants' offices was scheduled.

### 2.2.2. Interview

Participants were interviewed at their offices for the duration of 45-minutes. They were told that they could interrupt and withdraw from the interview at any point.

After the introduction the informed consent form (Appendix A) was reviewed. The following points were especially emphasized:

1) All the information shared during the interview will be kept confidential and included in the study anonymously.
2) The participants will be free to terminate and withdraw from the interview at any point.
3) The interview will be audiotaped and then transcribed only by the researcher herself.
4) The interview can contact the researcher if she has further questions on the research or if she has any negative feeling about it.

All the participants made clear that they understood the study and signed the consent form.

Before the research questions, a brief set of demographic questions (Appendix B) were introduced. The questions include their education level, training or further education on eating disorders, years of experience as a psychotherapist, the number of their current patients with Anorexia Nervosa, the total number of their patients with Anorexia Nervosa throughout their career, and also the time period that they worked with those patients.

Following the demographic information, participants were asked about their experience with their patients with Anorexia Nervosa through open-ended questions. Those questions were refined according to a pilot study with a psychotherapist who does not fit the selection criteria but who has experience with clients who have anorexic-like behaviors. Accordingly some unclear and repetitive questions were identified and revised as well as the duration of the interview was estimated.

The participants were first asked to differentiate their experience of psychotherapy with patients with Anorexia Nervosa with an open-ended question, "Could you compare psychotherapy process with your patients with Anorexia Nervosa and with your patients with other struggles?"

In the second open-ended question, participants' general feelings while working with patients with Anorexia Nervosa were investigated, "How did you learn that your patient struggles with Anorexia Nervosa? What feelings did you have when you first learned about the patient' struggle with Anorexia Nervosa and while working with this group of patients throughout the process?"

In the third open-ended question, participants' subjective experience of any challenging situation or feeling was investigated in a detailed manner, "Could you elaborate any challenging situation or feeling that you have experienced throughout the sessions?" The following probe questions were used:

- Could you manage to control these situations? How?
- Could you work with them in a clinically useful way?
- If not what do you think were the possible obstacles?

Finally, participants were asked to discuss their perspective on managing countertransference, "Could you tell me, in general, your ideas about the management of challenging feelings that might affect the therapeutic stance in the context of Anorexia Nervosa?" This question was followed up with probes:

- How does one identify countertransference feelings?
- How can these feelings be managed, controlled, and maybe transformed into interventions throughout the sessions?

## 2.3. DATA ANALYSIS

IPA (Interpretative Phenomenological Analysis) was selected for the analysis because IPA is considered to lead to a deep understanding of therapists' first hand experiences. In the literature, IPA is also suggested to be very efficient in order to capture first hand interpretations of personal experiences (Smith, Flowers, & Larkin, 2009). IPA is also recommended if the working sample is relatively small and if the researcher wants to maintain a more idiographic focus (Smith et. al., 2009). Since the goal of this research is to deepen the understanding of the five therapists' unique experiences about working with patients diagnosed with Anorexia Nervosa, IPA was quite beneficial. As IPA (Smith et. al., 2009) imposes, the researcher wrote down her analytic observations about the data on the interview transcripts. I, as the researcher, read and listened to each of the participants' responses again and again to reach clarity and to prevent any missed responses. These notes were used in order to develop themes. Once emergent themes were identified, superordinate themes were developed. Based on the superordinate themes, the framework for the analysis was organized. Emergent themes are shown in detail throughout the results part as well as discussed in the discussion part of this study.

# CHAPTER III
# RESULTS

In this section, the demographic information of the participants and the final thematic clusters resulting from the analysis will be presented.

## 3.1. PARTICIPANTS' PROFILES

**Participant 1** is a clinical psychologist with two MA and one PhD degree within the domain of psychology with ten years of experience as a psychotherapist. In the course of the interview, she expressed that she will complete her psychoanalytic formation soon. Currently she does not have a patient with Anorexia Nervosa. Her last patient with Anorexia Nervosa terminated treatment 6 months ago. In total, she has worked with five patients with the disorder: three patients for two years each, one for five months, and one for a three months of period.

**Participant 2** is a psychiatrist who had had the opportunity to follow up many anorexic patients in a hospital setting. She has thirteen years of experience in the field. She also has special education in eating disorders and participated in many working groups on eating disorders. She will complete her psychoanalytic formation soon. This participant has worked with more than 100 patients with Anorexia Nervosa five of whom she provided long-term treatment lasting on average four and a half years. As recently as five months ago she terminated with a patient who had two years of treatment.

**Participant 3** is a clinical psychologist with thirteen years of experience as a psychotherapist. She works in a health institution. In the course of the interview she expressed that she will complete her psychoanalytic formation soon. Currently she has two patients with Anorexia Nervosa. She has been following one of them for more than one year, the other one for more than two months. In total she has

had seven patients with Anorexia Nervosa with whom she conducted psychoanalytic therapy; however, if the number of patients she saw in the hospital were included, the number would be higher.

**Participant 4** is a clinical psychologist and an academician. She has a PhD degree on psychology and specialized in eating disorders in USA. She got her further educations on eating disorders in UK. Currently she is following her patients in a private clinic in Istanbul and teaching at university. She also leads working groups on eating disorders with her students. She has fifteen years of experience as a psychotherapist and has followed innumerable patients with Anorexia Nervosa. She reported that between the years of 2005 and 2011, seventy percent of her caseload in thirty hours of weekly working used to be composed of patients with eating disorders. Currently she is following six patients with Anorexia Nervosa. Treatments are taking places for between three months up to one year.

**Participant 5** is a clinical psychologist and an academician. She has a PhD degree in psychology. She has done her internship on eating disorders. She has fifteen years of experience as a psychotherapist and had numerous of patients with Anorexia Nervosa. Currently she accepts her patients in a private clinic and teaches at university. She is also a psychoanalyst. At the time of the interview the participant had worked with two patients with Anorexia Nervosa; the first for two years and the second was followed for one year. In the context of hospitalization, she saw number of patients with the disorder and on average sustained one year of treatment with less than 20 of them.

## 3.2. RESULTS OF THE DATA ANALYSIS

This research has four focus areas: 1) the therapist's conceptualization of Anorexia Nervosa, 2) the experience of therapy process on the part of therapists, 3) countertransference feelings reported by the participants, and 4) the management of these feelings in order to prevent any damage to treatment and ideally to improve the benefit of the clinical process. For each focus area emergent themes appeared throughout the analysis and superordinate themes were formed according to the emergent themes that are showed below.

### 3.2.1. The Conceptualization of Anorexia Nervosa: The Anorexic Mind

Throughout the interviews related to the therapists' own conceptualizations (formulations) of Anorexia Nervosa, four emergent themes appeared all indicating one superordinate theme: an anorexic mind.

It is believed that a unique anorexic core exists underneath the Anorexia Nervosa formation. Throughout interviews, all participants referred to some manifestations of the anorexic mind as expressed by obsessions with control, no giving no receiving in relationships, muteness of the disorder, fear of being fed as it refers to the awareness of pain, envy, dependence, truth, depression and also to denial of the illness and suffering. Indeed, the anorexic mind is full of life force underneath the surface. In sum, according to participants' discourses, the anorexic mind appears as a narrowing of being.

**Control-obsessed.** All and each participant mention control issues in the patient's life. The absence of a sense of control in one's life expressed by participants acts to facilitate the formation of the patient's fixations at one narrow area related to weight, body, and food. Participant 4 clarified how Anorexia Nervosa creates an alternative world for the patient in order so that she feels in control of herself and protects her ego formation from dissolution. In her words:

> Anorexia is a way of taking control of one's life. We cannot control everything in our lives but how we react is in our control. The one with Anorexia Nervosa does not have the skills to cope with difficulties in life. When as therapist you help her to develop these skills she does not need Anorexia any more. An eating disorder is a defense mechanism to keep the integrity of the patient's ego formation.

She also commented that the extreme control of the body in Anorexia Nervosa indicates the extreme restriction of one's life space:

> The life space narrows as much one draws back to her own body. When you expand your life space you find other things to control. In Anorexia Nervosa she has been left with nothing to control in her life. Everybody penetrated herself. Only the body is left to her to control. What I do in the therapeutic process is to widen her life space to make her detached from the body.

Similar to this, Participant 1 described Anorexia Nervosa as an extreme control of boundaries. She expressed that the patient with Anorexia Nervosa ends up without any genuine relationship because of her paranoid horror that others will penetrate her. Also, Participant 2 emphasized the patient's terror with regard to the diffusion of boundaries between herself and her mother, "In Anorexia Nervosa, usually there is a confusion about whether this is her own body or this is her mother's body. The patient tries to eliminate her mother's body from her own body." She further expresses, "Patients with Anorexia Nervosa are missing their whole life because of their extreme fixation on control of their weight, food, purging, eating… They are wasting their whole life all alone."

**Muteness.** Muteness about Anorexia Nervosa is also emphasized throughout interviews. For instance, Participant 1 interprets:

> These patients do not talk at all or they talk very little. They communicate their sorrow through their body. Their muteness requires extra attention on the part of the therapist. The therapist should observe the patient as she observes a baby.

Participant 2 differentiated the patient with Anorexia Nervosa from her other patients, “They do not express themselves with words instead they act. They remember by acting. They do not verbalize any feelings especially aggression.”

Participant 3 shared that many times in her therapy with patients with Anorexia Nervosa, she used to find herself thinking to give material such as a play dough, or some clay into their hands and ask them to do something with it, “Thus, with the help of this visual thing that she created we could make contact, talk about it in one session and could continue talking in the next session. I guess a visual thing may help them to express themselves.”

**Fear of being fed.** The fear of being fed appears in many forms throughout the discourses of the participants such as the denial or the removal of any awareness of suffering, envy, dependence, or need, or the refusal to make any therapeutic contact or alliance, as in closing the possibility receiving and giving. In sum, fear of being fed is revealed through the patient’s reluctance towards growing-up, making steps for a change or for a healing. As Participant 1 reflected:

> It is hard to generalize, but patients with Anorexia Nervosa have difficulties in settling down in the therapeutic process. It takes very long time for them to build a transference relationship. They deny any need for therapy, or they make fake contacts. When we made any contact or she felt something in a session, I knew that she would somehow sabotage the therapy in the next session.

This participant defined the anorexic state of mind on the basis of relationships. She expressed that those individuals do not receive anything in or give anything out, “They pretend to relate. This is a state of mind that takes the psychological food inside but then spits it out as they do to physical foods. They are doing the same thing to psychological food.” She added, “Even though I give them everything in small bites they transform them into a solid form again. My milk does not nurture them. Nothing works.”

To express the anorexic mind that colors their relationship with the world she explained:

> The patient may have no apparent weight problem but still I can sense the anorexic state of being underneath. An anxiety, a doubt appears in me about how we process. From the very beginning some challenging countertransference feelings arise in me. When I learn about an anorexic past I do not get surprised.

She also commented on the fear of being fed and recommended on how to work with it:

> For anorexia the issue is that they have a huge fear of being fed. That is why especially in the beginning it is better to go slow, with baby steps. Maybe it is better not to feed them at all, not to give any interpretation at all. It is better to contain them, just to stay with them in sessions. In the beginning being faced with any emotion or awareness of any emotion will be horrifying to them.

Very similarly Participant 2 stated, "It manifests as an unwillingness to go deeper in their therapies, or as premature terminations, which is very prevalent among this group of patients."

Another Participant 5 also pointed to the fear of being fed, expressing, "The most important thing to consider with Anorexia Nervosa is not to get intrusive and make fast interventions. Very slowly, as she gets ready and her symbolic world develops, she becomes able to benefit from the therapeutic good."

