

**WE ARE ALL WOMEN:
THE EXPERIENCE OF THERAPY WITH WOMEN
WHO STARVE THEMSELVES**

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Abstract

A therapist and her or his client are involved in a relationship that has implications for both individuals. The implications for the therapist have received little attention in counselling literature. Female therapists who work with women who starve themselves as a result of an eating disorder are confronted with a variety of issues. These may be experienced both personally and professionally. The purpose of this study was to explore the lived experience of female therapists who work with such clients. The question that has guided this study is: What is the experience for women therapists of working with female clients who are starving themselves? Phenomenological interviews, which are unstructured and focus on the experience of the co-researchers, were conducted with five female therapists. Co-researchers were selected based on their experience with clients who starve themselves, along with their willingness and ability to discuss their experience. Interviews were transcribed and analyzed for common themes and experiences using Colaizzi's (1978) seven step process for phenomenological data analysis as a rough guide. Five common themes emerged, which describe both the personal and professional experiences of the women interviewed. These themes describe the women's sense of heightened awareness, sense of vulnerability, increased sense of responsibility, sense of altered relationships, and need to develop coping strategies.

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In memory of my mother,
who always believed in me

... therapy affects the therapist profoundly and irrevocably. Every client moves us emotionally ... The business of bearing witness to so many lives transforms us as no other work could.” (Hill, 1997a, p. xxi)

The first distortion of truth in “the Myth of the Analytic Situation” is that analysis is an interaction between a sick person and a healthy one. The truth is that it is an interaction between two personalities, in both of which the ego is under pressure from the id, the superego, and the external world. (Racker, 1968, as cited in Gutwill, 1994, p. 144)

Chapter One

Introduction

Imagine yourself sitting in a room across from a young woman who is starving herself. You are a woman, a therapist, and she is a client who struggles with an eating disorder. You have met with her and others like her many times over the past years. You have looked into their dull eyes, seen their thin hair and fragile bodies. You have heard them talk about their fear of food, of gaining weight, of losing the battle they rage against their bodies. Many of them have few or no friends. Few can hold down a job. Some are in and out of the hospital to be renourished. Some of them have faded and wilted before your eyes, while others have blossomed into healthy, vibrant women.

What would you experience as you listened to them? What would you think, what would you feel? How would you feel about your own body, your appearance? When you left work, in what ways would you carry them with you? Would you watch yourself eating with critical eyes? Would you be able to enjoy your healthy body during exercise, during sex? Would you fight against messages admonishing you to be thin, to be infantile and powerless? How would you feel if you looked with envy at a model you know probably smokes and eats toilet paper to maintain her slender figure? How would you respond when your friends discussed diets? What about your teenage daughter? In what ways would you live your life differently? How would your world change?

These are questions that I have been forced to ask myself. For several years I worked as a nurse on an in-patient psychiatric ward with women battling severe eating disorders. I have been profoundly changed by this work. I experience my body and my world differently than I did prior to having intimate, empathetic contact with these

women. When I entered the field of counselling, I became curious about how women in a counselling role were affected by their work with women who starve themselves; how their experiences of themselves as women and their relationships with their bodies were shaped by this work.

Clearly, my interest in this topic is derived from my own experience, which has led me to become curious about the experience of others. However, I also believe this work is important for more than personal reasons. Rarely is there discussion in academic circles of the impact a therapist's work has on his or her non-professional life. I see this as an omission in the literature. It is my contention that it would be almost impossible to do empathetic counselling work and be unchanged. To quote Marcia Hill (1997a), "perhaps every professional license or certification should bear the warning: Your clients will change you. You will be both enriched and injured. You will never be the same: Be forewarned" (p. xxii).

Recently, some authors and researchers have begun to explore how therapists are affected by their work with traumatized clients and concepts such as compassion fatigue and vicarious traumatization are being identified (Figley, 1995a, 1995b; Pearlman & Saakvitne, 1995a, 1995b). The impact of the client on the counsellor was the focus of a special issue of the journal Women and Therapy (1997, 20[1]) appropriately entitled "More than a mirror: How clients influence therapists' lives."

