Our bodies, Ourselves

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Whether in the clinician's or the client's chair, all women are affected by contemporary culture's disparaging treatment of the female body and the cultivation of impossible standards for beauty. This keynote explores the interplay between female clients and clinicians in the area of body image. Body image disturbance is one of the most challenging symptoms to treat and is known for being the last thing to remit in recovery from an eating disorder. Careful exploration and understanding of body image is critical to successful treatment. Clinicians need to have a grasp of this topic, not only from the perspective of their clients, but from their own as well. Explorations of transference and countertransference issues specifically related to body image have been rarely written about or publicly addressed.

This article includes examples, observations, and suggestions gleaned from over three decades of experience as an eating disorder therapists and clinical supervisor. Three separate but overlapping issues related to treating body image and their subsequent transference and countertransference issues will be discussed: the clinician's relationship to her own weight, eating patterns, and body image; clients' tendencies to scrutinize and comment about the clinician's body; and self-disclosure and authenticity in the therapeutic relationship**.**

The Embodied Self

Through our bodies we come to know and experience ourselves as distinct, separate entities in the world. According to Freud (1961), bodily experiences are the center around which the ego is developed. We are embodied beings, using our bodies for everything from basic survival to interpersonal communication. Cultural messages and structures shape the experience and meaning ascribed to the body, and, in today's Western culture, the female body is a commodity, a unique form of currency and power. Females can attract mates, earn more, and garner attention and status based on how closely their body matches the currently accepted, idealized standard.

Based completely upon subjective perception, body image is a complex product of the imagination. According to Hutchinson (1994), it is "the psychological space where body, mind, and culture come together- the space that encompasses our thoughts, feelings, perceptions, attitudes, values and judgments about the bodies we have" (p..153). Kearney- Cook (1989), a pioneer in this area, writes that body image forms in childhood, but the ongoing social and somatic experiences of adolescence are superimposed on this image. Body image is always a work in progress, richly affected by the normal events of psychosocial development, as well as by trauma..

Individuals with eating disorders are commonly unable to see themselves realistically and are dissatisfied with, disgusted by, and even full of hatred toward their bodies. Those with anorexia are most known for extreme body image disturbance, not seeing how emaciated they really are, and not wanting to gain weight or "get fat" even

when at extreme and dangerously low weights. Those with bulimia and eating disorders not otherwise specified (EDNOS) may also suffer body image distortion. Regardless of actual distortion, eating disorder clients are obsessed with body image concerns and resort to unhealthy and destructive food patterns and weight-related behaviors**,** often posing serious health consequences.

While body image disturbance is central to the diagnoses of eating disorders, it also is a normative experience for women today (Levine and Smolak, 1998; Maine and Kelly, 2005). Whether in the clinician's or the client's chair, all women are affected by contemporary culture's disparaging treatment of the female body and the cultivation of impossible standards for beauty.

Incorporating body image as a focus for treatment raises many questions regarding how female therapists deal with their own body related issues: how much, if any, disclosure in this area is appropriate; how to stay honest and authentic, yet not disclose inappropriate personal body image struggles; what personal body image struggles are appropriate to share; how to avoid getting triggered by clients; how to protect yourself, care for your body, accept, and, even love, your own body in the midst of working with others who suffer from severe body dissatisfaction to the point of a mental illness. It is easy to see how issues of transference (the process in psychotherapy whereby the client unconsciously redirects feelings, fears, desires, emotions, and ways of relating with important people in their past onto the therapist) and countertransference (when the therapist unconsciously reacts to the transference of the client along with

general ways that the therapist's own emotional issues can be stimulated) arise around body image conflicts, whether acknowledged or not.

Body image countertransference issues can critically affect the success of the therapy, even causing personal consequences to some therapists. Professionals with no previous history of eating or body image problems can be triggered to scrutinize themselves and think critically about their own body, weight, and eating habits. Recovered clinicians might be better prepared to deal with these issues, having previously conquered such demons, but they are vulnerable to being triggered into relapse. All clinicians will be better prepared to deal with their eating disorder clients if they understand the potentials and pitfalls that can arise in dealing with body image issues.

Therapists treating eating and body image disorders have to navigate their clients' complicated relationships to their bodies while keeping themselves in check and balance. Clinical training rarely prepares therapists for the various kinds of personal challenges that arise. The following are real scenarios that eating disorder therapists will most likely face:

- How do you help a client turn her focus off of weight loss concerns if you are engaged in dieting behaviors?
- How do you deal with a client who hates her legs for being grossly fat when yours are twice as big?
- How do you get a client to stop weighing herself daily when you, too, do so?

