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Managing Eating Disorders: Countertransference Processes in the Therapeutic Milieu

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Abstract

The management of eating disorders (EDs) goes beyond symptom reduction towards reinforcing opportunities to encourage patients to develop new ways of thinking, feeling, and acting, and more adaptive interpersonal relationships. For this to occur, the treatment environment should act as a holding and containing environment. One of the most relevant factors likely interfering with an adaptive functioning of the treatment environment relates to the presence of abundant countertransference reactions on the part of therapists and staff. ED patients often induce intense feelings of anger, devaluation, hopelessness, love, or identification in their care-givers. The pseudo-family dynamics re-enacted in the therapeutic milieu further stimulate an emotional atmosphere potentially leading to contradictory countertransferential reactions of competition, rejection, or identification among different members of the therapeutic team. The present article reviews the process of countertransference in the context of treating EDs. It highlights the main causes for the abundance of negative countertransference reactions in the treatment of EDs, and discusses the team dynamics within the therapeutic milieu and the impact of countertransference on treatment process and outcome. The authors propose theoretical conceptualizations and therapeutic approaches to manage the different patterns of staff countertransference to generate a better treatment environment for both patients and therapists.

Keywords: Eating disorders, dynamic processes, therapeutic milieu.

Introduction

The management of eating disorders (EDs) is a highly complex and often a highly frustrating endeavor. The difficulties inherent in the treatment of EDs call for the expansion of prevailing multidisciplinary treatment strategies towards a more comprehensive interdisciplinary model. In recent

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years, the amount of research on the countertransference reactions of therapists and milieu staff to psychiatric patients and how it affects patients and treatment providers has increased considerably. It is now well recognized that management of staff countertransference is a necessary condition for the provision and maintenance of high-quality treatment services and for the reduction of staff turnover and burnout (1-3). However, the impact of countertransference issues in the context of treating EDs has yet received only limited attention.

The management of EDs requires a highly structured and systemized treatment program in order to reduce maladaptive eating and promote the development of intrapsychic and interpersonal changes considered necessary for recovery. Management of these disorders goes beyond symptom reduction per se. Rather, establishment of certain interpersonal conditions is essential to conduct an effective intervention that would encourage the ED patient to engage in treatment not as a form of compliance, but as a meaningful, genuine developmental process (4). The establishment of management in this sense is akin in its meaning to Winnicott's mother's-infant holding environment (5) or to Kohut's self-object functioning (6). As such, the staff has the potential to provide ED patients with such therapeutic functions as mirroring, tension regulation, vitalization and integration. Through the events experienced and relived in the therapeutic environment, the patients' primitive needs may be resolved by the therapists' wish and ability to foster a good-enough environmental holding state (7). Fostering adequate boundaries is likely among the most vital roles of the therapeutic milieu, yet at the same time among the most difficult to achieve. This is related to the likelihood of these boundaries to be under constant attacks, either conscious or unconscious, generated by the patients or by members of the staff. Staff members and therapists have to work constantly to set and maintain boundaries that are consistent, comprehensible, and meaningful, yet firm enough to maintain structures that are essential to manage potentially life- and treatment-threatening states of despair and destructiveness (8).

Both psychotherapy and milieu teamwork are essential components of effective ED programs. The meaning of the term milieu is "surroundings" or

"environment." The milieu has both structured and unstructured components. The latter include the diverse interactions that may take place among patients, staff, and other agencies, for example administrators or visitors to the facility that are not part of the multidisciplinary working team. Integrating among the different professions may prove frustrating, yet is an essential process in the management of EDs.

Within the therapeutic environment, the ED individual is geared towards incorporating positive coping, interpersonal relationships, and life skills (9). Nevertheless, the pseudo-family dynamics likely appearing in the milieu likely stimulate an intense emotional atmosphere potentially interfering with the therapeutic endeavor. Specifically, the diversity and intensity of negative feelings likely evoked when treating ED patients tend to exert considerable impact on staff performance, treatment process and outcome, and the psychological climate of the treatment environment (10-13).

Pathological interpersonal patterns in the milieu may be induced by several dynamics, including competition, power struggles, parallel processes, splitting mechanisms, and/or projected fantasies, all exerting an unfavorable impact on the workplace atmosphere. Empirical studies indicate that it is the overall psychopathology of the patient or specified clusters of patient characteristics (14), rather than specific psychiatric diagnostic categories, that evoke identifiable maladaptive countertransference reactions among the staff members. In order to work through the intense pain and anger that often dominate the ED therapeutic milieu, health care professionals have to take into account the effects of the intense transference and countertransference relationships that often develop when treating ED patients, primarily if the treatment is carried out in the context of a large multi-professional working team.