In a theoretical discussion of compassion fatigue, Figley (1995a) contends that it is natural to be affected by caring for a traumatized individual, and as such it is not a problem or failure on the part of the therapist. It is, he asserts, an area that has not been adequately addressed in traumatology literature. Figley has responded to this omission

by exploring the impact on the therapist of empathetic contact with traumatized clients. He likens it to post traumatic stress disorder (PTSD), as defined in the DSM IV (1994). Unlike PTSD, in compassion fatigue, the stressor is one step removed from the person. The individual is responding to the "serious threat to [the] traumatized person" or "sudden destruction of [the traumatized person's] environs" (p. 8). He notes that the DSM IV description of PTSD hints at the possibility that "close associates" can experience PTSD (DSM IV, as cited in Figley, 1995a, p. 4). Symptoms experienced by the caregiver are virtually identical to those experienced by the traumatized individual. However, instead of having recollections of a traumatic event he or she has experienced personally, the caregiver is responding to the event experienced by the traumatized individual.

Pearlman and Saakvitne's (1995a, 1995b) concept of vicarious traumatization was developed "to describe a particular phenomenon [the authors] have observed consistently in therapists who treat trauma survivors" (1995b, p. 152). They report that their theoretical work is being supported by a growing body of research which substantiates their contentions (Pearlman & Saakvitne, 1995a). Whereas Figley's (1995a, 1995b) concept of compassion fatigue addresses the impact of individual relationships, and is based on psychiatric diagnostic literature (DSM IV, 1994), vicarious traumatization "is not specific to one client or therapeutic relationship; rather, it takes place over time, across clients and therapeutic relationships" (1995a, p. 280). It does not focus on symptoms, and thus is not used as a diagnostic term. Rather, the focus is on the altered meanings that can result from work with trauma survivors. This also differentiates vicarious traumatization from countertransference, which refers to the therapist's

emotional reaction to a client during a session (Reber, 1985). Pearlman and Saakvitne emphasize that vicarious traumatization, a natural response to work with trauma survivors, refers to the negative impact of this work. They believe that it “inevitably affect[s] all of [a therapist’s] relationships: therapeutic, collegial, and personal” (1995a, p. 281). Like Figley, they link the experience of change in a therapist’s lifeworld as a result of work with trauma victims, to the nature of the empathetic relationship.

Pearlman and Saakvitne (1995a) suggest that there are two primary kinds of empathy, which influence therapists differently. Cognitive empathy refers to the understanding of a client’s experience on a cognitive level. Affective empathy implies an experience of relating on an emotional level to the client’s feelings. They contend that it is the experience of affective empathy that makes a therapist most vulnerable to vicarious traumatization.

These concepts are related to the phenomenon I chose to explore, but are not the same. Although at present literature on the impact of therapy on the lifeworld of counsellors focuses primarily on trauma therapists (Figley, 1995a, 1995b; Pearlman & Saakvitne, 1995a & b), it was my suspicion that clients need not be severely traumatized to have an impact on their therapists. It was my contention that one individual could not be in relationship with another without being personally affected. I did not believe that the impact was necessarily negative in nature. For example, in my work with women with anorexia nervosa, I have come to realize, on more than an intellectual level, that it is not I who am wrong for not fitting media images of women. Rather, it is the images themselves that are problematic. This has been tremendously liberating.

Therapeutic encounters with women living with eating disorders, who may or may not have been traumatized in the past, have the potential to alter a female therapist's life experience both positively and negatively. Women are in a particularly challenging position in North American society. We receive complex messages about how we are to appear and behave from a multitude of sources (Faludi, 1991; Fontaine, 1991; Wolf, 1990). Researchers suggest that women who develop eating disorders are enacting some of these mandates to an extreme degree (Bordo, 1993; Chernin, 1982; Orbach, 1978; Seid, 1994). As women and therapists, we are not immune to such pressures, and we may find ourselves challenged in a number of ways by clients who embody some of these injunctions.