- How do you help clients cultivate inner beauty when you are dieting or injecting Botox for those annoying wrinkles?
- How do you respond to a young woman who claims that she definitely does not want to look like you?
- Where can you safely discuss these issues to improve your insight, skills, and comfort level with such deeply personal material?

As a clinical director and supervisor, I have witnessed professionals confront, change, and/or justify their own body image dissatisfaction and eating habits as a result of working with eating disorder clients. Having suffered from an eating disorder in the past may be useful or particularly challenging. Those with a previous history of an eating disorder should be recovered for at least two years prior to engaging in this work and should engage in ongoing professional supervision to help navigate these issues. All female clinicians working with eating disorders must address their own body-related issues. Embodiment, our psychological experience of our physical selves, is an ongoing process that can enrich us personally and professionally; understanding it is essential to effective treatment.

The Clinician's Relationship to Her Own Weight, Eating, and Body Image

Ideally, female therapists can serve as positive healthy role models for their eating disorder clients by demonstrating self-acceptance, care, and love for their own bodies. It is healing for clients to see females who are comfortable with their own bodies, living a

life free from restrictive dieting or other disordered behaviors, thoughts, and desires. Acceptance does not mean that the therapist always loves what she sees in the mirror, can never have a negative thought about her own body, or can never engage in any behavior to improve it; rather, it means that she knows how to navigate these feelings and behaviors without being destructive to herself.

One way I help clients navigate body image issues is by using some of my own experiences that helped me recover from anorexia and exercise addiction. Early in treatment, I help clients separate their perception, attitude, and behavior towards their bodies. Perception is what the person sees; whether distorted or not. For example, the eating disordered woman will say and believe: "My stomach sticks out and is fat." Attitude is the meaning she makes of what she sees: "Therefore, I am unworthy and unattractive." Behavior is what she does about it: "I will vomit my food." All three, perception, attitude, and behavior, are important to explore. Despite being a difficult and long term task, it is important to help clients gain a more realistic body image. Trying to talk a client out of her own perception or out of feeling fat is a useless endeavor.

One way I work with clients on attitude is to instill the notion of "so what." When I suffered from anorexia I struggled to keep my stomach flat and not weigh over a certain amount, but ultimately had to face that it was getting me nowhere. I came to the realization that I could perhaps spend the rest of my life pursuing these goals but "so what," achieving them would not get me what I really wanted: happiness, love, joy. When I felt fat or unworthy because my stomach stuck out or had any similar "anorexic thought," I started to ask myself: "So what?" So what if someone's stomach sticks out or

she has big thighs? What, if anything, does a stick-out-stomach or big thighs interfere with? I ask clients to think about the people they like, love, and respect the most and question if these people are the thinnest people they know. Invariably the answer is, "No." I then ask clients to think about who likes them and why. I also ask them to consider what price they would have to pay for getting thinner thighs and if that price is really worth it. The intensity of these ideas diminishes with the use of "so what," while the client**s** are helped to understand and cope with the underlying feelings, no longer hating or hurting themselves. "So what" does not mean that the client's feelings do not matter; empathy and understanding are essential.

The "so what" technique only works when therapists have practiced this themselves and have come to terms with their own bodies. We can perceive and feel certain things about our bodies, but it is our behavior, and what we actually do about it, that will or will not get us into trouble. Therapists can sometimes help by sharing that they too have "bad body image days," or occasionally wish clothes fit better, or that they looked thinner. The art of "so what" is to notice these things and let them go, not put too much emphasis on them, or act on them destructively. This is the art of self-acceptance.

Mindfulness and Distress Tolerance practices such as those taught in Dialectical Behavioral Therapy (Linehan, 2005) are useful tools to address body image obsessions and promote self-acceptance. These techniques help clients to observe without judgment, take the emphasis off appearance, explore what really matters, and make peace with their natural size; they build these skills in the therapist as well. In fact, over the years, many

therapists have confided that they healed their own unrecognized body image issues by helping clients make peace with theirs.

Sharing details of my own history is one way I have used my embodied experience to help clients. To be truly authentic, therapists have to learn how to best use their experiences therapeutically, based on their own clinical theory, perspective, and comfort zone. This requires careful reflection to decipher if a specific personal experience is being shared for the sake of the therapist or the benefit of the client. I often will ask myself and those that I supervise: "How are you hoping that this will help the client? How might you be wanting to share this to relieve yourself or to take care of your own emotional needs?"