The aim of this paper is to critically review the concept of countertransference in the context of treating EDs. We further aim to discuss the team dynamics emerging within the environment of an ED treatment facility, and their impact on treatment process and outcome. Lastly, we will relate to approaches that may intervene with these countertransference reactions, to facilitate effective therapeutic process for both patients and staff.

Transference and Countertransference

Transference is defined as the displacement of feelings, thoughts and behaviors originally experienced in relation to significant figures during childhood, onto a person involved in a current interpersonal relationship, mostly, but not only, the therapeutic relations. In this respect, transference may represent a current ubiquitous, automatic, unconscious repetition of past object relationships (15,16).

Countertransference reactions are categorized into two recognizable subgroups. Freud and later "classicists" refer to countertransference in its "narrow" meaning, namely as the therapist's unconscious response to the patient's transference (17). On the other hand, "totalists" support the broad definition of countertransference, which considers all of the therapist's conscious and unconscious feelings and emotional reactions to the patient's transference and realistic needs, as evoked in the therapeutic interaction with the patient (18-20).

Most definitions acknowledge, to varying degrees, that therapists' reactions to their clients may be influenced by their own unresolved personal conflicts. When these conflicts are provoked both within and outside of the therapeutic session, therapists may display avoidance behavior, engage in reactive rather than reflective thinking, feel anxious, and/or develop distorted perceptions of their clients. These countertransference reactions may render, in turn, the clients to form weaker alliances with their therapists and to perceive them as less empathic (21).

Kornitzer (3) emphasizes the basic assumption that transference and countertransference relationships ought to be understood not only in the dialogue between patient and therapist but also in the dialogue between the patient and the multidisciplinary team. Indeed, Menninger's "Guide to the Order Sheet" (22) developed in the first half of the twentieth century, favors carefully designed interactions of the patient with milieu staff over individual therapy. Contemporary views suggest that patients recreate internal object relations within the interpersonal relationships they develop in their treatment facility (23), rendering it necessary for the milieu staff to be able to comprehend transferences and countertransference reactions to facilitate adaptive changes in the patients' inner and outer world.

Countertransference Reactions in the Treatment of ED Patients

Clinicians treating ED patients may often experience contradictory feelings of unconditioned love, idealization, inadequacy, devaluation, sadness, despair, hopelessness, helplessness, anger, hate, frustration, and rejection of the patient and/or feeling rejected by the patient. They may also feel under constant stress, overwhelmed, swallowed-up, anxious, jealous, controlled or controlling, punitive, and impotent or omnipotent. Franko and Rolfe (11) have shown that that across all ED diagnoses, patients diagnosed with anorexia nervosa (AN), particularly of the restricting subtype, may evoke more intense negative feelings (e.g., anger, helplessness, or stress) in therapists who specialize in the treatment of EDs, in comparison to patients diagnosed with bingeing purging spectrum disorders, e.g., bulimia nervosa (BN) (11). Still, BN patients are also likely to evoke strong negative countertransference feelings in their therapists, leading them to act out their hostility through retaliatory behaviors.

The emotional reactions of ED patients are often very powerful, due to their dysregulated temperament, affects and drives and their elevated reactivity (24,25). This heightened emotional responsivity of ED patients may be related also to their propensity to feel, think and behave according to patterns that might have been adaptive in the past, but that are highly dysfunctional in the present. As such, ED patients are almost duty-bound to induce strong feelings of rage, hate, devaluation, hopelessness, pity and sorrow, and/or alternatively love and idealization, in people with whom they become involved, including their care-givers (26).

Burket and Sherman investigated the attitudes of 90 therapists towards ED patients, and found that almost a third (31%) would prefer not to treat patients diagnosed with an ED (27). Many of these therapists were males, advocated individual therapy as the recommended treatment method, claimed that the prognosis of ED was unfavorable, and displayed overall less empathy towards ED patients in comparison to therapists who would treat these patients. Factors related by these therapists to their reluctance to treat EDs were issues related to transference and countertransference, the inclination

of ED patients to resist treatment, and the presence of comorbid psychiatric disorders in addition to the ED.

Treatment providers who work with high-risk patients, as is often the case in EDs, are particularly vulnerable to personal emotional distress, which may linger long after the resolution of the critical event (28). In this respect, Herzog et al suggested that ED patients evoke particularly intense countertransference reactions in their care-providers because of their extreme neediness on the one hand and their high resistance to this neediness on the other, particularly if these occur in the context of severe medical complications and high suicidal risk (29).