For many years now, feminist writers have been exploring the complex relationship we as women in the Western world have with our bodies and with food. One of the first to do so was Susie Orbach, who focussed on compulsive eating in her book, Fat is a feminist issue (1978). She links compulsive eating with the experience of being a woman in Western society. Because it is largely a woman's issue, Orbach contends that compulsive eating cannot simply be the result of character flaws. She theorizes that it occurs in response to women's subordinate position in society. As she observes, being thin promises power, by allowing women to attract men. However, it also takes away power, as women are then seen only for their sexuality.

More recently, Fredrickson and Roberts (1997) have explored the experience and consequences of being sexually objectified. They posit that "bodies exist within social and cultural contexts, and hence are also constructed through sociocultural practices and discourses" (p. 174). Based on a review of the literature, Fredrickson and Roberts outline

several consequences of the complex relationship between women, our bodies and society. As women we often experience shame over our perceived failure to meet bodily ideals, anxiety over our appearance and safety issues, a decreased experience of "peak motivational states" (p. 181) due to frequent monitoring of our bodies, and reduced "awareness of internal bodily states" (p. 181), possibly as a result of dieting and controlled eating. Although women will be affected by societal forces in varying degrees, no woman is immune, whether she be therapist or client. For this reason, I surmised that female counsellors could be deeply affected by work with women with restrictive eating patterns.

To date, this issue has not been directly addressed in the literature. Feminists have commented for many years on the complexities of women's relationships with their bodies (Bartky, 1990; Brown, 1985; Brownmiller, 1984; Chernin, 1982; Fontaine, 1991; Hutchinson, 1985; Orbach, 1978; Wolf, 1990). Therapists are beginning to explore how they are affected by their work with traumatized individuals. Although informative, traumatology literature does not address the possibility that therapists may be changed by their work with non-traumatized individuals, and that the changes experienced may be positive as well as negative. Professionals in the field of eating disorders have written about some of the challenges inherent in working with this particular group of women (Frankenburg, 1984; Hughes, 1997; Piran & Jasper, 1993; Vanderycken, 1993; Wooley, 1991). This literature has focussed largely on countertransference and the dynamics of the illness. However, an exploration of the lifeworld of therapists who work with women who starve themselves has not been undertaken.

According to Colaizzi (1978), phenomenology is an appropriate choice for research into a phenomenon that has not yet been explored. Phenomenology is a study of experience and meaning (Colaizzi; Osborne, 1994). To capture the essential structure of the phenomenon I hoped to address in this investigation, the question that guided my research is as follows: What is the experience for women therapists of working with female clients who are starving themselves? My aim was to begin to answer this question through the use of unstructured interviews with female therapists who have engaged in therapeutic work with women who have anorexia nervosa.

Before proceeding further, a word about the terminology that will be used throughout this work is necessary. In the medical model, women with certain patterns of restrictive eating are labeled as suffering from anorexia nervosa (DSM IV, 1994). Many of these women refer to themselves as "anorexics," and professionals working with this client population often do so as well. In acknowledgment of the prominence of this terminology, clients will be referred to at times throughout this work as anorexic women, eating disordered clients, or as having anorexia nervosa. As well, in recognition of some concerns about the hierarchies perpetuated by labeling, they will also be referred to as women who starve themselves (Enns, 1993; Rosewater, 1988).

A study of this type, focussed as it is on the interviewee's lifeworld -- "the central themes [an individual] experiences and lives towards" (Kvale, 1983 p. 174), -- is ideal for phenomenological research. An exploration of these issues is a study of meaning and experience. Rather than identifying a specific issue, I had a phenomenon to explore. I had a sense of some possible issues as a result of my own experience and discussions with colleagues. My interest had been piqued. I wanted to learn more from others,

particularly women in a counselling role with women who have eating disorders. Through my discussions with them, I hoped to encounter their personal experience of their work, and to begin to understand how they live with and make sense of their experience. This type of study is congruent with my belief as a counsellor in the value of subjective experience (Osborne, 1990).

The steps of a phenomenological study are not necessarily followed in a linear fashion (van Manen, 1984). I have used the outline provided by van Manen to structure my work. He provides his readers with four primary activities which compose phenomenological research: "Turning to the Nature of Lived Experience;" "Existential Investigation;" "Phenomenological Reflection;" and "Phenomenological Writing" (p. 42). The details of data collection and analysis are discussed in chapter three.