Recovered from an eating disorder several years before becoming a therapist, Rena Roberts, an eating disorder therapist in California, whom I supervise, knows severe body image struggles firsthand. Through disciplined self-awareness, integrating her personal and professional growth, she has learned what to share with clients, what to do with her own feelings, and how best to help her clients in their body image struggles. In her words:

> *If I am going to help a client improve her body image, it is important that my body image is solid. I need to have explored, processed, and accepted my own flaws in order to help another accept hers.*
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> *Although I have been recovered for many years, my own body image has needed continual work. As I go through different life phases, I need to continue to process feelings about my body and come to a place of acceptance again. For example, I*

could not ignore the feelings brought on by body changes due to pregnancy. As I age, it seems like every few years some new hormonal changes are also changing my body a little this way and a little that. Each step of the way, a decision is made about how I will respond to these changes and accompanying feelings. I call this body image maintenance.

For the first time in my life, I have been considering a tummy tuck because of the damage to my skin on my stomach during my pregnancies. I have terrible discoloration and stretch marks. Just considering this plastic surgery has made me feel guilty and indulgent and perhaps even hypocritical; on the other hand, it has helped me to understand and accept my clients with less judgment.

I have a client who has had various dermatological and plastic surgery procedures and she continues to desire more of this type of work. Previously, I felt judgmental regarding her behavior. With my experience, training, and ongoing supervision, I have contained that judgment and remained helpful to her. Since pondering my own tummy tuck, I have grown in compassion and humility with this client and aging women in general. The real question is how to deal with body image transference in an effective way? If we simplify client questions/concerns about our bodies as being about their eating disorder, we miss an opportunity to entertain deeper discussions where topics such as the body of the therapist might be included. Clients walk around all day comparing themselves to others, constantly worried that they don't measure up. When we directly address their concerns about us and our bodies, we dispel the power that their assumptions might have.

Scrutiny and Comments From Clients Regarding the Clinician's Body

As a supervisor, I explore body image transference and countertransference and try to cultivate a healing professional dialogue where it is safe to talk about these issues. . I still remember when an 85 pound teen with anorexia looked at me and said, "Uh, I don't want to be that fat." I responded by laughing and saying, "Well, good thing I love my body and am comfortable with it at this size, but we will have to see what size your body needs to be." I went on to tell her that I was not comfortable with my weight gain in the beginning and that it gets easier and easier as time goes on. I told her, "Your mind eventually catches up to your body." Later I discussed this exchange in supervision, and others shared similar experiences. We were all able to laugh together. Laughter is good medicine, for client and clinician.

Unfortunately, many therapists do not process countertransference feelings for fear of seeming inadequate, unprofessional, or "not recovered." These challenging scenarios are not personal failures, but rather opportunities to grow professionally. Those clinicians working in a treatment program who do not feel comfortable bringing issues up in supervision should find an outside therapist or supervisor to help. The worst thing is to ignore it and hope it all goes away.

During her supervision over the years, Rena worked through several of these discomforting body image challenges. At this point, Rena is an accomplished and seasoned therapist, but she recognizes that body image challenges always come up:

> *Once a client said to me, "I don't want to hurt you. No offense, I don't think you're fat, but I wouldn't want to look like you." It didn't feel all that great. Part of me thought, "Why not? I look pretty darn good. I definitely look better than your*

anorexic self. Wow, she's really sick." I even felt insecure that perhaps she had seen my tummy hang out sometime. I thought I should be more careful in how I dress and even that maybe it's my complexion and she associates that with eating. All of these things went through my mind instantly. But I knew it was hard for her to say and that she was looking to gain something from the comment.

First, I reassured her that I always wanted her to tell me what was on her mind even if it seemed rude or wrong in some way. I reassured her that she was very sensitive in her delivery of the comment and, I knew there was no ill will in the comment. I wanted her to know that she could have an open honest relationship with another human being. When we talked about the content of her comment my client was able to tell me some important things. She wanted to get better, but she didn't feel able to have a "normal" body. She still felt a great need to be thinner than everyone else. "Ok, I said, I knew that, but why did you start that topic with a comment about my body?" Then the underlying feelings surfaced. She felt sad and ashamed of her inability to recover more fully because she had been in therapy so long and had been to multiple treatment centers. She felt guilty because I had worked so long and so hard with her that she wished she could do it for me. She was very tearful as she explained how grateful she was for our work and how she thought she must be such a disappointment to me. She feared that I would not want to accept her and support her if she were to maintain a weight that was too thin. She stated, "I'm still waiting for you to give me the boot and tell me I'm a hopeless case."

All of this came from a discussion that started with my body! At this point I understood the transference and why it presented that way.