The Dynamics Involved in the Relationships of Therapists to ED Patients and Encountered Countertransference Reactions

In working with ED patients, therapists may find themselves in a painful grip of countertransference emotions, evoked by their identification with the patient (concordant), or alternatively with someone else in the patient's world, particularly her parents (complementary). For many ED individuals, an adaptive maternal containment has not been readily available during the early stages of development (4). As a result, the infant might have developed an impaired sense of her own physical and mental boundaries and has not been able to come to experience herself as a whole person separate from her mother (30). In years to come, the future to be ED patient still remains bound to her mother, unable to develop her own autonomous sense of identity. Many years later, a similar wish of the ED patient to be merged in her relation with the therapist is relentlessly sought but equally feared. This process might induce a conflictual turmoil not only in the therapist, but also in the milieu, through the involvement of complex parallel processes in the interactions of staff members both with patient and the therapist.

The inability to meet the challenges of life may often lead to libidinal and ego regression in ED patients upon reaching puberty. Such a regression is likely associated with the patient experiencing her parents as unavailable, inconsistent, or neglectful, enforcing too great a separation too early, or

maintaining a merger with her beyond the time for which it was appropriate (31).

The inclination of ED patients towards regression likely evokes intense countertransference feelings in their care providers. Because of the extreme distrust of ED patients with their interpersonal environment, they may often "test" their therapists to see whether they are similar to or different from parental figures, never finding an acceptable solution (4). Feelings evoked in the treating staff because of this never ending "transference test" occur most frequently in relation to four developmental issues: control and structure, autonomy and initiative, tolerance of aggression, and fostering of the "true self" (4). A significant overlap often exists among these developmental dimensions.

Transference Tests Associated with Issues of Control and Autonomy

Clinicians working with ED patients are often trapped in power struggles due to the patients' need for rigid self-control to overcome their embedded sense of ineffectiveness, and/or the reliance of the patients on "no entry" defense mechanisms (32). The ongoing struggle with the therapist renders the ED patient a sense, albeit illusory, of potency and excitement. The 'high' that these patients get from their sense of omnipotent control of important objects in their life protects them from the painful awareness of their actual inadequacy and from their underlying enduring paralyzing anxieties (33). Unrealistic self-expectations of the therapists resulting from these power struggles have been identified as the single most critical factor in the development of caretakers' burnout (34).

Menninger has suggested that frustrations might stem from the basic, albeit often unfulfilled, universal motivation of health-care personnel to help ill people and to restore their health (35). Countertransference reactions become specifically intense in therapists involved with patients reluctant to receive treatment, as is the case in AN. Underneath the therapists' conscious wish to help others and ameliorate suffering, there are accompanying unconscious needs to master illness and to control life and death, often expressed in the form of rescue fantasies. Patients not

readily accepting their therapists' wish to provide treatment might challenge the therapists' deepest beliefs in what they do and how they do it.

Transference tests of ED patients in relation to autonomy and initiative are mainly tests in which staff members are unconsciously provoked to curtail the patients' autonomy via over-control, usually because the patient has acted out or expressed her independence needs in a self-destructive devaluative manner (4). At times, the therapist's wish to "rescue" the patient from her distress may leave the patient feeling weak and impotent, or alternatively, she may grasp the therapist as seductive, both conditions being highly destructive for the patient's personal development (36).

If therapy is conceptualized to resemble nourishment (4), the therapeutic food may be experienced by the ED patient as unwanted, unsafe and poisonous, as an extension of the mother's failing feeding. ED patients might unconsciously want the care and support of their therapists. Overtly, however, they deny and resist any sign of dependency or intimacy, and bitterly and resentfully reject their therapists' endeavors (26,37-39). Moreover, the therapist's interpretation is often experienced by the AN patient as a forbidden intrusion into her inner world, as a wish to control her mind, as a recapitulation of earlier experiences in which she was told by superior significant others as to what her thoughts and feelings actually were (40).

The sense of the ED patient that therapy is not safe, and that her thoughts and feelings might not be hers when treated, may be projected onto her treatment providers. The treating staff may often feel, in this case, incompetent and rejected by the ED patient under their (at least at times erroneous) assumption that the patient's unresponsiveness and resistance are the result of their own incompetence. The staff's sense of rejection and inadequacy, might further increase as a result of the patients' projecting onto them their prevailing feelings of ineffectiveness and self-disgust (40). Altogether, ED patients, likely more than any other patients, might bitterly challenge not only their therapists' sense of self-efficacy, but also their entire time-honored traditions of clinical work (41).