This is an exciting area of study. To date I have seen no similar research. Between 0.5%-1% of "females in late adolescence and early adulthood" (p. 543) have anorexia nervosa as determined by DSM IV (1994) standards. Many others also have disordered eating, but do not meet the criterion (DSM IV). Undoubtedly, some of these women will seek counselling as they struggle with their restrictive eating behaviour. Given this, it is likely that female therapists will encounter such clients during their professional careers. This research may enable female therapists to deepen their understanding of their experience of working with eating disordered clients. It may also help therapists address difficult issues that arise out of this work, and to offer support to others working in this area. In addition, larger questions such as how to train counsellors, plan a practice, select an area of specialty, when to seek supervision, how to manage a caseload, are all possible issues that I hope might be informed by this research.

Chapter Two

Literature Review

Introduction

There are three areas of literature pertinent to my study. None directly address my project, but each has informed my research. To begin, I will review feminist literature about body image/consciousness as it relates to women in our society. This literature has been selected to contextualize the environment in which female therapists live and work. An understanding of our relationships with our bodies may provide some basis for conceptualizing why work with women with anorexia nervosa could prove particularly challenging or transformative. Both empirical (Cash & Henry, 1995; Ogden & Mundry, 1996; Thompson & Hirschman, 1995) and theoretical (Bartky, 1990; Fontaine, 1991; Wolf, 1990) work will be presented. I will then discuss literature in which professionals' work with women with eating disorders is explored (Frankenburg, 1984; Hughes, 1997; Vanderycken, 1993). Much of the focus has been on countertransference, a narrower concept than was addressed in this research (Frankenburg; Piran & Jasper, 1993; Wooley, 1991). However, it points to some of the challenges faced by therapists who work with this client group. I will conclude with a discussion of vicarious traumatization (McCann & Pearlman, 1990) and compassion fatigue (Figley, 1995a, 1995b). These are relatively new areas of study, which explore the reactions therapists and other helpers have to their work with victims of trauma. I chose to examine traumatology literature as it establishes that therapists can and do react to their work, and live in their world differently as a result. These three areas of literature are presented to provide a context in which to situate the present study.

Body Image/Consciousness

Therapists are easily or subtly prey to the cultural mandates for the female body...Even the most critically minded therapists must do at least some amount of internal battle against this mandate, because it represents itself to everyone in the name of health as well as beauty. (Gutwill, 1994, p. 152)

To contextualize a study of female therapists and their experience of working with women who starve themselves, it is imperative that I situate both therapist and client in their world. With this in mind, empirical research on the issue of body image (Cash & Henry, 1995; Grogan, Williams, & Conner, 1996; Thompson & Hirschman, 1995) will be presented first. This provides a background for the subsequent discussion of theoretical explorations of women's body consciousness.

Cash and Henry (1995) conducted a national survey on women's body image in America. The 803 respondents were representative of American women based on the 1990 census. For this study, the authors defined body image as "self-perceptions, cognitions, affect, and behaviors vis-à-vis one's physical attributes" (p. 19). Results showed that almost half of the women had significantly negative opinions about their appearance and worried about their weight. The level of dissatisfaction reported was relatively consistent in all age ranges. However, there was a difference between racial groups, with African American women reporting more positive body image than Anglo or Hispanic women. Although the racial/ethnic composition of Canada differs from that of America, it is likely that many Canadian women would show similar levels of discontent, as we exist in similar cultural contexts.

In an article published in The Journal of Consumer Research, Thompson and Hirschman (1995) describe a qualitative study in which 30 “consumers” were interviewed about their “self-image, body image, and self-presentation” (p. 140). Respondents ranged in age from six to 54. Sixteen were female and 14 were male. The majority were Caucasian and middle to upper middle class. One identified herself as having had an eating disorder. No distinctions were made between the responses of males and females. The researchers found that participants had complex relationships with their bodies and appearance. Respondents believed their appearance conveyed numerous messages “about ... personal worth, ... position in a field of social relationships, the merit of their lifestyle, and ... the degree of control they had over their lives” (p. 151). Participants reported their bodies needed to be disciplined and made to fit a normalized standard. They believed that hard work and avoidance of temptation would lead to reward at a later date. To accept the decay of the body, or even the transition from youthfulness, was viewed as moral flaw. They internalized a sense of being under constant observation and as a result worked hard to avoid ridicule. This study reveals some of the myriad of meanings that may be attached to the body.