To reflect the extremity of rigidness and solitude of Anorexia Nervosa another Participant 4 shared that she used to have difficulties in understanding their isolation in the beginning of her career but later with the help of trainings, and supervisions she grasped the mentality of the struggle:

> Anorexia says to the patient, "You belong only to me, I am your only friend, and only I can be in your life, no one else. While not eating we will keep the difficulties, anxieties, and fears away from you.

To indicate again the developmental arrest in anorexia, Participant 5 stated, "Anorexia Nervosa is the refusal of the new more sexualized, more impulsive body and its new power and responsibilities. Those patients are the ones who could not settle in their new, grown up, feminine bodies."

In line with this, Participant 2 noticed that it is very dangerous for the patient to get her periods or to gain weight early in the treatment, "The psychological and the physical development should go together in harmony. If they start to menstruate while their mind remains child-like they will highly drop out of the therapy."

Another of the participants, Participant 3, shared how she was relieved and touched when a patient of her expressed her feelings of gratitude towards her own sister who was taking care of her. She expressed that her patient's obviously improved ability to contact with others gave her hope and that it was a turning point for them in their therapeutic relationship.

**Untouched potential.** Four out of five participants emphasized that especially people who suffer with anorexia keep a huge potential of life force inside them that is also paradoxical to the apparent dryness in their lives. For instance, Participant 2 stated:

> They are perfectionist, intelligent, and bright. They can surprise you with their talent and creativity. When the depressive side in them starts to fade away with the help of therapy the creative part comes to the surface and they just proceed in life easily and quickly. They create their own supportive social network, find a partner, succeed in work.

Other participants reflected similar comments, "With all their resistance towards change they have an incredible power in them. Their resistance looks like as if it will never fade away, on the other hand this resistance holds a power for change. If this resistance can be broken up this power can flourish." (Participant 3), "They are very creative, intelligent, and successful people. In fact their life energy is huge. Their eating disorder serves to manage their vulnerability resulted from their repressed passion for life" (Participant 4), and "People with anorexia are highly intelligent and successful. But their social life is ended by the disorder. If we can manage to widen their social life in therapy, there is no reason that they won't have any satisfying life" (Participant 5).

On the other hand, Participant 1 expressed that an anorexic core stays with individuals once suffered from anorexia. She added that although the patient

seems to be recovered she can sense easily their rigidness and fear in relationships.

### 3.2.2. The Therapy Process with Anorexia Nervosa: Keeping on One's Toes

When the therapists were asked to differentiate the therapeutic process with their patients who struggle with Anorexia Nervosa and their patients with other struggles they all referred to keeping on one's toes in other words playing safe because of the medical risk of the illness, its high comorbidity with other psychological disorders, the patients' resistance to gain weight, and their reluctance to attend therapy.

**Medical condition.** To point out medical risks in Anorexia Nervosa Participant 4 stated:

> For Anorexia there is a medical reality that is why in the beginning, my approach is totally behavioral and medical. Absolutely, they should be followed up by a team that includes a dietician, psychiatrist, internist, endocrinologist, gynecologist, and psychotherapist of course. It is obvious that individuals with Anorexia Nervosa have chemical imbalances. There is improvement in therapy only if the process includes drug support such as anti-anxiety, anti-depressant, or anti-psychotic drugs. The comorbid struggles should be broken up.

She also added that she does not accept any patient below a certain body mass index for outpatient treatment, "At the point that the patient needs to first strengthen her body psychological work does not do so much. Anorexia is a dangerous illness, they may have an heart attack and die any point." Accepting a patient below a certain body mass index is not ethical.

Similarly another Participant 2 explained:

> They are taking the risk of being at the end of their life so easily. But as a psychotherapist and a doctor I cannot take any risk. From the beginning I get support from a dietician, an endocrinologist, of course, who knows anorexia and who does not force the patient to gain weight too soon. When

> I used to work at the hospital it was easier to work as a team; yet in my private clinic I also have my team with whom I follow this group of patients.

She also mentioned that Anorexia Nervosa has the highest mortality and suicide rates among psychiatric illnesses. She continued:

> When the matter at hand is Anorexia Nervosa you need to monitor her medical conditions very carefully. Her heart may stop anytime. Her electrolyte balance, her potassium level, has to be checked regularly. You cannot keep your psychoanalytic approach when treating anorexia.
>
> Participant 5 expressed:
>
> This group of patients requires much faster interventions than any other patients due to the medical risks. You need to move fast without any waste of time or energy, without letting the patient fall into desperateness. I have a higher level of anxiety with these patients. Moreover most of the time they seek treatment as a last exit, after the disorder becomes chronic. This lateness urges you to hurry up.

**Comorbidity.** All participants explained how complex and challenging the therapy process is with Anorexia Nervosa due to the comorbidity with other psychological struggles in general. Participant 4 stated:

> Anorexia Nervosa is not coming as an eating disorder alone. In general, together with it, there is sexual violence, alcohol, drug addictions, bipolarity, depression, obsessive compulsive disorders. This population with Anorexia Nervosa has high level of comorbidity. Working with them requires a team of professionals, further education, and strict and close supervision.

She also pointed out an obsessive compulsive pattern in anorexia that should be controlled by psychiatric drugs.

Participant 2 also commented on the comorbidity, “Anorexia and depression are comorbid. Anorexia does not come without the second.” She underlined the importance of working on depression in the treatment of anorexia. She expressed that the recovery of anorexia passes with the removal of the

depressive part, “Once the depressive, dull part of the diagnosis starts to diminish with the help of the therapeutic process, a very creative, playful part of them appear. And they just walk on their lives.”

Finally, Participant 5 emphasized the use of projective tests in the complexity of Anorexia Nervosa in order to identify the personality organizational level and type and make a treatment plan as soon as possible.

**Resistance to gain weight as the biggest challenge.** All participants agreed on the resistance of Anorexia Nervosa to gain weight as the most troublesome and crucial part of the treatment process. Participant 4 expressed:

> From the very beginning, I don’t accept any patient for an outpatient treatment without checking the blood test. I weigh them regularly especially in the beginning of treatment. The biggest challenge in their therapy is the resistance to gain weight. I weight them but they do not see the number. This is a treatment technique. Sometimes, they come having drunk a lot of water, or eaten, or with many things in their pockets. As a therapist you should to be experienced to deal with their resistance. They are not only deceiving you, they are sabotaging the process towards their healing.

Furthermore she underlined that in Anorexia Nervosa, the body and the brain do not get enough nutrition, which may cause a diminished capacity of reality testing. She explains that Anorexia’s psychotic-like fear of gaining weight may be due to that deficiency. To overcome this resistance she shared:

> In my therapy I make them believe that I am not here to make them fat but to make them healthy. I tell them that I am not fat because I am doing what I am telling them. As a therapist I act as a role model and I teach them not to be frightened of food again.

Similarly Participant 2 said, “In the beginning they are so afraid, as if they will soon become obese. Their agitation should be calmed down otherwise they do not keep coming to the therapy.”

Participant 3, who works in a hospital setting, shared, “Their resistance to get and maintain a healthy body weight is a kind of suicide. They are many times so out of hand that as a team we can not keep them in treatment.”

Participant 1 commented, “With these patients the most important thing in the process is slowing down as they have an extreme fear of food. With psychological food as well, the same fear prevents them from getting anything nutritious inside them.”

Similarly, Participant 5 explained:

> Especially in therapy the resistance to gain weight is the primary challenge in the process. The aim seems to be weight gain but simultaneously it is very risky and destructive for progress. Throughout the process the psychological and physical development must go in harmony. The therapist should not put weight gain at the center or take it as an indicator of a healing. On the other hand, due to the medical realities, weight gain is at the very center of the process.

**Two steps forward two steps back.** Participants verbalized the slowness of the process of working with Anorexia Nervosa and the patients’ reluctance towards therapy. For instance Participant 1 described the process:

> The work with this population of patient is like two steps forward one step back even I can say two steps forward two steps back. When any progress happens in a session, she disappears in the next, or she forgets to pay, or she behaves in a very aggressive
> manner. The therapist should bear to proceed in baby steps.

She also shared her astonishment and frustration, “Even after two years in treatment, the same topics, same struggles were coming again and again. I used to ask myself how it is possible and whether it is real or not.”

Participant 3 stated:

> Being a psychotherapist of a patient with Anorexia Nervosa is like paddling hard to one side while seeing her paddling to the opposite side. However this is not a waste of time. I keep going thinking that at least we

are not going back. Sometimes only being stable gives the hope to go forward.

Participant 2 also stated similarly:

When the patient feels any tiny transference feeling most probably she does not come to the next session. Usually those patients do not come and work, or try to resolve her feelings instead they break off the relationship and inhibit the progress.

Participant 5 argued that also the family factor slows down the therapy:

Even for adults, family and friends are too interested in her eating and their over-involvement really sabotages the process. They are unconsciously promoting her anorexia. We try to understand the dynamics behind it and to keep them calm and away from the therapeutic process.

She cited another factor that contributes to the near-stable slowness of the therapy process with anorexia which is the patient's tendency to drop out of the therapy once she starts getting better, "With Anorexia Nervosa the better she gets the higher the risk of escaping from the process."

### 3.2.3. Countertransference Feelings

Across interviews there were several emotions and feelings that were mentioned by therapists while working with their patients with Anorexia Nervosa. All participants expressed that the complexity of the emotional life of this group of patients have made the therapeutic sessions particularly challenging for them. The feelings reported throughout interviews are grouped under three themes: maternal feelings, abuse-related feelings, and starvation-related feeling.

#### 3.2.3.1. Maternal Feelings

**Feelings of insufficiency.** All participants stated that they occasionally felt insufficient for their patients with Anorexia Nervosa. Participant 4 shared that in early years of her career she used to have difficulties in understanding Anorexia Nervosa, the disorder itself:

> I could not make any sense of anorexia's isolation from life and her fixation on food and weight. But later with the help of many educations, trainings, seeing many patients, hearing same stories again and again I noticed that anorexia has a logic. Anorexia draws all the energy, all the attention of the patient in order to protect her from further disappointments in life.

Participant 1 again shared her feelings of insufficiency:

I used to give bites in small pieces again and again to the patient as if giving to a baby but each time she transforms those bites back into their solid states. At the end you see that your milk does not feed her. In those times I used to feel that I could do nothing good for her.

A third therapist, Participant 2 talked about her deep feelings of insufficiency as resulting also from the projective identification mechanism. She stated that those feelings may also reflect those of the patient:

> Besides the feelings of anger, anxiety, sadness, working with Anorexia Nervosa may elicit deep feelings of insufficiency in therapists. I used to ask myself, "Why am I not enough? What can I do further?" Those feelings are predominant while working with Anorexia Nervosa.

Also, Participant 3 reflected her insufficiency feelings:

> I used to feel like a machine working for nothing as if we were doing over and over the same things. I used to have difficulties in keeping myself in the process. In those times my own analysis and supervision used to help me to stay in.

Likewise, Participant 5 shared:

> When a patient gets worse I obviously feel insufficient and I struggle on deciding how far to go with that patient. Working closely with a team and deciding together whether to send her to hospital or not calms me down and helps me stay stronger behind the decision. Because sending the patient to hospital may mean to her being left alone with her destiny.

**Anxiety.** All participants talked about their anxiety feelings due to the medical conditions. They all agreed that Anorexia Nervosa is a medical disorder

thus the patient's medical condition should be monitored constantly. Likewise, they all shared that the treatment of anorexia requires a teamwork and some urgency.

Participant 2 expressed:

> Among the psychiatric disorders the mortality rate is the highest for Anorexia Nervosa. It is a dangerous disorder that is why I am anxious and nervous throughout the therapy process, especially in the beginning. I have to keep many things in my mind and find a balance between reality and fantasy, between her medical conditions and the transference-countertransference world between us. The work with Anorexia Nervosa is different from regular psychodynamic work.

