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Moving Beyond Transference and Countertransference to Connection

Despite my 45 years as a psychotherapist specializing in the treatment of eating disorders, reading JK's case history evoked in me a visceral sense of defeat and hopelessness about her potential to heal. What, in fact, would define "healing" for a patient with such extensive and complex family and treatment history? Multi-faceted treatment challenges would require constant vigilance of JK's high-risk physical and emotional status. In the face of her merging, and ever-emerging issues, treatment goals would need to remain fluid, shifting between crisis intervention and intrapersonal growth and stabilization.

It is critical that the seeds of a healthy connection be sown from the very start of JK's care. I would extend my first invitation for her to join with me emotionally by recognizing and acknowledging her strengths, and engaging with them directly and immediately. To minimize her fears and defensiveness and evoke a sense of safety and readiness to engage, I might comment on the strength and courage she demonstrates in simply showing up for her first session. As an example, "You know, it takes a lot of courage and spunk to re-engage now in the hard work of therapy, with me, a total stranger. I know it's not easy for you to be here today, but I see your perseverance and your determination to heal as a very real predictor of successful outcomes." JK's responses might shed light on her own self-perceptions and feelings about therapy, as well as on any transference issues that she might be harboring.

The potency of damaging transference responses might be further mitigated by attention to the here-and-now… to the immediate and pressing needs of the patient and the unique requirements of the ever-changing therapeutic moment. Even while collecting didactic diagnostic information, I would actively and intentionally investigate JK's expectations, fears, hopes, wishes and agendas for this initial session, a strategy designed to stimulate the budding of an emotional connection. Any lack of congruency between her expectations about treatment and my own would provide fodder for immediate and future attention.

In greasing the path to a mutually trusting connection, I would attempt to establish a collaborative treatment partnership, empowering her to become a contributing member of her own treatment team. In so doing, I might inquire as to her perceptions of what worked in past therapies, and what did not; what she liked best and least about prior treatment experiences, in an effort to mobilize a sense of self-trust, self-determination and self-regulation… all benchmarks of eating disorder recovery.

Offering the safety of ground rules, easily attainable goals, [such as the recommendation to make specific, small and gradual changes in what and how she eats] and realistic expectations in an otherwise unpredictable and elusive recovery process would help to minimize unknowns for JK, thereby maximizing her confidence in the process. Particularly in light of her suicidality, a prerequisite for care from the very onset of treatment would be to require a commitment to medical and psychiatric monitoring, scheduled regularly and as needed. Making myself personally and professionally transparent by demonstrating my own value system, personality, treatment and attachment style often helps to break down defensive barriers. I would describe my own unique perspective of what eating disorder recovery is about, what it means, and what

it entails. Beyond the ability to feed and care for herself, the recovery process would mark the return and re-integration of her core self, temporarily exiled by her disorder.

Over the years, I have discovered that genuinely liking and enjoying my patients energizes them, the treatment process, and me. It is a widely held misconception among professionals that genuine affection between therapist and patient connotes inappropriate "friendship," boundary breeches, and lack of professionalism. I do not see it this way. In my practice, I make myself readily available at unscheduled times, welcoming, and responsive to occasional 'crisis' emails seeking a word of encouragement, etc. I believe that the more deeply and authentically I care about the patient, the more palatable become my 'tough love' demands and limit setting, so necessary in moving the healing process forward. In my work, I take fearless stands behind the demands of reality and healthy life values, encouraging the patient's engagement in emotional, behavioral and relational challenges for the sake of learning, even if these might result in what she might perceive to be 'failures' and discomfort.

Motivating treatment engagement and change

I envision psychotherapy as a process of change and growth. "This time around, things will be different" is a powerful message that I would convey to JK through my request for, and insistence upon, her commitment to making changes consistently *throughout the process.* The nature, choice and pacing of change belongs to the patient; it is for me, as her therapist to be by her side and *on* her side, throughout that process. As a discussion about making changes is likely to trigger resistance, I would actively invite and welcome her thoughts about her own ambivalence to heal, setting the stage for her honest self-appraisal and feeling 'heard.' As an example, "I wonder what it might be like for you to consider making changes when we know how tough it can be to let go of a disorder that has been a reliable crutch and source of comfort for you through the years."

When the diagnostic process is used to assess not only pathology, *but also the patient's evolving recovery progress,* it can become a powerful motivational device. In tracking recovery growth through treatment, I create the sense that 'recovery' is a *verb*, rather than a noun… an ongoing, action-based, and rewarding dynamic that happens *throughou*t care, rather than as a 'slam dunk' finale at the end of care. If JK finds it difficult to acknowledge personal progress and growth, I would encourage her self-reflection: " I notice that it seems so easy for you to be self-critical, but that you find it far more difficult to acknowledge your strengths. When I speak of your strengths, I wonder if you think that I have allowed myself to be fooled by you, or that I am not being truthful with you. If so, can we talk about that?"

The patient's surges of emotional arousal, traumatic life experiences and evidence of relational dysfunction might respond well to therapeutic interventions based in CBT and DBT, which speak directly to the needs of malnourished patients like JK. These techniques create structure by providing education, options for healthy problem solving, and a mindful presence in the moment. Collaborating with JK to create, execute and monitor achievable behavioral tasks would provide a platform for learning, self-reflection and accountability to herself and the treatment process. Once she becomes physically and emotionally stable, appropriate treatment tasks might focus on a job search and her productive functioning within an employment setting.

Adjunctive care; accessing the embodied self through somatic education

The dysfunctions of attachment that sabotage JK's relationship with others also sabotage her connection with herself, fostering an inaccurate perception of body and self-image. Dr. Moshe Feldenkrais developed a means to reintegrate a fragmented sense of body, self, and mind, creating neurological reintegration through *movement with attention and intention.* A resulting 'felt' sense of self and self-awareness moves the patient beyond dysfunctional thinking patterns that limit and distort self-image and inhibit authentic self-expression. Feldenkrais'Awareness through Movement© groups stand apart from yoga or other forms of somatic education by providing highly specialized movement patterns designed to clarify self-image.This is accomplished through a focus on the experience of each part of the movement and its effect on total body image. The work decreases compulsive behaviors while fostering improved body image.

Because JK's history includes many years of traditional treatments, the Feldenkrais Method might provide her with a dynamic and pleasurable alternative form of body-based learning, unburdened by the constraints of language. The experiential, non-verbal quality of the learning offers a sense of universality, novelty and joy, potentially stimulating changes within her neurological function. Empowering and self-informative, this work would negate any obsolete notions she might carry about the intractability of her condition, and defy a belief system based in hopelessness and incurability. [For more information about the Feldenkrais Method and eating disorders, see

http://www.aedweb.org/source/newsletter/index.cfm?fuseaction=Newsletter.showThisIssue&Issue_ID=19&Article_ID=343.]

In conclusion, my hope and vision for JK is to create and infuse energy into a treatment relationship through which she can learn to value and trust herself and her body, ultimately learning to care for them both. Over time, small behavioral changes accrue to become larger developmental achievements, and within the context of a healthfully dependent treatment relationship, would evolve into JK's autonomous functioning… first within, then outside of, the treatment venue. The treatment process would provide a practice ground for JK to learn to manage herself, and to prosper, in the face of uncertainty, which is not only an intrinsic part of recovery, but of life itself. Termination of treatment would be contingent upon JK's learned readiness to recognize her need for support and willingness to ask for help.

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