A number of quantitative studies have looked at the variable nature of body image in response to different stimuli. Most of these studies have been conducted with college students and thus are not representative of the population as a whole. Nonetheless, they do indicate that an individual’s body image is not the same in every situation.

In a study on the impact of media images on 103 non-eating disordered college students, both male ($n = 43$) and female ($n = 60$) participants were either shown pictures of models of the same sex or photographs of what were deemed neutral subjects

(Kalodner, 1997). Participants then completed the Self-Consciousness Scale, the Body Self-Consciousness Questionnaire, and the State Trait Anxiety Inventory. Women who viewed same sex images reported a higher level of state anxiety and private self-consciousness than controls. Curiously, they also reported higher levels of body competence. Kalodner hypothesizes that these might be the types of images young women look at to motivate themselves to exercise. Men in the control and the experimental groups did not differ significantly in the areas measured. The author concludes that even non-eating disordered women "experience societal pressure, expressed in the media, to be thin" (p. 55).

In a similar study, Grogan, Williams, and Conner (1996) showed 49 male and 45 female university students pictures of either same gender models or landscapes. They completed the body-esteem portion of the Body Image Scale both before and after viewing the pictures. It was found that men had higher body esteem than women. However, contrary to the researchers' predictions, both men and women experienced a decrease in body-esteem scores following the viewing of same sex models. There was no correlation between attitudes toward food and change in body image for participants of either sex. These results indicate that media images have a negative impact on the body esteem of women. Unlike Kalodner's (1997) findings, men were also negatively affected by same sex media images. These contradictory findings reveal that while it seems clear that women do experience changes in their body image when viewing same sex models, at this point in time, we do not know enough about men's responses to make definitive statements.

Ogden and Munday (1996) had 20 male and 20 female medical students complete measures of body satisfaction both before and after looking at pictures of either overweight or thin people of the same sex. Both sexes reported more body satisfaction after looking at overweight individuals and less after looking at thin individuals. Male participants reported more satisfaction with their bodies overall, and women showed a greater range of responses in both directions. There was no mention of the length of time these effects lasted. These results indicate that non-eating disordered women are vulnerable to a decrease in body satisfaction when looking at images of thin women, and that body image is not a constant factor.

Haimovitz, Lansky, and O'Reilly (1993) also found that body image was not static. In their study, 144 female undergraduates listened to guided imagery tapes describing four different scenarios:

- (a) walking by a group of attractive men and women at the beach in a bathing suit; (b) having a conversation with a close female friend over lunch; (c) getting dressed to go to school in privacy; (d) trying on bathing suits in the dressing room of a department store (p. 77).

Prior to, and following listening to each described scenario, participants completed the Color-A-Person Body Dissatisfaction Test. Results showed that with the exception of certain body parts (e.g., hair, face, and hands) there were significant differences in body image while imagining different circumstances. The authors found that when participants imagined situations in which they were more likely to be closely observing their bodies (scenarios a and d), they reported being more critical of their appearance. The authors

contend that body satisfaction is in part state dependent. They postulate that body satisfaction may be composed of both consistent and fluctuating variables.

The four previous studies, although conducted with young adults, lead to the conclusion that a woman's feelings about her body may change in a variety of circumstances. It also appears that many women are vulnerable to feelings of shame and inadequacy in response to media images of the same sex. I have included these studies to suggest the possibility that work with same sex clients who starve themselves may have an impact on female therapists' body image. The studies by Cash and Henry (1995) and Thompson and Hirschman (1995) reveal some of the complicated beliefs and cognitions many women have about their bodies.