All participants shared that with anorexia the possibility of a medical complication is very high and this in turn, creates anxiety and a feeling of urgency in them. Patient 5 spoke out those feelings, "Anorexia's symptoms are those called by Freud as deadly symptoms. Hence we do not have the luxury to say to patient, "Lay down on the couch and let's work for years." She also mentioned, to express again her feelings of urgency, that this group of patient usually seeks treatment long after having struggled with the illness with an increased sense of being overwhelmed. In her words; "I feel an urgency to intervene immediately to alleviate their symptoms and calm down their overwhelmness."

**Sadness.** Sadness is another prevalent feeling shared by all participants. For instance, Participant 1 expressed that witnessing those patients destroying themselves used to stir up intense feelings of sadness in her. She also shared, "They are sad, and grieving people. They are grieving for another life, for the loss of another life." Likewise, Participant 2 expressed, "In my first meetings with patients with Anorexia Nervosa I feel sad for them. They are so fixated on eating, weight, purging that their whole life passes by. They miss their whole life."

Participant 3 as well verbalized her feelings of sadness:

> As I work in a hospital setting, they come first for inpatient
> treatment. I go to their hospital room, I introduce myself and I invite them to therapy room. It is like I go to their home to get them. They are in

their sleepwear, in their slippers. Foremost, their situation is so traumatic.

Participant 5 shared her sorrow and her helplessness when she had to send a patient whose condition had gotten worse to the hospital, “This may mean to her that she is left alone with her destiny.”

**Hope and Reverie.** Hope is asserted throughout the interviews accompanying the therapy process even though many times it is hard to keep it alive with patients with Anorexia Nervosa. Participant 5 explained:

> I put myself in a very maternal position because especially in the beginning, a therapist should be very inclusive and very enduring to the patient’s strong anger, aggression, stubbornness, resistance towards her own mother. However, after a while, if the patient has the capacity and the desire to get well my anxiety turns to the feelings of freshness and I find myself fantasizing about her future.

Participant 2 similarly expressed:

> After a while in therapy with patients with Anorexia Nervosa if they keep coming, a very creative part of them appears. Together we start fantasizing about possibilities ahead. The process and play between us becomes very colorful, astonishing, and exciting.

Participant 3 also talked about hopes for the future:

> The patient’s ability to fantasize about her own future goes as far that my ability of fantasizing about her future goes. Thus the therapist should first mobilize her own creativity then work on her patient’s capacity.

Furthermore, Participant 4 who first worked with a more direct approach with Anorexia Nervosa underlined similar feelings of hope:

> When I first meet patients with Anorexia Nervosa I feel that I can help them. Because I have a very strong education and structured-plan of treatment. I know what to do in each step of the process. I know many cases who got well. I know the highly possible good results. That is why there is always hope. I tell them that they are at the right door.

On the other hand, Participant 1 expressed that although she has hope that those patients may be recovered she has hard times to keep this hope alive.

### 3.2.3.2. Abuse-Related Feelings

All participants spoke about their patients' sabotage of or withholding from the therapy process which in turn result in the therapist's experiences of feeling like a victim such as: feelings of being attacked, tortured, disabled, and manipulated by their patients. However it can also be said that it is a reciprocal process since two participants noted feeling as the aggressor (feeling like a controlling or castrating mother) towards their patients when they were explaining the way they respond to the steadfast manipulations of or resistance of the patients towards the therapeutic process.

> **Feeling like a victim.** Participant 1 expressed feelings of being disabled:
>
> Throughout the therapy process, my patients with Anorexia Nervosa were creating a sense that they do not need any help, any therapy at all, or the therapy is not helpful at all. I used to think that my milk was in no sense beneficial to them. They were not growing at all. They used to seem to take it in but then were spitting it out immediately. This group of patients is difficult to settle down in therapy.

She continued to explain her feelings as if she were the target of an intense aggressiveness on the part of her patients, "When I think about my patients with Anorexia Nervosa I remember that they were aggressive to the therapy framework, not making any contact at all, their smiles were as if they were grinding their teeth." She also shared, "With patients with Anorexia Nervosa I used to frequently experience the intense feelings of being attacked, tortured. I also used to feel anger towards the patients' internal objects."

Participant 5 reflected similar comments, "As a therapist you have to tolerate the patient's intense anger towards her own mother that is reflected on you. In those times you may feel anger towards the mother, father of the patient." Participant 2 expressed her anger about having being manipulated at all cost when a patient was using her bloodthirsty behaviors towards her own body to control the process. Participant 3 also shared her anger, "You need to be very strong and patient with people suffering from Anorexia Nervosa. The process is slow, they

are so angry and this may turn to make you angry." She also reflected her feelings of being disabled, "When I look back to my work with Anorexia Nervosa I can tell that I was not enough to work with this group of patients. Maybe not experienced enough, I don't know but simply not enough"

Another two participants also mentioned the importance of the therapist's experience in order to face and to efficiently manage the patients' strong inclination towards sabotaging their own therapies. Participant 4 explained that in order to encounter persistent, steadfast manipulations of such a complex disorder over the therapy process, the therapist must have experience and moreover, special education. Participant 2 commented that a psychotherapist who does not work usually with such patients can get angry and exhausted very easily by their continuous trickeries and deceptions, and blame them for their sorrow or struggle.

**Feeling like an aggressor.** Participant 2 shared that in order to deal with the patient's resistance to treatment and her constant sabotage of the process, she may behave and feel as an over-controlling mother. She commented that in those times reminding herself to consider both respecting the autonomy of the patient and firmly following her medical situation helps her to find a balanced way of responding to the patient. Likewise Participant 5 described her feelings as a castrating mother in order to encounter the patient's manipulations of the process, "With this group of patients, I have to be clearer, firm, or more even over-authoritarian about the therapeutic framework in order not to be taken in by her manipulations."

She also portrayed how sometimes being a little threatening works in the process:

> When a patient is getting worse after a while in therapy, reminding her of the obvious possibility of hospitalization maybe in a little threatening way may help her to bounce herself back and to be motivated again to work on throughout outpatient treatment if the therapeutic alliance is already formed.

### 3.2.3.3. Starvation-Related Feelings

This inference emerged from participants' expressions of feeling as if drained or even further feelings of deathliness.

**Feeling drained.** Participant 3 shared how she used to feel helpless and alone with one patient of hers and how she was relieved and her feelings of isolation disappeared when she saw the patient's sister at hospital taking care of her. She also communicated feelings of desperation throughout the interview by describing the therapy process with Anorexia Nervosa as; "two steps forward one step back," "a machine that works for nothing," and "I am paddling to one side while she is to the opposite side." Throughout the interview she also expressed how feelings of insufficiency and helplessness used to lead her to feel drained. She shared that at these points it was difficult to keep going, to keep herself in the process, and to keep herself happy.

Likewise Participant 1 described the therapy process as, "two steps forward two steps back." She also voiced her desperation:

> The patient may never come to the point of being diagnosed with Anorexia Nervosa or a patient may be apparently healthy but have a past of Anorexia Nervosa, whatever the situation is you can always sense the anorexic core, which manifests itself through the stiffness in relationships.

She also conveyed how she used to feel exhausted, astonished, and drained when talking about one patient of hers who had being in therapy for two years:

> I used to ask myself, "It is really nothing gonna happen? Is this real? I have given her everything in small bites but my milk does not make her grow. In these times a huge desperation is what you feel.

Other participants reflected similar feelings. Participant 2 disclosed how she felt exhausted when witnessing patients' strong fixations on losing more and more weight although they were extremely at low weight. Participant 4 expressed her frustration as if she were talking to the patient, "How can you break through that much, how can you go so far that you end yourself?" She also shared her feelings of exhaustion especially in the beginning of her career while seeing

patients with Anorexia Nervosa enclosing themselves into their homes in order to count calories, to ruminate on food, on eating, and on vomiting and not having interest in anything else. Patient 5 revealed that working with a team appeased her feelings of hopelessness that can appear while working with Anorexia Nervosa and pointed out the importance of not being a sole holder of the demanding, risky, and unpredictable situation.

**Feeling of deathliness.** Feelings of deathliness may be conceptualized as a further version of being starved. Two of five participants, Participant 1 and 3, touched upon this experience of deathliness. Participant 1 talked about the "gloomy" depression, which is usually comorbid with Anorexia Nervosa. Another participant (Participant 2) portrayed sessions with her patients with Anorexia Nervosa:

> In sessions I used to feel that I was looking at a skeleton. It was as if a skeleton used to sit in front of me. While smiling they were only showing their teeth, their eyes were staying fixed. They were dismissive, unaware of me, of any need, or any therapeutic good, making fake conversations, connections with me. They are killing themselves while living.

The same participant pointed out Anorexia Nervosa's clinging on preventing any happy result out of the therapy:

> In Anorexia Nervosa's psyche Thanatos prevails over Eros. You, as a therapist, try really hard to seduce them towards life but this might be suffocating and deadly to them. The therapist works by holding over their libido which is very weak so one must reduce the speed.

Referring to the same feeling of deathliness another Participant 3 described her sessions, "It was as if nobody used to sit in front of me. My mind used to get confused about their presence in the room. It was like non-existence in the existence."

In order to deal with starvation related feelings four out of five participants (Participants 2, 3, 4, and 5) strongly emphasized the supportive feature of team work for cases of Anorexia Nervosa. They suggested that working with a knowledgeable team, taking decisions together on the patient's progress brings

some rationality, objectivity, and ease to the process. Participant 1 also mentioned that Anorexia Nervosa requires a team work but she did not emphasize that much the supportive function of a team work for the therapist.

### 3.2.4. Management of Countertransference

Throughout the interviews the themes of "working on awareness in and outside the session", "working on an empathy/attunement/understanding of the patient", "working on the patient's self-awareness", and "having support resources & engaging in self-care" were found to be vital themes while referring to countertransference management.

#### 3.2.4.1. Working on Awareness In and Outside of Sessions

This theme emerged from all participants' emphasis on constant self-checking and constant observation of their patients and the process as they play a crucial role of countertransference management.

**Constant self-checking.** Constant self-checking appeared as a tool to identify countertransference feelings in order to manage them effectively in sessions. For instance one Participant 5 expressed:

> Supervisions of course allow you to identify your countertransference feelings. You notice your position in the therapeutic relationship. In analytic work, always you have to work on yourself. Otherwise you cannot work with any patient. The more you work on yourself the more you notice your feelings and identify their origins.

Participant 2 also stressed the importance of self-checking with the help of supervision. She also added that reading books, watching movies, and writing on her feelings help her to understand herself, the patient, and their process. Moreover she shared:

> Throughout the sessions I am paying attention to my bodily sensations also watching my mind. I am witnessing my thoughts, my feelings. I am not manipulating them just watching. In order to define the climate between

the patient and myself, I ask myself: “Who am I now? Am I her mother? Is she talking to me as she is talking to her mother?” It is always good to ask yourself those questions. Otherwise you may immerse yourself too much in the transference-countertransference play.

Similarly, Participant 1 highlighted the importance of her own analysis and intense supervision in order to identify and master her own countertransference feelings:

> I am in my own analysis for eight years now. I used to work also on challenging points of my work as therapist in my analysis. From the very beginning of my professional life I am under intense supervision, which helped me a lot. Also my thesis helped me in my work with Anorexia Nervosa.

Likewise, Participant 3 expressed:

> Me, I feel a strong need of supervision. My psychoanalysis as well continues where I speak also about the patients. Both help me to identify and overcome my countertransference feelings. A third eye becomes a part of the process. Out there I find many opportunities to understand my countertransference feelings.