Transference Tests in the Context of Tolerance of Aggression

Transference tests in the context of tolerance of aggression are mainly in response to the ED patient's propensity to express her autonomy wishes in a provocatively noncompliant, demanding and rejecting manner, potentially provoking retaliatory or abandonment reactions on the part of the therapist. ED patients are frequently both highly demanding and highly sensitive to the reactions of others, thereby inducing a sense of burnout in their treatment providers. These patients unconsciously bring their therapists to feel as they themselves do, as they frequently employ projective identification defense processes. In this respect, patients might unconsciously wish to recapitulate early developmental stages, in which the infant projects unwanted parts of herself (mainly aggressive feelings) onto the mother for her to hold them by her capacity for "reverie", re-introjecting these parts again in a more manageable and benevolent form (42). Unfortunately this does not happen in therapy, as therapists of ED patients likely feel locked in dynamic interrelationships where they feel inadequate, impotent, and vomited upon, as the patient "spews out" her jumbled emotions onto them. Therapists may experience that nothing they supply feels sufficient or right to the patient, likely leading them to feel rejected, angry, and helpless, and not infrequently to react via maladaptive counter-projective identification processes.

Moreover, when the patient acts out her original, historical role and responds to the therapist as if being in a past relationship with a significant other, the therapist may identify not with the patient, but with the "depleted mother," i.e., the neglectful parent. Alternatively, the therapist may allow the patient to subtly take care of him/her, just as the patient has learned in her early years to take care of her mother (43). When roles are reversed, the patient may come to identify with her mother, whereas the therapist may feel as the patient has originally felt, in some cases over-controlled, misperceived and invalidated, and in other cases as the caretaker of the mother, or merged with her.

Transference Tests Associated with Not Fostering the "True Self"

Transference tests associated with the staff not fostering the patient's sense of "true self" are those in which staff members are unconsciously provoked by the patient to push her away towards "pseudo-independence", to assert her own needs and feelings too early, not taking into consideration that self-denial might be adaptive in the context of her current life situation (4).

According to self-psychology conceptualizations (7,44), ED patients feel and behave as if they are selfless souls born to serve the needs of significant others. These patients cannot accept the possibility that other people are willing to give up, even temporarily, their own interests and viewpoints to be geared towards the patients' needs and wishes. In Kohutian terms, ED patients do not believe that others can and wish to serve as their self-object (6). This often results in the patients' readiness to give up their own well-being and to deny even their most basic needs, first and foremost the right to be nourished, to supply the needs of significant others. Geller et al (45) claim that ED patients tend to 'silence their self' and to inhibit their self-expression, so that they would not jeopardize important interpersonal relationships. Their therapists might find themselves trapped in similar parallel process relations, where they are unconsciously ready to give-up their long cherished therapeutic stance for the sake of not risking the therapeutic process. Alternatively, in such relations, therapists might find themselves provoked to push the patients away although knowing that they are still unable or unwilling to assert their own needs in an adaptive manner. A vicious circle may then develop, where patients respond in a counterproductive-regressive way to what they mistakenly grasp as the wish of their therapists towards independence; therapists, in turn, may find themselves feeling frustrated and guilty, sometimes acting out these countertransference feelings. Other patient-therapist dynamics may also evoke intense countertransference reactions in the therapists:

- Concrete thinking and orientation. Early difficulties in differentiating between self and object may leave ED patients in a stage of

concrete thinking, in which the lack of symbolic equations does not enable the expression of true symbols. This may render ED patients unable to engage in symbolic body-oriented action or stimulation, thus precluding the regain of bodily investment putatively offered by a need-meeting object (46). The concrete mental functioning of ED patients may additionally represent paucity or absence of verbal accompaniment, often contributing to frustrating and non-productive silences in the therapeutic situation. It is difficult to engage ED patients in treatment, as they are trapped in the concreteness of body symbolism, and because their deficiency in reflective function often leads them to act out their symptoms rather than take part in their treatment (47). All these handicaps may render therapists to become non-committed and impatient in their relation with their patients, or even worse, to act out their feelings of aggression, rejection, and frustration, leading in some case towards potentially treatment-destructive interventions (48).

- Competition on thinness. Frankenberg (49) suggests that AN patients may view their female therapist as another competitor in their never-ending battle for thinness. This competitive stance likely interferes with the establishment of a sound therapeutic alliance. It can leave the therapist, especially if being overly concerned with her own weight, paralyzed by her negative reactions toward her patient and her inability to empathically connect with the patient's painful sense of fragility and ineffectiveness (50). Shisslak and associates (51) have found that 28% of the therapists working with ED patients are greatly affected by their work with these patients, becoming highly aware of their eating habits and physical condition. Whereas some therapists have reacted with positive changes in their eating habits and body image, and increased awareness of their physical condition, other therapists have reported less favorable changes.