Self-Disclosure and Authenticity

Therapists working with eating disorder clients must consider how to respond to questions about their own body, weight, and food. This brings self-disclosure front and center, an issue for which there is a wide spectrum of beliefs, theories, and practices. What is best for the client must always be the main guide. Whether or not a therapist chooses to disclose anything personal is a matter of choice and therapeutic style. In any case, it is important to be able to deliver an authentic therapeutic response.

Before sharing personal information, clinicians need to be trained in how to avoid inappropriate self-disclosure, becoming overly involved with a client, sharing too much detail, or overly personalizing material. Therapists need to acquire skills in how to respond authentically, while holding back personal information that would not be in the client's best interest.

A great example of the risks and art of self-disclosure occurred during group therapy when an intern's stomach was growling. The client sitting next to her interrupted the group by asking the intern if she had eaten breakfast. The intern responded by saying: "No, as a matter of fact I haven't." Everyone could then feel the tension in the room. All of the clients were in residential treatment, all had to eat breakfast every morning, and we stressed the importance of this meal. Several questions arise with this scenario: How should the intern have responded? Should she tell the truth; if not, isn't that lying? How should I, as the main group facilitator, have responded? As her supervisor, what should I say to the intern later?

Of course, there are a variety of responses to the previous questions. What I did was to immediately respond by asking the client if the growling stomach made her uncomfortable and why. I then let all the clients discuss the situation and how they felt about the intern not having breakfast. I used the current situation to discuss how the clients get affected, or "triggered' as they often call it, by others. I pointed out to the clients that they were going to routinely run into people who engage in behaviors, such as skipping breakfast or a snack, that to a normal person might not mean much but, to someone recovering from an eating disorder, could be inappropriate and potentially dangerous. We also were able to explore what being "triggered" really means and where personal responsibility comes in. The discussion was helpful to the clients, but it took some work getting the focus off of the intern and her lack of breakfast.

What did the intern need to learn from the breakfast incident situation? In supervision, I told her that I understood her dilemma, but that telling the clients she had not eaten breakfast was inappropriate. This kind of personal disclosure could cause all kinds of conflicts for clients, as well as causing them to worry that she is not a good role model. Her disclosure could give clients an excuse to not eat breakfast and/or to mistrust her. The intern admitted that she was confused about what to do when she was put on the spot. Not knowing how to respond, she thought it was best to tell the truth. I explained kindly, that the whole truth is not always the right answer. In this situation, the best response to "Did you eat breakfast" would be not to lie, but rather to reply with something that brings the issue back to the client such as:

- *"Oh I see that my stomach growling bothers you, why is that?"*

- *"My stomach growls when I eat and when I don't, how is it affecting you?"*
- *"Well, I guess my stomach is still hungry, does that bother you?"*
- *"That's a personal question, but what would it mean to you if I did or didn't eat?"*

Eating and food questions come up in individual therapy sessions routinely. I have been asked: if I ate, when I ate last, and what I ate, all in the same day by different clients. Most of the time I can just answer truthfully and tell the client yes I ate …and fill in the details. I do this if I think the answer is either useful for the client to hear, or at, the very least, not problematic, and will end the topic quickly so we can move on. Other times, answering is not so simple, and could be triggering; for example, if I have not yet eaten lunch and it is late. I try to think more of the process of the questions, or the deeper meaning, rather than the content. Sometimes the therapist needs to answer indirectly, as I suggested regarding the breakfast incident: not to lie, but also not to feel trapped by the content of the question and, instead, to address potential clinical meanings. There is a balance here. It is important to not always evade giving a direct answer, otherwise the eating disorder client will feel put off and avoided. These clients are very sensitive, so answering their questions is important. The key is to know when to answer with content and when to answer with a process comment.

Self-disclosure can be helpful sometimes, while other times, it can be problematic or damaging. If unsure, err on the side of an authentic, honest but non- disclosing response as in the breakfast examples I provided, and do not disclose anything that makes

you feel uncomfortable. This will only cause tension that the client may misinterpret. It is even appropriate to say that you are not comfortable discussing the details of what has been asked. Everyone has a right to privacy and boundaries. Understanding why they may want to know more about you and what you can comfortably share takes time and experience. Self-disclosure and authenticity are important issues to discuss with colleagues and supervisors on an ongoing basis.

It can also be quite useful when therapists disclose some of their own healing and recovery in the area of body image. For example, I might discuss how difficult it was to gain weight and how I kicked and screamed through every pound. I let clients with anorexia know that they cannot wait to be "ready" to gain weight and that no one is ever really ready. When appropriate, I share a few mantras that I used to say over and over to myself such as, "Full is not the same thing as fat" or, "You cannot be the judge of your own body." I tell my clients that I had to find someone I trusted more than I trusted the eating disorder. All of these ideas sprang from my own struggle and recovery from anorexia and my own body image problems. Therapists can draw on many types of experiences in their own lives to help clients understand the process of letting go, giving up old habits, and managing fear.