**Constant focus on the patient and process.** All participants mentioned the importance of constantly and consciously checking their countertransference feelings with the reality of the patient and the process when the case is Anorexia Nervosa dark-colored by possible medical complications and high tendencies of dropping out of the treatments. Participant 5 commented:

> The biggest challenge regarding Anorexia Nervosa is the likelihood that the patient may run away once she starts getting well. Gaining weight is both the aim and the risk. It is at the center of the therapy. Weight gain is necessary because the disorder is life threatening but the therapist should not work by putting it at the center of the therapeutic encounters. On the other hand, there is also a medical reality that may worsen at any point. Therefore the therapist must closely follow the patient and the process. In the case of Anorexia Nervosa the therapy is beyond the classical analytic

work, the therapist cannot keep her analytical stance. It requires closely working together with a team, with a psychiatrist, a dietician.

She also signified the importance of the coherence of the physical and psychological improvement, she commented, "The therapist must communicate to the team and constantly monitor the patient's physical conditions and psychological readiness and make her therapeutic adjustments appropriately."

Similarly, Participant 2 outlined the importance of the coherence between biological and psychological development and the close observation of the patient and the process. She exemplified, "It is very dangerous if they start to menstruate all of a sudden or gain weight fast. This cut them off the treatment. The body should not go further than their mind, which is still a child." She shared that the therapist should consider the reality and in the same time immerse herself in the therapeutic transference/countertransference playground of reverie:

> Alternating between is like double work and both need to be inspected very closely. Everything may go well in the world of reverie but if her potassium level drops down she may die. There is a reality part, a physical part of the treatment.

Similarly, Participant 1 stressed:

> Regarding Anorexia Nervosa the therapist should always keep in her mind not to go fast, not to interpret fast. You have to wait long and go slow. Because this is the struggle itself; these patients have an enormous fear of being fed. Especially if the situation is acute it is better not to feed them at all, just to contain, to stay with them. Later, after a while they may open up to accept interpretation, psychological and physical food in dribs and drabs.

Participant 4 said that as Anorexia Nervosa is a medical illness she follows up the patient with an internist, an endocrinologist. She commented:

> If I accept a patient for outpatient treatment, every three months I ask them for a blood test. I also have a psychiatrist and a dietician in my team. It is obvious that there is a chemical imbalance in Anorexia Nervosa. Thus there is a need for psychiatric drugs. Together with the psychotherapy, the

drug use heals the patient. In a word, Anorexia Nervosa should be followed by many professionals.

From participants' words it can be concluded that they use medical monitoring to adjust their countertransference feelings, to understand how much comes from the reality, how much comes from the therapeutic transference/countertransference playground. They use medical data to make adjustments between psychodynamic work and physical treatment.

### 3.2.4.2. Working on Empathy/Attunement/Understanding of the Patient

All participants talked about how they used their countertransference feelings so that they could empathize with their patients. The attunement with the patient may be taken as one of the most prevalent management theme indicated by all of the participants of this study. Participant 5 expressed:

> What I feel in the sessions may be related to the patient's projections. I may share these feelings with her in order to ask and clarify whether these are similar to her own feelings or to her significant ones. In many times this sharing works but on the other times with manipulative patients, such as people with Anorexia Nervosa who are highly manipulative, sharing does not work. They may use them most probably afterwards to manipulate the therapist.

Further, Participant 4 highlighted the importance of grasping the mentality of the disorder, "In sessions I use my countertransference feelings to speak out, to voice the disorder for the patient in order to clarify and show the meaning of her own symptom to the patient herself."

Participant 2 explained, "It is hard to feel anger in the beginning but it helps you to notice how it is hard for the patient to be with that feeling throughout her whole life. In parallel, Participant 1 shared, "I try to use these countertransference feelings in order to understand my patient's feeling. Where they sit in her dynamics, towards whom she feels them, or through projective identification what she wants to communicate to me.

Finally, Participant 3 exemplified the confusing part of the use of countertransference feelings in order to attune to the patient. She talked about her astonishment when she met one of her patient's sister at the hospital taking care of her:

> At this point I felt relief and I noticed how I used to feel alone and unsupported with this patient and thinking of her as if she was unsupported. But she had her sister caring for her in the outside world. It was me actually who was feeling unsupported that I attributed it to the patient.

#### 3.2.4.3. Working on the Patient's Awareness

This theme was another significant recurrent management theme that was identified actually as an ideal outcome of an effective countertransference management, as a beneficial transformation of countertransference feelings by all the participants of this study. Participant 5 asserted:

> At the end, the therapist should transform her feelings to the patient's language. Only our feelings and our awareness of them do not suffice, we need to transform them, to try to place them in the patient's symbolic world at the right moment. We need to offer her those feelings in order to make her feel. There is no any other way of intervening with countertransference feelings.

Participant 4 who favored more direct cognitive behavioral techniques in the beginning of the Anorexia Nervosa treatment explained:

> Usually in order to differentiate the illness and to give the patient the taste of the possibility of taking the control of her own life back, we call the anorexia "Ed." While doing this, we remark that Ed is not the patient herself but a part of her. Together with the patient we make Ed talk, we give it a gender, a voice. While I talk to Ed with the patient I talk of my feelings. I use my feelings to understand the dynamics of the patient.

> Because in those conversations the patient talks with many relationship dynamics.

Concordantly, Participant 2 expressed that she utilizes her countertransference feelings to pave the way towards the patient's capability of feeling and naming these feelings for herself:

> In the moment of readiness I share with the patient what I feel in the sessions. If an imagination appears in my mind I tell it. Based on my feelings I investigate the patient. I create a space to make her talk on those feelings. Definitely I take advantage of my countertransference feelings in order to understand the patient and communicate to her, also in order to make her speak on her own feelings and experiences.

Again in line with previous statements, Participant 1 shared:

> I benefit from my countertransference feelings for the use of understanding my patient's feelings. Those feelings dwell in her relational dynamics. Towards whom she is feeling like that? What is my patient communicating to me through projective identification? Finally how can I give her back those feelings in order to make her analyze herself in a different way, to make her understand more? How, when, how much should I give those back to her?

Finally, Participant 3 commented on the similar use of her countertransference feelings; "Based on my countertransference feelings I try to move the patent's thoughts and capacities to feel about her own not mentalized material that generated her symptoms. I try also to use my countertransference feelings to open up a space to fantasize together about the patient's future.

#### 3.2.4.4. Having Support Resources & Engaging in Self-Care

Supervision, especially, was clearly indicated by all the participants of this study as a vital necessity to manage countertransference. In other words, for the use of countertransference as a therapeutic tool in an ideal therapeutic process supervision was vital. In addition, most participants indicated the cruciality of

working on themselves, of continuing their own psychoanalysis or therapy as an effective strategy in managing countertransference. Gatherings with other professionals in order to get a second perspective and non-biased ideas, congresses, reading topic-related books, watching related movies, writing on the feelings were also expressed as being helpful to identify and to release as well an issue coming up in sessions.

Participant 3 admitted the importance of supervision and her own psychoanalysis in order to gain another perspective. She also expressed, "in times of feelings of desperateness continuing supervision helped me to stay in the process and to keep me happy." Likewise, Participant 1 stressed the importance of having another perspective in order to clarify and to gain some confidence on her countertransference feelings:

> Always working on yourself, having supervision, being in your own therapy, psychoanalysis, are the legs of our career. Those are musts. Reading as well, reading books, articles, listening to colleagues' experiences, participating congresses are very beneficial and nourishing. We, as therapists, need to nourish ourselves.

Further, Participant 2 appreciated that sharing with another person at supervision used to lightening her up. She added; "movies, books, also writing on my own feelings helped me to keep my feelings in control."

Participant 5 expressed:

> Getting intense supervision, many educations, trainings on eating disorders, listening many cases from very successful therapists on the subject helped me to understand the disorder. Working with eating disorders requires further education and constant supervision. If you want to work with eating disorders you need to get supported by many resources. Because eating disorders are very challenging. They are very challenging patients. Because usually they are not coming with an eating disorder alone. It can be combined with addictions, bipolarity, depression, obsessive compulsive disorders, sexual abuses. The comorbidity is very high. I continue refreshing my

knowledge. I participate to congresses, trainings, sometimes to the same trainings in order to make fine tunings in my work.

Furthermore, Participant 4 acknowledged that it is very important, on the part of therapist that she demonstrates that she cares for her own body and health, "The therapist has to be a role model first. She, first has to adopt the same life style, the same healthy, controlled eating habits that she suggests to her patients."

## 3.3. SUMMARY

In this chapter the qualitative data obtained from interviews with five psychodynamically oriented psychotherapists were presented in two parts. In the first part demographic variables were presented. Accordingly, it was indicated that the participants had a mean of years of experience of fifteen. In the second part results of data analysis were provided. The result part was composed of four sections. In the first section, participants' conceptualization of Anorexia Nervosa as having an anorexic core emerged. By anorexic core it was indicated the patients' general tendency towards narrowing their existence such as control obsession, being fed, lack of self-expression and also paradoxically keeping a large potential of life force. In the second section, participants described their clinical experience regarding Anorexia Nervosa. The medical risks, the comorbidity, the patients' resistance to gain weight and reactions towards therapy were highlighted as the major challenge throughout the process. The third section focused on participants' countertransference feelings revealing that the most frequent feelings were identified as maternal feelings, abuse-related feelings, and starvation-related feelings. Finally, the last section presented how they manage those countertransference feelings. Participants, first, indicated the importance of working on self-awareness to identify their countertransference feelings. The prominence of processing those feelings in order to attune to the patient and also to work on patient' self-awareness and capacity to feel and to own her own feelings was highlighted. Lastly having support resources and engaging in self-care was expressed as vital in order to keep going in a healthy, and effective way.

# CHAPTER IV
# DISCUSSION

This study was conducted to investigate how psychotherapists experience therapy process with Anorexia Nervosa, their countertransference feelings, and especially how; if possible, they manage those feelings in the sessions in order to get better therapeutic benefit.

There are studies on the concept of countertransference, which demonstrated that if countertransference unidentified and not addressed, it might have a negative impact on treatment of eating disorders (Warren et al., 2009; Zerbe, 2016). It is also shown that countertransference may be used as a therapeutic tool in treatment (Hayes et al., 1998) and that therapists work on divers but cohesive ways to manage countertransference (Gelso, Latts, Gomez, & Fassinger, 2002). However, there does not appear to be much in the literature that directly discusses the ways those therapists who work specifically with Anorexia Nervosa experience and manage countertransference. This study may begin to fill this gap by illustrating the perspectives of five psychotherapists who are currently working with Anorexia Nervosa. Furthermore, this study can help therapists who are considering work with patients struggling with Anorexia Nervosa to make an informed decision as to whether this is a challenge they are ready for at this time in their careers.

Throughout the interviews, participants revealed their awareness of the challenges associated with countertransference in this patient population. During the course of our open-ended interviews, participants elaborated on their conceptualization of Anorexia Nervosa as an illness and diagnosis, the process of conducting therapy with patients with Anorexia Nervosa, and their perceptions, identification and management of their consequent countertransference.

*The conceptualization of Anorexia Nervosa*

As described in the results of this study, Anorexia Nervosa is conceived as an extreme effort to gain control, as a failure in early relationships with caregivers

that results in present problems with allowing oneself to be fed by either relational or physical foods, as muteness with regard to the denial of giving-up self-expression, and as a dormant yet powerful life force. These conceptualizations are also largely mentioned throughout the literature on the subject. For instance, Golan et al. (2012) suggest that clinicians often express being cornered by anorexia's rigid attempt for control. Hartmann, Zeeck, and Barrett (2016) differentiated Bulumia Nervosa and Anorexia Nervosa by putting control at the center. They clarified that patients with Anorexia Nervosa are often proud of and get their self-esteem from the way that they experience controlling food; however, those with Bulimia Nervosa may feel shame with regard to their lack of control over food intake. They further pointed out that the anorexic's desire to take charge in life and in relationships is shifted to control over eating and weight. Hughes (1997) explained that the illusion of omnipotent control protects anorexics from the painful awareness of their actual inadequacies and paralyzing anxieties (as cited in Golan et al., 2012). The participants' interpretations verified these statements. All mentioned how Anorexia Nervosa creates an alternative world in order to create the sense of being in control and protecting ego formation from dissolution.