Countertransference Reactions Encountered by the Therapeutic Milieu

In the case of multidisciplinary teams, different specialists work independently with the patient. By contrast, an important merit in interdisciplinary teams, as is often the case in EDs, is that the different specialists, despite having well-defined roles according to their training, communicate and share information and opinions with each other in the process of patient care. If staff members treating ED patients are aware and supportive of this sharing, their combined efforts to alleviate the patient's symptoms may block regressive expressions from the side of both patients and care givers of aggressive discharges in the form of splitting, projective identification or introjection of hostility (52). Several dynamics may appear in the context of milieu therapy in EDs

- Different professional concepts. In an adaptive environment, the different professions may work along parallel lines, yet at the same time are supervised for their interactive endeavors to facilitate true cooperation and harmony, despite having different professional concepts. The medical system, often perceived to have a paternalistic modus operandi, has to take into consideration issues such as physical dangers to the patient and time constraints. These elements counteract by their very nature necessary developmental processes that are fostered by the psychological system, including the provision of autonomy and psychological space, potentially creating a tension in the multidisciplinary team. The balance between being strong, consistent and adhering to one's therapeutic stance, but at the same time also understanding, empathizing and compassionate, is one of the greatest challenges of any team treating ED patients.
- Under-management and over-management. Goodsitt (7) warns against the hazards of the two extremes of under-management and over-management. Under-management is often the result of over-reliance on introspection and joining the patient's point of view, whereas over-management is induced by relying exclusively on the external reality, primarily the view point of the therapists and staff. The presence of a third party, often a coordinator who is not part of the treating team, may be of merit in alerting the staff to the existence of any of the two "collusions." The inclination of the ED patient towards acting-out or asserting herself in a self-destructive way, may frequently provoke the team to respond in either an over-controlling or under-controlling manner, i.e. to provide too little structure in collusion with the patient's denial, deception, or false self-presentation, or alternatively to block any possibility of listening and taking into consideration the patient's perceptions and wishes. Both processes may similarly set in motion powerful transference reactions and distorted projections. These are often expressed as bitter attacks on the treatment program and/or the treating staff, inducing, in turn, intense countertransference reactions of frustration, anger, abandonment or retaliation, in the milieu.
- Issues related to impotence, importance and competition. Frequently, staff members may be locked in dynamic interrelationships with their patients, feeling inadequate, impotent, rejected, angry, and helpless, or alternatively, omnipotent, and admired. Both poles may be evoked as a reaction to patients' competitiveness and acting-out behaviors, reflecting unresolved countertransference conflicts, as well as the preoccupation of therapists with issues of self-efficacy, competency, and being significant to others, all highly amplified in the context of treating EDs. These reactions may be further amplified if conflictual interdependent relationships do exist between the medical staff and members responsible for the emotional components of therapy. Therapists caught in these multifaceted conflictual interrelationships may at times feel "depleted", if they additionally perceive that the organization in which they work does not endow them with adequate resources, in the

form of work place, salary, or administrative assistance.

- Splitting. ED patients may create chaos in inpatient and ambulatory facilities treating them as a result of their use of primitive splitting defenses in their relationships with different parts of the treating environment. This, in turn, may manipulate caregivers towards antagonistic view points and conflicting interrelationships among themselves, with the patients, and/or with the families, likely inducing considerable tension in the staff. A culture of blame is one of the most prevailing reactions to the tendency of ED patients to split 'good' from 'bad'. The use of splitting originates in the infant's need to sort out his or her sensations to hold on to the good ones while getting rid of unpleasant and frightening sensations. In pathological conditions that necessitate the continuation of primitive defenses into adult life, splitting protects the patient's vulnerable ego from conflicts by the dissociation of introjections and identifications of a highly charged and conflictual nature (53-55). Patients may at times idealize their caregivers, only to consider them as "bad" at other times, leading staff members to feel confused, insecure, demeaned, humiliated and attacked. These dynamics tend to occur more frequently in patients presenting with a co-morbid personality disorder in addition to the primary ED, primarily, but not only, borderline personality disorder (4).

It can be acutely upsetting for caregivers to be perceived as bad by their patients, to find themselves on the wrong side of the split. As a result, therapists may deny or project the hated 'badness' in the self, or collude with the patients against the goals of treatment to regain their love and admiration.

