Transference and Countertransference in working with consumers with Eating Disorders

Hosu Ryu
Acting Team Leader
Specialist Unit (Eating Disorders & Neuropsychiatry)
Royal Melbourne Hospital & NorthWestern Mental Health
Common attitude of health professionals towards Eating Disorders

Short recap of Eating Disorders

Transference in Eating Disorders

Countertransference in Eating Disorders

Facilitators in Nursing Practice

Key messages
WHY THIS TOPIC?
COMMON ATTITUDE OF HEALTH PROFESSIONALS TOWARDS EATING DISORDERS

“I will help people who only want to be helped…”

“You feel like your work is counterproductive... I’m scared of saying the wrong thing”

”Why not eat, I love food”

“Why it’s so difficult to eat: I don’t know why they hold onto it? I think they’re just vain to start with”

(Walker & Lloyd, 2011, p385)
BRIEF RECAP OF EATING DISORDERS

- **Anorexia Nervosa**
  - Restrictive Subtype / Binge & Purge Subtype
  - Highest mortality rate of mental health disorders

- **Bulimia Nervosa**
  - Binge & Purge
  - Could be in “Healthy weight”
  - Poor emotion regulation

- **Binge Eating Disorders**
  - Included in DSM5
  - Most common eating disorder
  - Distinct from Obesity

- **OSFED (Other Specified Feeding or Eating Disorders)**
  - Other Specified Feeding or Eating Disorders
  - Formerly called EDNOS

• Included in DSM5
• Most common eating disorder
• Distinct from Obesity
• Binge & Purge
• Could be in “Healthy weight”
• Poor emotion regulation

(Eating Disorders Victoria, 2017)
WHAT IS TRANSFERENCE?

“Transference is a process by which the patient transfers onto his/her therapist/nurse, past experiences and strong feelings or dependency, which they have previously experienced with significant persons in his/her lives.”

(Swatton, 2011, p.38)
FACTORS INFLUENCING TRANSFERENCE IN EATING DISORDER TREATMENT

- Previous trauma
- Length of stay
- Attachment style (Bowlby's attachment theory)
- Clinician's involvement

Transference in ED
COMMON CHALLENGES

Restrictive environment

Increase in eating disorder symptoms

Barrier to develop autonomy

Feeling of abandonment and neglect

Enable dependency

Clinician putting responsibility back to consumer

Increase in eating disorder symptoms
“Countertransference applies to those thoughts and feelings experienced by the therapist/nurse in response to the patient and how the patient makes them feel. This can have a positive or negative affect on the therapist/nurse–patient relationship. “

(Swatton, 2011, p.38)
When you see positive results, you feel excited and good that things are moving forward but most of the time you feel you are going round and round in circles so it makes you feel a useless therapist... it just takes too long to get the rewards for your work.

‘Frustrating... it can be really frustrating to get people to engage when there is clearly a problem, when they are not willing... it can be very frustrating for the clinician to stay motivated’

‘You can get quite angry with them... frustrated with them when it goes on and on. I looked after a girl who used to rip out the naso tube... after some time, you would get feelings of immense anger and frustration’

Hopelessness
Anxiety
Anger
Feelings of incompetency

(Walker & Lloyd, 2011, p386)
FACTORS INFUENCING COUNTERTRANSFERENCE IN ED

- Overidentification
- Clinician’s own body image & attitude towards food
- Misconception of ED
- Comorbidity with BPD
- Length of stay & Multiple admission

Counter-transference
MISCONCEPTION ABOUT CONSUMERS WITH EATING DISORDERS

58.2% Nurses and doctors believed that individuals were responsible for Eating Disorders (Raveneau et al., 2013)

- They are vain
- It’s self-inflicted
- ...only occurs in young girls
- They are not skinny, so must not be serious (or opposite)
- They don’t want to get helped
- They don’t recover. They always come back.
Grad nurse “Sarah”
- 23 years old Australian
- Recently finished university
- Vegetarian
- Plays volleyball every week

Consumer "Veronica"
- 22 years old Australian
- Currently studying pharmacy
- Vegetarian
- Former gymnast

Above names & identity are fictitious
CLINICIAN’S OWN BODY IMAGE ISSUES OR ATTITUDES TOWARDS FOOD

The longitudinal study on general public, found that 74% woman desired weight loss, including 68% of health weight and 25% of underweight individuals.

‘Working with eating disorders does make you look at your own body image and your own self image ... you need to be fairly intact and confident to work with them ... you can see them evaluating you ... it can be quite distressing on a bad day...’

‘I think body image is more an issue with females due to social pressures ... it doesn’t bother me so much being a male ... but I do think I become more aware of healthy eating...’

(Walker & Lloyd, 2011, p386)
COMORBIDITY WITH BORDERLINE PERSONALITY DISORDER

AMONG THE INPATIENTS WITH BPD DIAGNOSIS

- Anorexia Nervosa 22%
- Bulimia Nervosa 24%
- Other eating disorders 8%
- Doesn’t meet the Criteria 46%

(Zanarini et al., 2010)

- Poor emotion regulation
- Unclear self image
- Non-suicidal self injury
- Impulsivity
- Feeling of abandonment
- Idealisation or devaluation
FACILITATORS FOR NURSING PRACTICE

- Training & Learning
- Clinical supervision
- Self-reflection
FROM THE NURSES WORKING IN EATING DISORDERS

I feel like we (nurses) are really involved in their recovery. We have crucial role and I find that empowering to nurses. There’s so much we can do.

It was scary at the start… However I learned so much. You think it’s just eating disorders at the start but there are so much more underneath. Great specialty to learn.

I like seeing the changes in people. It can be very slow and by a little but it’s there.

Of course it’s challenging, but it is rewarding as much as it is challenging. You really get to know them, and it makes you feel so happy when they are doing well.

It really developed my skills. I learned how to provide structure while still giving empathetic support. I also feel like I have more self-awareness as a clinician.

Of course it’s challenging, but it is rewarding as much as it is challenging. You really get to know them, and it makes you feel so happy when they are doing well.
As a clinician, it is very common to feel various negative emotions when working with consumers with Eating Disorders.

However, learning about eating disorders and common misconceptions, having genuine curiosity about the individuals, being aware of countertransference, practicing self-reflection and participating in clinical supervision can make working with consumers with eating disorders a... highly rewarding experience!
Questions & Discussion & Feedback
REFERENCE