The silence of the anorexic patient stands out as a characterizing theme throughout the interviews. It is mentioned that the patient with Anorexia Nervosa does not articulate her feelings but instead her body communicates the sorrow. This is also discussed in the literature. Barth (2008) clarifies that patients with Anorexia Nervosa are verbal and intelligent, and can cognitively learn very easily about themselves; however, they cannot process their feelings through words and may not develop a capacity for self-regulation. Farber, Tobin, Jackson, and Bachar (2007) revealed that self-harm is a pre-symbolic form of communication that must be decoded and confronted in time in order to allow for recovery. Geller, Cockell, Golder, and Flett (2000) stressed that the silence that actively inhibits self-expression allows the patient with Anorexia Nervosa to guarantee interpersonal relationships (as cited in Golan et al., 2012).

Anorexia's dormant or reversed life force, and mental capacities, were mentioned by almost all participants similar to Barth (2008) who writes also on the paradox of intelligent, insightful people, struggling with Anorexia Nervosa, who cannot use language to manage their feeling. She reported that the patient with Anorexia Nervosa exhibits intelligence and brightness but her inability to use her thoughts for emotional processing has long been acknowledged in the literature. She also commented that to address this confusing paradox, the therapist's effort to maintain a sense of safety and being understood may allow the patient, in time, to become more self-reflective and to engage her capacities to build up a more productive life. A study by Lopez, Stahl, and Tchanturio (2010), where anorexic patients were administered the National Adult Reading Test (NART) as well as Wechsler's Intelligence Scale also supports the paradox mentioned by the participants of this study. According to their investigation, patients with anorexia consistently showed a higher-than average premorbid IQ (as measured by the NART) and at least average current IQ (as measured by the WAIS).

Participants all described how patients fear being fed, receiving any nourishing interpersonal encounter, and equally her refusal to grow up. One of the participants suggested that if therapy can be conceptualized as a form of food, at the beginning of therapy it is better to slowly introduce interpretations; in this case, the therapist's interventions act to feed the patient, which may be perceived as very intrusive and horrifying. As Golan et al. (2012) remarked, the therapist's interpretation is often experienced by the patient with Anorexia Nervosa as a poisonous food and a harsh intrusion into her inner world. Zerbe (2016), also commented, "therapists must avoid the temptations to offer good food such as life-saving advices, tools, or psychodynamic interpretations in the beginning as they would disrupt the internal mechanism essential for psychological survival" (p.13). The theme "fear of being fed" is similar to what Williams (1997) called the "no-entry" defense. This idea was suggested after the discovery that patients with Anorexia Nervosa suffer from massive failure according to Bion's container/contained model of relationship (as cited in Zerbe, 2016). Williams

(1997) explained that Anorexia Nervosa blocks the desire for survival since the early caretakers were more concerned with using the infant (the future anorexic) to hold and metabolize their own issues with regard to need and anxiety. The infant thus is left to cope with his/her own feelings as well as process the caretakers' emotive burden. Consequently, her emotional work is doubled from its original amount. Williams (1997) concluded that weight loss and blocking any emotional contact seems to protect the patient from an invasion of a suffocating emotive burden of a needy, invasive object. In line with this, Kunold, Friederich, Stadnitski, Wesche, Herzog, Schwab, and Wild (2016) suggested that the patient's difficulty tolerating severe emotions stops them from seeing a social situation in a positive light; in other words from getting fed by any therapeutic food, thereby deepening disordered behaviors that consequently meddles with a positive experience of interpersonal relations. Throughout the interviews, participants described the patients' difficulties in building up transference relationships and settling down in the therapeutic process, both of which are mentioned often and also reflected in the literature. For instance, Sands (2003) explained that the patient's suppression of her body's needs is so compelling that her awareness of desire and need almost disappears, thus preventing her from developing a self-object transference. Sands (2003) also clarified that the patient with Anorexia Nervosa equates the absence of appetite and nutrition as the absence of a need for support and personal interaction. Accordingly by getting rid of any need she secures her bond to her caregivers who may be overburdened or threatened easily; simultaneously she manages to feel real and alive.

It is also remarked that physical and psychological development, should go in harmony as one participant expressed that if they start to menstruate or their bodies become more feminine shape, very early when their minds are still child, they would probably drop out. With regard to a developmental deficit, Gowers, Norton, Halek, and Crisp (1994) clarified that typical age of onset for the disorder is puberty and he suggests that the disorder is the patient's effort to go back to a prepubescent reality and childhood, perceived as a simpler life. This way of conceptualizing Anorexia Nervosa as an inability to respond properly to the

requirements of developmental stages makes obvious the stress experienced by the patient's mind in a menstruating, feminine body.

*The Therapeutic Process with Anorexia Nervosa*

When the therapists participating in this study were asked to differentiate aspects of the therapeutic process with patients who struggle with Anorexia Nervosa, they all immediately mentioned the medical risk and comorbid conditions that they have to continuously consider throughout the process. They also reported that the patient's refusal to gain weight and reluctance to engage in therapy are representative factors that make the process extra challenging. Shaffner and Buchanon (2010) expressed that the wide range of comorbid features and medically risky conditions have long been argued in the literature as presenting ongoing challenge throughout the recovery process. They commented that when treating individuals with Anorexia Nervosa there is a need for a greater flexibility and the implementation of more multimodal interventions in inpatient, outpatient, or partial hospitalization settings. Similarly, one participant expressed that when the matter at hand is Anorexia Nervosa, the therapist should monitor her medical conditions very carefully, i.e. potassium levels and electrolyte balances must be checked regularly. She added that fort his population, the therapist must put aside her psychoanalytic approach consistent with Murphy, Russell, and Waller (2005) who commented that psychotherapists that employ a psychodynamic approach should add behavioral and direct techniques such as weighing patients or monitoring diet. They remarked that the focus should be exploring the intra and interpersonal dynamics of presenting symptoms while strongly implementing interventions to achieve symptom remission in the context of Anorexia Nervosa.

Colli, Gentile, and Tanzilli (2016) conducted a study to examine psychotherapeutic interventions for patients with eating disorders. They collected naturalistic data from psychotherapists belonging to two main theoretical approaches: cognitive behavioral and psychodynamic. They reported that psychotherapists from both orientations used adjunctive treatment techniques for

eating disorders at a similar level. Participants in this study also agreed that the high comorbidity of Anorexia Nervosa with other psychological struggles makes the treatment process more complex and challenging compared to other patients' psychotherapy processes. One participant voiced that Anorexia Nervosa is often combined with alcohol, drug addictions, bipolarity, depression, and obsessive-compulsive disorders. She also stressed that possible chemical imbalances can occur because of starvation. Other participants pointed out that depression is anorexia's shadow. Yet another noticed that patients with Anorexia Nervosa seek therapy only when the sickness becomes chronic after many years of suffering, which also contributes to the difficulties of the recovery process. Bell (1999) also supports the high comorbidity of Anorexia Nervosa with other psychological stresses. It is argued that given that eating disorders provide strategies to manage feelings and solutions to other problems such as low self-worth, no one without other psychological problems would develop an eating disorder.

The findings of this study as well as previous research consistently emphasize the patient's resistance to gain weight as the biggest challenge, the most troublesome but crucial part of the treatment process. Blaase and Elkit (2001) call this resistance weight phobia and stated that it is understood as the most significant symptom of Anorexia Nervosa in the western world. Brockmeyer, Grosse, Bents, Herzog, and Friedrich's study (2013) found that the there was a correlation between low body weight and fewer negative experiences from exposure to sad autobiographical memories. In line with this, again Brockmeyer, Holforth, Bents, Kammerer, Herzog, and Friedrich (2012) found that among patients with acute Anorexia Nervosa, the lower the body mass index in patients, the less they exhibited difficulties in emotion regulation. Racine and Wildes (2013) also concluded that self-starvation is such a effective regulator of negative emotions that only at higher weights could patients with Anorexia Nervosa soak in emotion regulation difficulties. Vitousek, Watson, and Wilson (1998) also noticed that the satisfaction of losing weight and avoiding food leads to a sense of euphoria because the control is a "success;" thus it acts as the reinforcer responsible for their resistance towards treatment and weight gain. The

literature and participants of this study highlighted that the most challenging part of the therapeutic process with Anorexia Nervosa is the fact that to the patient, her destruction is perceived as that, which will save her.

Lastly, when participants described the therapeutic process with patients who suffer from Anorexia Nervosa, they all indicated that there is a slowness, almost a stagnation of the process and reflected on the astonishing and harassing reluctance of the patient towards the recovery. For instance, one participant uttered the words "two steps forward two steps back" while sharing her experiences on the process. Another expressed that throughout the long process that is seemingly going nowhere she would calm herself down by redirecting her thoughts with the idea, "at least the symptoms are not worsening." The deep, unfathomable resistance of patients with Anorexia Nervosa towards therapeutic good appears largely in the literature as Abbate-Daga, Amianto, Delsedime, De-Bacco, and Fassino (2013) stated that the profound resistance towards the distress of change is the most remarkable aspect of eating disorders. They reported that in Anorexia Nervosa both, avoidance of treatment and dropouts range between 20 and 51 percent in the inpatient population and from 23 to 73 percent in outpatient samples. They concluded that those numbers signify great difficulty for patients who suffer from Anorexia Nervosa in engaging and in maintaining their treatment adherence. They explained that patients perceive the consequences of their symptoms in a positive way. They continued that pathologic beliefs and symptoms are intertwined thus providing a self-protective interpretation. Barth, in 2008 commented in a similar way, that eating behaviors serve to soothe and restabilize oneself against disruptive emotions. According to her, even patients who ask for help and come to therapy, either consciously or unconsciously fear that if their symptoms are removed they will be in emotional danger. Likewise Bell (1999) mentioned that disavowing painful emotions is particularly present among patients with Anorexia Nervosa and that the conflict around of giving up symptoms leads to increased awareness of painful emotions should be taken as a central issue on the part of therapists in the therapy process. Gale, Holliday, Troop, Serpell, and Treasure (2006) explained that symptoms for the patient are

equalized to safety, structure, specialness, and the communication of emotions. Furthermore, Serpell, Treasure, Teasdale, and Sullivan (1999) reported that for patients with Anorexia Nervosa, how they narrate their disorder is characterized by cutting down negative emotions and promoting positive feelings such as safety, orderliness, a sense of pride and specialness, taking away the life chaos, unpredictability, and insecurity (as cited in Merwin, 2011).

*Countertransference Feelings*

The participants' awareness of intense countertransference feelings while working with patients with Anorexia Nervosa was evident during interviews. They all put forward the importance of their awareness of countertransference feelings and the need to process them in order to make sense of the work with their patients, not only those struggling with Anorexia Nervosa but with other kind of psychological conditions. Before discussing the feelings that were revealed in the interviews in light of existing literature, this study's definition of the term "countertransference feelings" should be clarified. This study takes "countertransference feelings" in its broadest sense, as defined by Golan et al. (2012) as all of the therapist's conscious and unconscious feelings and emotional reactions to the patient's transferential and realistic needs. Here, it is also worthy to remember Hayes and Gelso's (2001) concern over the myth that "the good therapist does not have countertransference." In their words: "This myth has no foundation but only reinforces the taboo aspect of countertransference and discourages therapist's honest self-examination and open-disclosure about countertransference with supervisors and colleagues to keep the level of countertransference at a therapeutically optimal level" (p.1047).