- Triangulation dynamics can also be observed in the treatment of EDs. The three-party system (patient, therapist, manager) may reenact some aspects of the therapist's own oedipal conflict, or it may reenact a preoedipal theme in the context of a

countertransference process. In the latter instance, therapist and patient may be engaged in blissful symbiosis, with the supervisor or medical manager perceived as intruding outsiders (17). These triangulation dynamics may generate a negative psychological climate in the therapeutic staff.

- Dynamics of parallel processes may also increase the burden encountered in the milieu. Grey and Fiscalini (56) regard the parallel process as a chain reaction occurring in any interconnected series of interpersonal situations that have evidence of dynamic similarity. The process may, thus, involve a significant person in the patient's life who affects the patient who, in turn, affects the therapist who, in turn, affects the staff or medical manager (57). Some of these parallel reenactments are negative (e.g., rebellion, anger, or control), likely interfering with the psychological climate of the treating facility and creating conflicting reactions within the therapeutic milieu or towards the directors. Moreover, parallel process dynamics may impair decision processes generated within the therapeutic milieu, thus exerting considerable influence on the treatment outcome. Working with the caregivers' countertransference reactions may represent, in this respect, a unique opportunity to understand the parallel processes enacted in the treatment facility, potentially increasing the likelihood of promoting a more favorable working atmosphere (33).

The Effect of Countertransference Reactions on Treatment Outcome

Countertransference reactions emerging during treatment in relation to the patients may be regarded as a double-edged sword for the therapists. If not understood and adequately worked through, they are likely to lead to undesired emotions and/or behaviors on the part of the therapist, which, not surprisingly, are often destructive repetitions of the patient's past relations with significant others. Hayes and associates (58) have reported that the extent of

countertransference reactions exhibited during treatment, as measured with the Countertransference Factors Inventory, has been found to be inversely related to the impact of treatment in cases with poor to moderate treatment results, whereas no such relationship has been shown in more successful treatments. Additionally, therapists who are more self-integrated, with more cohesive personalities and more stable interpersonal boundaries, have been shown to demonstrate less countertransference reactions (58). Hayes and Gelso (59) suggest that the more the therapist engages in an "ego-oriented" behavior rather than focusing on the patient's unresolved suffering, the less likely are the client and therapist able to agree on the goals and tasks of therapy and to feel a close emotional bond. This mismatch by itself may stir up many unresolved conflicts in the therapist.

Both patients and therapists have the wish and potential to grow and develop during treatment. To enable this process to take place, relationships in treatment should be such that closeness is not fusion, separation is not detachment, and engagement is not enmeshment (60). By contrast, the presence of intensive countertransference reactions may bring about a failure to achieve such reparative therapeutic relationship, likely hindering the potential towards growth of both patient and staff.

The Management of Clinicians' and Milieu Dynamics

Strains in the alliance between caregivers and patients are inevitable in the process of treating ED patients (61). One of the most important skills required to deal therapeutically with this negative process so that injuries in the therapeutic alliance are repaired, is related to the therapists' awareness and ability to deal with their own countertransference reactions (13).

The first step in the management of negative dynamics is indeed to identify them. If therapists become aware of the countertransference process, it can potentially serve as a valuable source of insight into the illness and the therapeutic relationship (59). The ED patient's confusion between her inner world and the dynamics exerted in her relations with her

family can be often acted out in the therapeutic relationship. If therapists are aware of their countertransference reactions in these interrelationships, they will get a first-hand experience of the frustration that both patient and family have originally experienced. By contrast, unidentified countertransference reactions may cause therapists to become furious with their patients or pessimistic with regard to treatment outcome, or even undermine or abandon treatment (62). One important opportunity for therapists to monitor their countertransference reactions during the psychotherapeutic process is by paying attention to their bodily reactions (63). This line of therapeutic stance considers psychotherapy an investigation into the intersubjective space between client and therapist, in which the emergent bodily reactions of both potentially representing the vary basis of subjectivity (63).

The handling of negative dynamics in treatment also relies on the therapist's ability to assist the patient in growing out of a cyclical pattern of hurting/being hurt in the therapeutic interrelationships towards healthier relational pattern. For this to happen, therapists of ED patients, often feeling inept, devaluated and rejected, should be able to identify and break out from their own maladaptive cyclical countertransference reactions such as being another rejecting adult figure, or another perceived weak figure that totally complies with the patient's destructiveness (13).

In order to work through the intense emotions of depression, anxiety, and anger that often evoke in the treatment of ED patients, the staff must become aware of their own bias towards these negative emotions; namely, do they consider these emotions as destructive or constructive, and are these considerations different in different conditions. Treatment providers are further required to examine how comfortable they are in working through these intense feelings within the context of the entire therapeutic milieu.