When therapists disclose personal information about overcoming a problem, they must avoid assuming that the client will need the same things or respond in the same way. What works for the therapist may not work for the client. Talking about the details of one's problem or illness should always be avoided. It is the process of getting through something, not the specific details of the problem, which clients can benefit from. Rather

than discussing how many laxatives one took or weight one lost, a more appropriate form of self-disclosure for a recovered therapist would be discussing how the therapist was able to conquer problems such as laxative abuse, or accept a more realistic body weight, or any methods or strategies used to stop engaging in eating disorder behaviors. Rena describes an interesting self- disclosure experience:

> *Due to adult acne, I once decided to try a recommended alternative treatment that involved a diet. As a result I lost about 5 pounds. One of the natural laws of treating eating disorders is that eating disorder clients will notice any changes in their therapist's weight. One client began the session by saying she was worried about me and that she wasn't sure how to bring it up. "Are you ok?" she said. "I can see you have lost weight. I am sorry to put you on the spot but it's bothering me."*
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> *In the first instant, I was annoyed. I am recovered and have worked in this field for over 10 years. I don't want to discuss my acne or medical choices with my clients. It was hard enough to stick to this diet. I wanted sugar and caffeine, damn it! I wasn't in the mood to help her with her body comparison issues. I then felt bad. But the truth is, it is hard to have my body under constant scrutiny from clients or colleagues. Because I specialize in eating disorder treatment, I have found that people watch my eating and scrutinize my body and question my recovery. I tried the best I could to just listen to the client, tell her I was o.k. and hide my feelings. After the session, I vented these feelings to my mentor, Carolyn Costin. She reminded me that this kind of reaction from a client goes with the territory and helped me understand my feelings.*

I helped Rena to not take the client's comments personally. Our processing helped Rena to understand her own reactions so they would not interfere with the therapy. To process before responding is helpful. If a therapist becomes upset by something in a session and can control it enough so it does not show, she should move past the issue as best she can and process it later. If she cannot hide her feelings, it is best to acknowledge them briefly, breathe deeply to become calm and centered, and ask to come back to the issue at a later time. This gives the therapist time to work things through, before further discussing it.

Rena continuing*:*

During the next session, I asked her what her observation about my body had brought up for her. We discussed a few issues, but things still seemed tense. Then, I decided to disclose the truth to her. She was right that I had lost weight so I validated her observation. I told her that I was on a special diet to treat adult acne. I did not give her specifics about the diet. I told her there was initial weight loss that had stopped,, that I was being monitored by a doctor, and that we had discussed the weight loss and were doing things to address this. Instantly she relaxed. Relieved at the explanation, her interest switched to how it was for me as a recovered person to experience weight loss. She wondered if it triggered me, or worried me. Now, she was comparing our levels of recovery rather than our bodies. She began discussing how she feels when her pants fit a little looser. She talked of her desire to someday be fully recovered so that if she needed a "special diet" for some kind of health reason she could do it without being triggered to relapse. Her worry that I may be relapsing completely

flipped to her trying to glean from me what it takes to be fully recovered. Maybe more importantly, she began to talk about being fully recovered one day.

Rena was able to turn a precarious situation regarding her own body into a therapeutic conversation. Another skilled therapist who is substantially overweight often brings up her own body shape, asking if the client wants to talk about it. The important thing is to be comfortable in one's own embodied self.

Embodied Awareness: A Tool for Recovery

Eating disorder and body image treatment is difficult, challenging, but rewarding work. Helping clients heal the wounds that underlie their mistrust, dissatisfaction, and hatred of their bodies takes tremendous empathy, skill, expertise, and finesse. The work requires therapists to be aware of their embodied experience and of the constant cultural pulls toward body dissatisfaction.

All clinicians grapple with the ideas expressed in this chapter as they weave their way through their clients' recovery and their shared experiences regarding eating, weight, and shape in a society struggling with these issues. Even those therapists who are grounded and balanced in regard to self and body acceptance will need to explore these issues and practice self-care. Caring for one's self physically, reading and staying connected to feminist and spiritual ideas, and engaging in soul nourishing activities, will all help to keep one's head and heart in the right place when dealing with our own and our clients' bodies and souls. Each therapist needs to find her own way to connect to what is truly important in life in order to be a conduit for that connection to take place in clients. Carefully tended and appropriately nourished, the therapist's embodied

experience can be one of personal joy, as well as a useful tool in the efforts to help clients navigate recovery.

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