Countertransference feelings mentioned by participants throughout the interviews can be categorized into maternal feelings, abuse related and starvation related feelings. Hughes (1997) suggested that the therapist-patient relationship might mirror that of the patient-mother relationship. The reported feelings of insufficiency, anxiety, sadness, hope and reverie suggest maternal feelings. Russell and Marsden (1998) argued that the therapist may identify with the

patient's mother who may have been unable to protect the child from her own risky behaviors and feel helpless, out of control, and tired. Hughes (1997) talked about therapist's feelings of anxiety and elevated sense of responsibility as a result of thinking that she is the only person in the patient's life who can ensure her safety and keep her alive. In this study, one of the participant's mention of how she was relieved having seen her patient's sister taking care of her in the hospital provides a suitable example to this. Hughes (1997) concluded that maternal feelings might be a reaction to a lack of expressed worry and anxiety in the client. Strober (2004) related these feelings to the risk of high mortality, medical complications, and to the high dropout rates for this patient population. All therapists who participated in this study supported this statement mentioning the cruciality of constant monitoring the patient's deadly symptoms and how they felt sad, insufficient, and anxious when encountered with the patients' lack of anxiety regarding their own self-destructive behaviors. Sadness is also voiced frequently by participants in this study as they witness the patient wasting her life, living as if non-existent and, self-destructing while living. As Strober (2004) expressed "We sit with a patient whose life is in all practical ways sadly extinct, whose physical presence is but a lamental footnote in a history that now seems so difficult to retrieve" (p. 253). Hope and reverie that come from the opposite side of the same continuum signifying the birth and life ahead, is also expressed by all participants, especially when the therapy has gone well. Those feelings may be taken as similar to what a mother feels when she assists her child in growing up. Likewise, Rabinor (2000) shared her experience with one of her patient who recovered from Anorexia Nervosa as an opportunity to feel a deep sense of reward and gratitude and to witness rebirth of the human spirit (p.172).

In terms of abuse related feelings, each participant reported that their patients' sabotage of, or withholding from the therapy, in other words their explicit and implicit refusal to take from the therapy, create in them experiences of being attacked, tortured, manipulated, and disabled. Those feelings were taken as signifying the general feeling of being a victim. Likewise Abbate-Daga et al., (2013) argued that in response to Anorexia Nervosa's resistance to treatment and

self-harming attempts particularly feeling of being manipulated, excessive worry, and frustrations were common when investigating therapists' countertransference features. As an important aspect when working with patients with Anorexia Nervosa, Zerbe (1992) pointed out that the therapist might feel like an abuser. Accordingly the client may identify with her own aggressor and then split off her own unwanted aggression and unconsciously make the therapist feel like the abuser. Concordantly, Golan et al. (2012) remarked that frequently the patient's acting-out or asserting herself in a destructive way provoked the therapist to be either over or under-controlling. Russell and Marsden (1998) also expressed that with Anorexia Nervosa the therapist may identify with the abusing parent and feel hardened, cold, and even sadistic. They also mentioned the ability of patients with Anorexia Nervosa to evoke very strong hostile countertransference feelings in therapists, which may force them to reject their patients. Similarly, Sands (2004) shared her own anxious need to control her patient and force her to take care of her own body alone outside of the therapy room and forget about the physical harm that she is giving to her own body. Strober (2004) indicated that when the illness is worsening, the agony of caregivers becomes violent and confusing. From the participants' discourses it can be concluded that patients' lack of ability to keep themselves healthy and alive, in other words their needs for the therapeutic process but simultaneously their attacks on it, arouse maternal and abuse related feelings in participants. Zerbe (1992) also referred to this mixed communication of needs in the context of Anorexia Nervosa and warned that this may paralyze the functionality of the therapists.

When analyzing therapists' descriptions of their feelings while working with Anorexia Nervosa feeling drained, exhausted, helpless, desperate, and empty were mentioned. All can be understood to signify starvation. Starvation related feelings were thought to have a common sense of depletion. In line with this, Franko and Rolfe (1996) reported that therapists who work with Anorexia Nervosa tend to experience more hopelessness and helplessness than those who work with Bulimia Nervosa or depression. They also reported therapists' opinions on the therapy work with Anorexia Nervosa as such a waste of time and energy,

investing too much and getting back too little; in other words therapists reported that they do not get satisfied with their work with Anorexia Nervosa, symbolically they keep starving and not getting full. Zerbe (2016) also explained that feeling drained, frustrated, and exhausted might result from the patient's repetitive and insistent disruptions of the treatment relationship.

During interviews, feelings stronger and perhaps more disturbing than starvation came up as well. For instance, one pf the participants described her sessions with patients with Anorexia Nervosa, "I used to feel that I was looking at a skeleton. While smiling they were showing their teeth, their eyeball were staying stable. They are killing themselves while living." The same participant explained that in their psyche Thanatos conquered Eros; even the therapist's hard work to seduce them towards life will suffocate them. Sands (2003) articulated that the patient's emaciated body horrifies the therapists. Exactly in the same manner as this participant, Strober (2004) described the immediate sensory impression of sitting with a patient with Anorexia Nervosa, "a stark skeletal visage of a life tragically depleted of passion, vitality, and challenge, that is riveting but uneasy to hold" (p. 247). Another participant expressed that in sessions her mind was getting confused about their existence in the room. Participants also shared that "gloomy depression, and mourning of a whole life that passed by" was charging the air in the room. It can be concluded that these feelings are a step further than starvation related feeling and felt against the patient's refusal to take in anything good. Concordantly, Hughes (1997) commented that the patient's restrictions of taking in or giving out anything are in essence killing the sessions.

*Management of Countertransference*

All the intense experiences mentioned above may give us a perspective on the challenges of working with a group of patients who showed resistance to treatment. Hayes, Mc Cracken, Mc Clanahan, Hill, Clara, Harp, and Carozzoni (1998) also reported that when therapists talk about their countertransference reactions, not in the challenging context of Anorexia Nervosa but in general, they

usually mention negative feelings (as cited in Rosenberger and Hayes, 2002 b). Coming back to the context of Anorexia Nervosa, Strober (2004) talked about his supervisees seeking guidance while working with this group of patients. He shared: "They were deeply discouraged by a lack of measurable progress, struggling with feelings of ineffectiveness, wavering inconsistently and confusingly between aggressively confrontational or passive approaches and weighted down by paralyzing countertransference to resolve the paradox of caring for patients who seem so decidedly opposed to change" (p. 246). Countertransference feelings owing to the psychological scars inherent to human conditions (Hayes, Nelson, and Fauth, 2015, p.127) seem to experienced more powerfully when treating patients with Anorexia Nervosa. Hayes, Gelso, and Hummel (2011) also recognized that certain patients (such as patients with borderline features, patients for whom producing change is difficult, patients with poor prognosis) are likely to evoke countertransference feelings difficult to manage. Thus, managing those feelings may be interpreted as gaining vital importance with this group of patients who disposes heavy triggers for heavy feelings in therapists in response as the dynamic of those feelings in sessions may be concluded to effect radically the process and the outcome of psychotherapy for the patient as well as for the psychotherapist. This is also important because the clinical wisdom supported by research showed that unrecognized or otherwise unmanaged countertransference has a deleterious effect on therapy (Gelso and Hayes, 2002; Hayes and Gelso, 2002).

Before starting to discuss participants words on countertransference management in light of the existing literature, it may be clarifying to define what this study means by countertransference management. As Hayes (1995) conceptualized, this study takes countertransference management to refer to the therapist's ability to regulate his or her countertransference manifestations such as cognitive, affective, or behavioral reactions to the triggers on the process (as cited in Hayes et al., 2015).

In this study, the participating therapists indicated several ways to manage countertransference that they believed to be of importance. Discussing their cases

of Anorexia Nervosa, participants indicated the essentiality of working on awareness in and outside sessions, both in terms of self-awareness and closely monitoring the patient's conditions. They also emphasized the importance of having support resources to empathize with, attune to, and understand the patient's subjectivity, ultimately in an effort to work on the patient's awareness and capacity to contain and process her own feelings. All the therapists who contributed to this study reported an understanding of countertransference management as a process of transformation to understand and to penetrate the patient's relational world, and to put her unspoken, unseen feelings in a more intelligible form in order to allow her to get in touch with those blind spots and ultimately release the energy stucked in there for use in other new areas of life. This understanding of countertransference as a process of transformation reflects Bion's theory of container/contained (1962) and Money-Kryle's model of countertransference (1956, 1960) (as cited in Weiss, 2014). According to Weiss (2014), Bion began to question the process by which indigested elements in a primitive psychic organization are organized when they are taken up by a receptive structure. He revealed that these essential features transform in the receptive organization before they are able to re-introject thus in modified and milder form such as building blocks of symbol formations. Bion described this transformation process as $\alpha$-function (p. 741). Weiss (2014) argued that failures in this process of transformation might occur if the therapist reject some countertransference or are unable to get out of their responses. He recognized that disturbances in the process of re-introjection in the part of the patient might also damage the process of transformation. The latter is expectable when working with patients struggling with Anorexia Nervosa who are known to ask or accept very little from the therapeutic encounter.

Coming to Money-Kyrle' s model of countertransference as a model of transformation (1956, 1960), Weiss (2014) argued that this model concentrates more closely on the analyst's internal processes and is composed of three phases. Initially the therapist's introjective identification is with specific parts of the patient's internal experience. Secondly, change occurs as the therapist is able to

compare his/her younger self by assuming the position of a third position. Thirdly, is "the re-projection of the material, which approximates understanding by having been worked through in the countertransference" (p.743). This model elaborates on the process of working through countertransference phase by phase and anticipating that the projections of the patient can be modified and transformed into more intelligible forms by the therapist's absorption of the some of the patient's despair and his or her capacity to take a third position in order to give back. In other words, reorganized and structured in order to project back the rough material in its milder form, as all the participants expressed is the ultimate goal of countertransference management.

The findings of this study revealed a very conscious, curious even enthusiastic and devoted process of working on processing and managing countertransference, on the part of all the participants, in order not to act on the patient's attempts to actualize a transference fantasy. Thus it is worthy to have a close look at how the participants' reflection on their work to manage countertransference while addressing it has resonance in previous research.

*Working on awareness in and outside of sessions:* The first important theme that was prevalent in the interviews and corresponds with previous research relates to the participants continuous work on awareness in and outside of sessions. This theme appeared to have both intertwined and concurrent phases: constant self-checking and constant focus on the patient and on the process. They all highlighted the cruciality of conscious reflection on and monitoring of their affective, cognitive, as well as physiological responses to patients and their patients' responses to them. They all emphasized this simultaneous phenomenon as one aspect of the therapist's professional role. This can be captured in Kachele, Erhardt, Seybert, and Buchholz (2015)'s suggestion: "controlling countertransference means the psychoanalyst's sensitivity to both the patient's emotions and his own affects in order not to transform them into actions" (p. 96). Cartwright, Rhodes, King, and Shrines (2015) expressed that in their method for teaching clinical psychology trainees to conceptualize and work with their

countertransference they first focus on developing skills to be more aware of the responses of oneself and the patient. Hayes, Gelso, and Hummel (2011) suggested that therapists who work on self-checking in and between sessions have the feeling of successfully managing their countertransference. They reported previous research demonstrating that the therapist's awareness of her/his feelings towards the patient is inversely related to demonstrations of countertransference behavior. Likewise Hayes, Nelson, and Fauth (2015) suggested that the therapist's skills that help him/her to stay aware of her/his own internal experiences and attentive to the patient in session, as well as self-care outside of work, facilitate successful outcomes of psychotherapy work.