An essential goal in any treatment is to alter the patients' recurring maladaptive pattern of handling of anger in important relationships to a more adaptive one. One approach for such a change to occur is by assisting the ED patient to feel more competent and apt in her coping, so that anger conditions would not

be necessarily conceived by her as dangerous and destructive. Correct identification and handling by the therapists of their countertransference reactions to their patients' altered expression of anger, may assist the patients in communicating hitherto unexpressed and unaccepted wishes. It is essential that staff members learn to identify and translate their reactions to the patients' anger into clear, non-accusatory statements that give a sound meaning to the patients', as well as their own, reactions. The expression of anger and hostility can be conceived, in this sense, as communicative, defensive, or destructive, depending on how they are interpreted and handled by staff and patients. For example, anger expressed in a group therapy session of ED patients can interfere with working through more deep-seated emotions, e.g., anxiety or despair (9). In this respect, Sullivan (64) has related to the potential of angry feelings to defend against the anxiety associated with disappointment and deprivation occurring within the context of interpersonal relationships charged with unfulfilled expectancy. Winnicott has emphasized the co-existence of hate and love in countertransference reactions (65). The understanding and tolerance of the therapists of the existence of such ambivalent feelings in relation to their patients is essential in facilitating effective and empathic interventions (65). Nevertheless, it is important to note that although the treatment literature does offer the therapist a variety of theoretical models and treatment strategies to deal with "difficult" clients likely invoking charged and disturbing countertransference reactions, it offers only little help in dealing with a dislike or aversion to a specific client in a specific condition.

Williams and Day (66) suggest that if therapists have only minimal unresolved personal issues, simply recognizing and acknowledging their existence may free them to perceive their patients differently, in a more favorable manner. This by itself may, in turn, encourage the patient to develop a more benevolent self perception. Therapists are nevertheless required to be alert to and monitor their reactions towards their patients at all times; they should also be alert to the possible influence of negative feelings of other people towards the patient on their own perception, particularly in the case of their appreciated colleagues. Therapists in general, and those treating ED patients in particular, should be involved in an

ongoing supervision, to minimize the likelihood of their own unresolved issues to cloud their perception and interrelation with the client. It is further recommended that if a specific client elicits a particularly strong counter-transference response on the part of the therapist, he or she should consider pursuing their own personal therapy.

Other strategies to manage negative dynamics in the treatment process include approaching the patient as separate from the problem. The narrative approach suggests along these lines that the person is not the problem, but the problem is the problem (67). Moreover, looking at the client from a multi-generational context can often develop greater compassion and empathy towards him or her (66). Unfortunately, these approaches do not reduce the inclination of the ED patient towards destructiveness of behaviors.

Team work and support are essential components in the management of negative dynamics in the therapeutic milieu. This requires the staff to function as a communicative, cooperative, and cohesive working team. An important task in an adequate growth-promoting treatment process is the coordination of the entire working process by a professional designed to be the leader and coordinator, facilitating an ongoing collaboration on the part of all disciplines. The task of the team, particularly but not only its leader, is to implement the treatment plan across all treatment modalities. This requires the establishment of a consensus of opinions among the different professions in regard to the aim, structure, process, and content of the treatment plan for each and every patient (68).

Team members need constant support and supervision in their efforts to hold onto an imperfect, although reasonable, wholeness that includes mistakes and painful feelings but also hope and growth. Care providers need even more support to keep a receptive frame of mind that can and is willing to regard hateful projections on the part of the patients as desperate unconscious attempts to communicate, rather than as aiming towards the destruction of treatment and care providers. The quality of team interaction exerts considerable influence on therapists' autonomy, sharing of tasks, and decision making while providing structure, time limits, and leadership (69). Given and Simmons (70) suggest that several personal qualities

of care givers are vital to facilitate interdisciplinary team function. These include the ability to accept differences and perspectives of others, to function independently, to negotiate roles with other team members, to form new values, attitudes and perceptions when required, to tolerate constant review and challenge of ideas, to take risks, to have a well-integrated personal identity and integrity, and to be ready to accept the team philosophy of care. Holmqvist and Fogelstam (71) have found that treatment facilities characterized by interpersonal dynamics of "work" and "pairing" score high for helpful and autonomous feelings, whereas unhelpful feelings are evoked in facilities characterized by the dynamics of "dependency" and "fight"

Low levels of team support may arise as a result of both organizational/institutional and personal causes. Therapists with less experience in the treatment of EDs likely feel more frustrated and angry compared with more experienced therapists (11). This may be related to the inclination of experienced therapists to have a longitudinal view of EDs that takes into consideration the prolonged period required for improvement, rather than to react negatively to more immediate experiences with a hostile or oppositional patient (12). Reluctance to ask for team support may stem from the fear of care givers that any request for team work, or team work itself, may lead to their colleagues regarding them as inapt or incompetent. Care givers may even come to fantasize that such views from important others will culminate in painful criticism and rejection. In addition to the influence of organizational/institutional and personal factors on the part of the team, anxieties related to incompetence and weakness are particularly frequent when treating EDs, reflecting the projection of similar, even greater, anxieties from the part of the patients onto the therapists.