*Constant self-checking:* In an effort to monitor the degree to which their countertransference impacts their ability to remain attuned to the patient, all the therapists who participated in this study emphasized the necessity of first getting supervision, personal therapy, and peer supervision. Four out of five participants also suggested additional readings, trainings, education, and watching movies on eating disorders as helpful tools. One of the participants strongly highlighted the importance of continuously fine tuning the work. She shared that although she has been working with eating disorders for a very long time she will continue to join congresses and sometimes to repeat the same training programs in order to stay vigilant to the very subtle points in her work. She indicated that hearing many cases from her professors helped her to understand and to control the process with her eating disordered patients. Those tools for countertransference management supported Franko and Rolfe (1996)'s earlier study. Accordingly, the researchers concluded that having supervision, consulting other professionals, and keeping in contact with colleagues was helpful in reducing countertransference responses. Strober (2004) commented that the challenge of countertransference should be undertaken with colleagues and by periodic supervision, or joining a supervision group in order to reduce the need for emotional discharge. Cartwright et al. (2015) reported that the emotional maturity of the therapist which may be developed by personal therapy to prevent the potential countertransference needs to interfere

with the therapist-patient relationship is also mentioned in the literature. Golan et al. (2012) also commented that seeking out supervision and pursuing personal therapy is prudent while working with Anorexia Nervosa.

*Constant focus on the patient & process:* Constantly focusing on the patient and the process, as mentioned above, is highlighted by the participants as the simultaneous counterpart of focusing on the self especially with patients with Anorexia Nervosa. As Strober (2004) pointed out, their ambivalence and medical fragility requires close monitoring of how, when, and how much to articulate the aspects of transference and countertransference. This is clearly revealed by Participant 2. She warned that the therapist could easily get immersed in the transference-countertransference play, having forgotten the reality that the patient's heart may stop at any time if the potassium level drops down to a certain limit. All participants expressed the need of teamwork – to work with a team that knows the disorder, can served to double-check their therapeutic work, bring them objectivity, and help them to relax in the process. For example, Participant 5 mentioned that with team the responsibility is shared, and continuous team consultations brought about objectivity to her therapeutic decisions. Participant 1, 2, and 5 strongly emphasized that physical and psychological improvement should be in harmony and that by following the patient's psychological conditions, her physical health should be restored over time with the priority of preventing any physical danger. Teamwork is also emphasized by Golan et al. (2012) as an important component in the management of countertransference, working in a communicative, cooperative and cohesive way (p.143). Haig and LeBreck (2000) mentioned that a consensus of opinion and treatment plan for each patient facilitates the therapist autonomy and objectivity (as cited in Golan et al., 2012). Besides the patient's medical fragility, her psychological delicacy is also mentioned by all participants and also echoes the previous research on the topic. They put forward anorexia's resistance to treatment, poor motivation, high drop out rates, and their fear of receiving any therapeutic tool as the distinctive features that separate her from other patients' struggles. This illustrates the therapists' in

this study as well as general clinical wisdom and the strong emphasis on the awareness of the whole process as Abbate-Daga verbalized:

> With Anorexia Nervosa up and down process cannot be mapped in advance. From the very beginning the therapist renders the decisions of extraordinary delicacy. The slightest misstep even interventions vital to her welfare become flashpoint of angry and entrenched resistance, symptom exacerbation, or abrupt termination (p.313).

*Having support resources:* All participants expressed the dual role of having support resources (e.g., supervision, personal therapy, getting consultation, peer gatherings, seminars, congresses, trainings); the first one is, as it is mentioned above, for the management of countertransference feelings in order to keep objectivity expressed as a professional requirement. The second one is more for the purposes of self-care, well-being, and the personal growth of the therapist. All the participants acknowledged that working on personal growth would, in turn, affect their professional work with their patients. This is clearly pointed out by Tishby and Wiseman (2014) who stated that the therapist's growth and change over the course of therapy is an important facilitator for the collaboration with the patient. Participant 5 expressed that if the therapist does not work on herself, she cannot work with others. Participant 1 and 2 emphasized that getting together with colleagues and listening to their experiences opens up new perspectives in their work and is empowering. Participant 1 added that therapists particularly should nourish themselves. Participant 3 shared how supervision and personal therapy helped her in times of stuckness in her process with her patients with Anorexia Nervosa in order to keep her going and stay in the process. Participant 4 and 5 expressed that the self-confidence, the firmness of the therapist on boundaries, which are improved via the support resource system, help the patient to own and to trust the process. In line with this, Abbate-Daga (2013) commented that therapists coping skills offer be a useful model for the development of the patient's coping skills. Participant 4 strongly emphasized the importance of

engaging in self-care activities for the therapist. She mentioned that the therapist should care for herself well, should eat in a healthy way, exercise regularly, take time for herself and should be a role model for the patient. She added that otherwise it is not fair and convincing for the patient to comment on her health. Her remark is supported by Zerbe's (2016) who said that the therapist must take in particular care of her own body to allow and to model the patient's positive identification with her own self-care. She further pointed out that the therapist's demonstration of care for her own physical and psychological needs frees the patient to look after herself (p.14).

*Working on empathy/attunement/understanding of the patient:* When talking about countertransference management, all participants expressed that they used their countertransference feelings in order to empathize with, attune to, and to reach a deeper understanding of the patients' inner worlds. All shared that with the help of their own countertransference feelings in response to their patients, they were able to immerse in their relational dynamics, extract what their patients wants to communicate, and clarify their tranferential role in the therapeutic relationship. Likewise Abbate-Daga et al. (2013) commented that an empathic approach could be used to understand the patient's inner world and to communicate and work on the meanings of the illness and of recovery. For all the participants in this study, empathy is described as seeing the patient's struggles from the patient's point of view while keeping a professional stance. Participants made clear the distinction between empathic understanding and countertransference feelings. Empathic understanding is expressed as a product of a conscious intention to manage the countertransference feelings. This understanding of empathy is supported by Gelso and Hayes' (2001 a.) study, which defined empathy as the therapist's partial identification with the patient to focus on her issues while always staying alert in order not to act on them. In other words, the therapist's empathy should have holding but also handling qualities; for instance certain pathological self-harming behaviors should be clearly prohibited as Abbate-Dga et al. (2013) indicated.

This intentional therapeutic use of countertransference to empathize with the patient's psychic world is largely echoed in literature. For example Klautau and Coelho (2013) clarify that empathy results from the therapist's quality to use countertransference as a way to get knowledge on the patient's conscious or unconscious emotional struggles. Know (2013) argues that empathy means to understand the patient's feelings from the patient's own point of view, which might be still unknown, or unbearable to know to the patient himself (p.498). They also pointed out that countertransferentially aroused affects may impair the therapist's 'fair' objectivity (p. 148). Thus not countertransference but empathy (countertransference feelings worked on in order to gain an empathic perspective) plays the largest part in the understanding of the patient. Countertransference feelings need to be managed in order to get an empathetic understanding of the patient. Participant 4 suggested that she uses her countertransference feelings to grasp the mentality of Anorexia Nervosa in that specific patient's life in that specific time point and to prevent her from falling into the patient's transferential needs, or push-and-pulls that enable her to focus on her real needs and intervene appropriately. Her intentional work on the use of her countertransference feelings in order to understand the meaning of the disorder found its reflections on Abbate-Daga et al., (2014)'s study. Accordingly, clinical effort aimed at understanding the meaning of the illness from the patient's inner world can become an operational tool to overcome treatment resistance. They reported that especially for the patient with Anorexia Nervosa who struggles with feelings of profound and unique despair, loneliness, and death, there is no possibility of overcoming her resistance to treatment by a therapist who can not empathically understand those feelings and restrain them with messages throughout the transference-countertransference relationship.

*Working on the patient's awareness:*

As the final purpose of countertransference management, all participants referred to the translation of their countertransference feelings to their patients into clear statements that can give meaning to their own reactions, attitudes, and feelings in turn. For instance, Participant 5 described that only feeling like the patient does not suffice; in the end the therapist should transform and place those feelings in the patient's symbolic world at the right moment and should offer those feelings back to patient in order to make her feel them. Participant 2 shared that she takes advantages of her countertransference feelings in order to understand the patient and to facilitate the patient's ability to feel and to verbalize her own feelings and experiences. This effort of the therapist in an attempt to work on the patient's awareness and capacity to allow herself to feel her own feelings seems to gain particular significance in the case of Anorexia Nervosa. Sands (1994, as cited in Sands, 2003, p.110) expressed clearly what was also brought up by the therapists who contributed to this study. Accordingly, if the therapist can contain different sometimes contradictory feelings in herself she can better comprehend and contain the patient's experience and finally, with time, she can put those feelings into appropriate interpretations to address the patient's long-disavowed feelings. This can move an integration process in the patient's affective communication style so that instead the body she may start using more symbolized forms such as words to communicate her experiences once unbearable and out of conscious awareness.

Overall, Golan et al.'s (2012) mention of countertransference management provides a concise summary of what the participants of this study describe: The first step is identifying the negative dynamics between the patient and the therapist. The second step should consist of breaking out of the maladaptive pattern with the help of assistance or supervision. The last step is with the correct identification and handling of countertransference, assisting the patient to communicate and express her wishes behind the maladaptive patterns (p.142).

In sum, all participants acknowledged difficulties and failures as inevitable while treating Anorexia Nervosa and believed that failures on the part of

therapists may be prevented by managing countertransference. During the treatment they pointed out the importance on focusing on one's own process concurrently with the patient's process and the dyad between them in order to identify non-healing transference-countertransference play and to take a more objective stance. They underscored the importance of close supervision and personal psychotherapy in order to examine intense feelings and gain the ability to work through them. It is these very feelings and the ultimate goal of translating them to the patient in order to assist her to give meaning to her own feelings and reactions that can facilitate the healing process.

## 4.1. IMPLICATIONS FOR CLINICAL PRACTICE

This study has attempted to reach and to categorize some tentative themes in order to describe psychotherapists' experiences when working with anorexic patients. They shared their experiences and their feelings while working with Anorexia Nervosa and they reflected how they draw meanings from their challenging feelings and make their experiences manageable for therapeutic intentions.

The findings of the present study revealed initially the complex nature of psychotherapy with this group of patient and the importance of self-awareness in relation to the dynamics with the patient. The co-existence of seemingly opposing, paradoxical feelings such as maternal and abusive feelings and the up-and-down, time-requiring nature of psychotherapy with Anorexia Nervosa are set forth.

All the participants indicated that they all need space and time to reflect their emotions on their anorexic patients.

All the participants also referred to the importance of noticing their feelings as they relate to their patients and to view them as significant signals that occur within the therapeutic dyad, in the patient, and in the therapist. They suggested that working to reflect and to process their emotions helped them to understand the dynamics of the therapeutic process and finally to better manage their

countertransference feelings, to implement better interventions and to better manage the overall process.

In an effort to explore the aspects within themselves and their patients, they all made clear the cruciality of their own personal therapy and supervision. Individual therapy was mentioned as a prerequisite for the personal self-care. It is indicated that the therapists should first model to their patients struggling with Anorexia Nervosa how to take care of their emotional well-being and how to tolerate and make sense of the challenging, paradoxical feelings. Supervision was noted as a prerequisite to ensure recognition and clarification of their feelings or reactions towards their patients, to better understanding present dynamics in the therapeutic process, and finally intervening appropriately.

Seminars, professional gatherings, reading, movies on the topic, educations were all mentioned to increase knowledge and skill for working with Anorexia Nervosa, and give them a space to become cognizant of their own feelings.

The study has also illustrated the importance of team work (dietician, psychiatrist, endocrinologist, and gynecologist) with anorexic patients. Consulting a patient with a team was expressed to help the therapists to process better their experiences, to better manage their stress level, to implement appropriate interventions and to prevent any potential of countertransference.