Van Wagoner and associates (72) have identified five factors likely promoting an effective handling of countertransference reactions: self-insight, anxiety management, conceptual skills, empathy, and self-integration. Alternatively, Hayes and Gelso (59) suggest that only two factors have been identified empirically as facilitating countertransference management: self-insight and self-integration. In this respect, self-insight relates to the awareness of therapists of areas of unresolved conflicts, whereas

self-integration reflects the degree to which one's conflicts are resolved.

At the organizational level, a high case load and a treatment model encouraging care providers to manage patients and families single handedly, contribute to feelings of isolation and burnout. Thus, in comparison to therapists with a smaller case load, those who see more patients tend to score higher on the countertransference assessment subscales of 'frustration,' 'feeling manipulated,' and 'helplessness/hopelessness' (11).

Team leaders should empower the staff in their struggle to hold adequate boundaries while at the same time maintaining hope in the face of the patients' destructiveness in all its different forms. The staff should be additionally encouraged to work through maladaptive interpersonal familial-like dynamics, to facilitate team spirit in a way that enables crises to be lived through and even serve as a potential towards growth, and recovery to be cherished, despite the ever-present threat of relapse (8).

An appropriate supervisory process is additionally crucial for the management of team dynamics because of the potential of countertransference issues in long-term treatment of patients with EDs to be mirrored and recapitulated in the supervisory process (73). Such countertransference phenomena paralleled in supervision may include an inclination towards being secretive, intrusive, blaming, over-controlling, overindulgent, or over-identified. Supervisors should offer understanding, empathy and support for the difficult feelings that patients often induce in the staff. At the same time — in work-discussion groups — they should offer relevant evidence-based theoretical links and therapeutic conceptualizations, so that the thoughts and feelings elaborated in one situation for some patients can be generalized to other interactions and become part of the shared treatment culture of the facility (8).

Conclusion

Intense countertransference reactions are common in the therapeutic milieu of ED facilities. These reactions arise from multiple sources, including

the patients' and therapists' personal history and personal attributes, and the activation, in the treatment session and the milieu, of intrapsychic and interpersonal processes such as identification, rejection, competition, testing, projective identification, splitting, or parallel processes. Often traits that allow the individual to become an excellent therapist, for example the ability to empathize, can also render him or her vulnerable to personal emotional distress related to the activation of maladaptive counter projective-identification processes. Working with high risk clients, as is often the case in the treatment of EDs, produces reactions indicative of treatment providers' burnout. These include the loss of drive and motivation, appearance of physical, mental, and emotional exhaustion, professional isolation, and the drain related to being constantly empathetic to patients who are not only difficult to treat but often reluctant to be treated, and having to be content with often modest long-term improvement (74).

The therapeutic milieu should act as a holding and containing environment in which staff members are encouraged to use their countertransference reactions as the channel for moving inward to uncover the underpinnings of their own deep emotions. It should become, in this respect an environment that provides highly reinforcing opportunities for new ways of thinking, feeling, and acting, as well as for the expression and examination of old patterns and motivations. Therapists must work through feelings associated with their unmet needs and desires to be free to create opportunities that would encourage the patients to engage in mutually gratifying relationships in the here-and-now therapeutic situation. They should strive to understand the origins of their unmet countertransference reactions to activate them in therapy in the best interest of the patients, rather than satisfy these needs through the patient.

Interventions within the milieu must interrupt the vicious cycle of malevolent transformations wherein the unmet, unacknowledged, and often unaccepted wishes of the ED patient towards warmth and tenderness likely induce anxiety, pain or reluctance on the part of the therapist. Through appropriate interpretations of attitudes and behaviors with their transferential and countertransferential underpinnings, the treatment staff can potentially create an

environment that keeps negative phenomena in check, is empathetic and responsive to the underlying needs of both patients and treatment providers, and offers healthier alternatives for the expression of intense, yet valid, feeling states. This adaptive environment should exist for both patients and care providers, encouraging therapists towards continuous expansion of their therapeutic capacities in the service of providing an ever better care.

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