In sum, at first this study informed about the additional importance of countertransference feelings as they appear as the only way out, as the only exit from the stagnation of the disorder and the process because Anorexia Nervosa is mute and blind on feelings. Secondly this study informed the additional importance of countertransference management as the right amount of intervention at the right moment is especially important with Anorexia Nervosa due to the high risk level of medical complications and patients' high tendencies of dropping out of therapy. Thirdly, the vitalizing and nutritional function of personal therapy and supervision, professional gatherings, seminars, further educations, movies, books are emphasized against the dull and desolate nature of psychotherapy process with Anorexia Nervosa.

## 4.2. LIMITATIONS OF THE STUDY

When it comes to limitations this study had several constraints that limits its generalizability to a more heterogeneous population. These limitations are sample size, sample representation, methodological concern and translation concern.

This study's results rely on data gathered from only five psychotherapists. This sample size may not allow for meaningful and valid generalizations about the larger population.

In this study the sample was purposive. All psychodynamically oriented psychotherapists who have focused on eating disorders as part of their clinical practice were recruited. As a result, the sample was composed only female psychodynamically oriented psychotherapists who have done further professional education and who have strong interest in research and in related literature. They were, all, eager to participate to this study from the first contact. One may argue that the participants are mostly comfortable in their role as psychotherapist and are more self-confident in working on their countertransference reactions. Thus their responses may differ from the experiences of therapists with fewer anorexic patients and this may have impaired the generalizability.

Qualitative methodology was used to gain in-depth information from psychotherapists; however, it also has some limitations. A semi-structured interview was used to gather data from participants in which a lack of consistency in the order and the phrasing of questions are inherent. Therefore the interviews may have been diverged slightly from each other in content and depth. It may also be debated that having no standardized assessment tool and gathering data via semi-structured interviews may make way for the researcher's agenda to shape the responses. Moreover, inherent in the nature of qualitative methodology and IPA which were used in this study, the data were resulted from two interpretations. One is participant's interpretation of her own experience, then the researcher's interpretation of the spoken up interpretation. Smith, Flowers, and Larkin (2009 as cited in Swancott, 2012) indicate that although this method does not allow the exact presentations of personal experiences, still close representations are

possible. Furthermore, the concept of priming may also have biased the researcher's interpretations of the data. Interpreting the first transcript may prime the researcher to make similar interpretations (Smith et al., 2009 as cited in Swancott, 2012). The researcher while conducting the research and the ones who review the results should be cognizant of this limitation.

Therapists were interviewed about their personal countertransference feelings and about how they have managed the therapy processes with their patients who struggle with Anorexia Nervosa. This always indicates a possibility that they made socially acceptable and professionally competent presentations.

The interviews were conducted with Turkish psychotherapists, in Turkish. The data were transcribed, examined for emergent themes, and then translated into English. Even though the researcher is bilingual, some of the themes, ideas, or nuances may have been lost in translation and might have had an impact on the reliability of the findings.

Nevertheless, the findings of this study are consistent with previous research. Thus, it can be concluded that this study has touched some of the major themes that therapists experience with their patients struggling with Anorexia Nervosa.

## 4.3. AREAS FOR FUTURE RESEARCH

The scope and the size of this study which purposed to get an initial exploration of experiences of therapists while working with Anorexia Nervosa in Istanbul, Turkey was limited. There can be controlled studies in future with a larger sample size, using some standardized measures in order to get empirical evidences of initial findings of this study.

It would be also highly informative to use data gathered from different gender dyad such as male therapist-male patients, male therapist-female patients, or female therapist-male patients.

Future research may also be conducted by therapists who use other therapeutic models to work with Anorexia Nervosa. Furthermore, as future

research, defining the participant group as working with other manifestations of eating disorders such as Bulimia Nervosa, binge eating or Anorexia Nervosa and comparing the results with the contributions of this study may also be another appealing area to investigate since all are food related metaphors.

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# APPENDICES

## APPENDIX A

## KATILIMCI BİLGİ ve ONAM FORMU

İstanbul Bilgi Üniversitesi Sosyal Bilimler Enstitüsü Klinik Psikoloji Yüksek Lisans Programı

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Bu araştırma İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programında, Mia Medina danışmanlığında, Ece Tansu tarafından yürütülen yüksek lisans tez çalışmasıdır. Araştırmanın amacı; anoreksiya nervoza ile psikodinamik yönelimle çalışan terapistlerin klinik ortamdaki deneyimlerini derinlemesine incelemektir. Katılımcı olmak için; klinik psikolog/psikiyatrist olmak ve bütün meslek hayatı boyunca en az 10 **veya** son beş yılda en az üç tane DSM-5'in anoreksiya nervoza tanı kriterlerine uyabilecek danışan ile en az 6 ay süreyle psikoterapi çalışması yapmış olmak **veya** güncel olarak bu örneklem grubu ile dinamik psikoterapi yapıyor olmak gerekmektedir.

Araştırma boyunca sizden kimlik belirleyici hiçbir bilgi istenmeyecektir. Araştırma sorularına verdiğiniz cevaplar ses kayıt cihazı ile kaydedilecek, araştırmacının bilgisayarında şifrelenmiş şekilde araştırma sonuna kadar saklanacak, sadece araştırmacı tarafından çözülecek ve araştırma sonunda imha edilecektir. Cevaplarınız tamamıyla gizli tutulacak ve sadece tarafından değerlendirilecektir. Elde edilecek bilgiler bilimsel yayımlarda kullanılacaktır.

Araştırma 2 bölümden oluşmaktadır; ilk bölüm bazı demografik sorulardan oluşmaktadır, araştırmacı verdiğiniz cevapları not alacaktır. Ardından, ikinci bölümde araştırmacı size anoreksiya nervoza (DSM-5) tanı kriterlerine uyabilecek danışanlarla çalışma deneyiminiz hakkında yarı yapılandırılmış sorular sorulacak ve bu derinlemesine görüşme bölümünün daha çok sizin aktardıklarınızla

ilerlemesi beklenecektir. Tüm görüşmenin toplamda yaklaşık 45 dakika süreceği düşünülmektedir. Bu araştırmaya katılmak tamamen isteğe bağlıdır. Katıldığınız takdirde araştırmanın herhangi bir aşamasında herhangi bir sebep göstermeden onayınızı çekmek, görüşmeye devam etmemek hakkına sahipsiniz. Bu formu imzalamadan önce, araştırma ile ilgili sorularınız varsa lütfen sorunuz. Araştırma hakkında ek bilgi almak istediğiniz takdirde ya da kendinizi görüşme sonrasında olumsuz bir durum içinde bulursanız lütfen araştırmacı ile yukarıdaki adresler üzerinden iletişime geçiniz.

Yukarıdaki metni okudum ve katılmam istenen araştırmanın amacını anladım.

Araştırma hakkında soru sorma imkanı buldum.

Bu görüşmeyi istediğim zaman ve herhangi bir neden belirtmek zorunda kalmadan bırakabileceğimi anladım.

Bu koşullarda söz konusu araştırmaya kendi isteğimle katılmayı kabul ediyorum.

Formun bir örneğini aldım / almak istemiyorum (bu durumda araştırmacı bu kopyayı saklar).

İmza:.....

Tarih (gün/ay/yıl):...../...../.....

## APPENDIX B

## DEMOGRAPHIC DATA FORM/DEMOGRAFİK SORULAR

Cinsiyet:

Meslekteki çalışma yılı:

Eğitim durumu:

Yeme bozukluğu ile ilgili özel bir eğitim aldınız mı?

Teorik oryantasyonunuzu nasıl tanımlarsınız ?

Çalıştığınız yerin kategorisi nedir?

Özel-Kamu-Diğer

Şu an anoreksiya nervoza tanısı alabilecek kaç danışanınız var?

Varsa bu danışanlarınızı ne kadar zamandır görüyorsunuz?

Cevabınız hayır ise en son ne zaman anorexia ile çalıştınız?

Şimdiye kadar toplam kaç tane anoreksiya tanısı alabilecek danışanınız oldu?

Onları ne kadar süreler zarfinda gördünüz?

## APPENDIX C

## INTERVIEW QUESTIONS/GÖRÜŞME SORULARI

**1)** Anoreksiya nervoza tanısı alabilecek danışanlarınızla yaptığınız psikoterapi çalışmasını diğer danışanlarınızla olan çalışmalarınızla karşılaştırabilir misiniz?

……
…….

**a)** Anoreksiya ile çalışırken anoreksiyaya özgü terapiyi aksatabilecek, engelleyebilecek zorluklar var mı? Varsa neler olabilir (riskli davranma, terapiyi bırakma,…)?

……
……

**b)** Bu danışanların anoreksik semptomlarında ve/veya hayatlarının diğer alanlarında ilerlemeler oldu mu? Nasıl değişimler oldu?

……
…….

**c)** Anoreksiya ile çalışırken psikodinamik çalışmayı destekleyen başka teknikler/kaynaklar kullanıyor musunuz?

……
…….

**2)** Şimdi sizin anoreksiya ile mücadele eden danışanlarınızla çalıştığınızdaki hislerinizle ilgili sormak istiyorum.

**a)** Nasıl öğrendiniz (psikiyatrist yönlendirmesi, tanı için sorgularken, kendi söyledi, siz şüphelendiniz,…)?

……
…….

**b)** Öğrendiğinizde neler hissettiniz?

……
…….

**c)** Bu danışanlarınızla çalışma sürecinizde seans içinde veya seanslar arasında sizde ne gibi duygular belirdi?

……
……

**3)** Seanslarda yaşadığınız anoreksiya bağlamında zorlandığınız bir deneyim veya duygulanımı detaylı tarif edebilir misiniz?

……
……

**a)** Bu deneyim/duygularınızı nasıl yönettiniz?

……
……

**b)** Bu deneyim/duygularla klinik olarak faydalı olabilecek şekilde çalışabildiniz mi?

……
……

**c)** Hayır ise engeller neler olmuş olabilir?

……
……

**4)** Anoreksiya bağlamında terapötik duruşu etkileyebilecek duyguları yönetme konusundaki genel düşüncelerinizi almak istiyorum.

**a)** Bu duygular nasıl tespit edilir?

……
……

**b)** Nasıl idare edilir? Yönetilir? Hatta belki müdahaleye çevrilir?

……
……

# APPENDIX D
# RESULT OF EVALUATION BY THE ETHICS COMMITTEE

**ETİK KURUL DEĞERLENDİRME SONUCU/RESULT OF EVALUATION BY THE ETHICS COMMITTEE**

(Bu bölüm İstanbul Bilgi Üniversitesi İnsan Araştırmaları Etik Kurul tarafından doldurulacaktır /This section to be completed by the Committee on Ethics in research on Humans)

**Başvuru Sahibi / Applicant:** Ece Tansu

**Proje Başlığı / Project Title:** The Experience and Management of Countertransference among Therapists Working with Anorexia Nervosa: An Exploratory Study

**Proje No. / Project Number:** 2017-20024-07

| | | |
|---|---|---|
| 1. | Herhangi bir değişikliğe gerek yoktur / There is no need for revision | XX |
| 2. | Ret/ Application Rejected<br>Reddin gerekçesi / Reason for Rejection | |

Değerlendirme Tarihi / Date of Evaluation: 9 Şubat 2017

Kurul Başkanı / Committee Chair
Doç Dr. Itır Erhart

Üye / Committee Member
Prof. Dr. Aslı Tunç

Üye / Committee Member
Prof. Dr. Hale Bolak

Üye / Committee Member
Prof. Dr. Turgut Tarhanlı

Üye / Committee Member
Doç. Dr. Koray Akay

Üye / Committee Member
Prof. Dr. Ali Demirci

Üye / Committee Member
Doç Dr. Ayhan Özgür Toy