Some of the previous literature also suggests that men may experience a decrease in body satisfaction when looking at same sex models (Grogan, Williams, & Conner, 1996; Ogden & Mundray, 1996). However, as approximately 90% of people with anorexia nervosa are female (Bordo, 1993), I have chosen to exclude men from this study and to focus on the experience of women working as therapists with same sex clients who have anorexia nervosa (who will likely form the majority of their eating disordered clients). This is not to imply that men may not have significant reactions to therapeutic work with clients of either the opposite sex or the same sex who suffer from anorexia nervosa.

To develop a clearer understanding of the relationship we as women have with our bodies, I will now review feminist literature since the late 1970's about this complex issue. Throughout this literature, a link is made between women, our bodies and the society we inhabit. The complicated relationship that many of us have with our bodies is

hypothesized to be the product of living in a patriarchal society (Bartky, 1990; Brown, 1985; Brownmiller, 1984; Chernin, 1982; Fontaine, 1991; Hutchinson, 1985; Orbach, 1978; Wolf, 1990). This is held to be the result of a number of factors. Wooley (1994) contends that its roots can be found in patriarchy's overthrow of goddess based religions centuries ago. Christianity also provides fertile ground for an attack on women's fleshy bodies. The foundational story of Eve as seductress serves to assert the dangers of the female body (Bordo, 1993). In mediaeval Christianity, women who aspired to become holy did so by attempting to overcome their evil, lust-filled female bodies. In essence, they strove to "become like a man" (Wooley, p. 35) through fasting and celibate lifestyles. An historical proclivity toward dualistic thinking has left us with a frame for conceptualizing the body in which we separate our physical being from our true selves. The true self is confined and inhibited by the flesh (Bordo). With our more earthy bodies, women are primed to feel dissatisfied with and worried about our physical selves (Ussher, 1989). Female bodies fail us "by becoming fat, emitting unpleasant odours and bleeding" (Ussher, p. 38). Throughout history, we have been required to modify our natural bodies to overcome our inherently flawed state. Corsets, Chinese foot-binding (Brownmiller), the removal of ribs (Bordo), and genital mutilation (Rothblum, 1994) are but a few examples of the efforts to which women have gone to overcome perceived flaws.

Several authors observe that as women have gained power as a result of feminism, we have been required to take up less physical space, thus presenting less of a threat (Bartky, 1990; Hutchinson, 1985; Wolf, 1990). Wooley (1994) notes that with the successes of feminism, women have entered into the public arena in larger numbers than

ever before. Women are well aware of the dominant, appraising eyes of the men with whom they interact. Both men and women are surrounded by what Wooley perceives as pornographic images of women. He contends that "pornography [has] appropriated the 'middle ground' in a double sense: the middle part of the female body (the hips, abdomen, buttocks, and breasts) and the middle-sized bodies" (p. 43). We have responded by pursuing a body type that minimizes female sexual characteristics and size. Wooley remarks that "fat may have become a more important sexual difference than genitalia" (p. 37).

Bartky (1990) notes that the contemporary model of femininity is infantile, and Chernin (1982) observes that thinness, to the extent that women lose the ability to menstruate, has become the cultural ideal. Soft flesh has become a source of shame (Chernin). Seid (1994) asserts that "the goal is to suppress female secondary sexual characteristics" (p. 8). The ideal body is more reminiscent of the male than the female form (Seid) making it very difficult for us to know how a healthy female body should look and feel (Sanford & Donovan, 1978). The injunction to avoid the natural form and function of the female body serves to occupy our minds, thus distracting us from other issues (Bordo, 1993; Brown & Jasper, 1993; Kilbourne, 1994). Brownmiller (1984) explains it as follows: "the drive for a perfect appearance ... is the ultimate restriction of the female mind" (p. 51).

Women are repeatedly informed by the media that our natural bodies are inadequate (Bartky, 1990; Bordo, 1993; Brownmiller, 1984; Chernin, 1982; Ussher, 1989). According to Fontaine (1991), we receive the following messages about our bodies: (a) control and power are equated with being thin, therefore to be fat, or even

less than thin, is to be helpless and without control; (b) being thin means being beautiful -- to be fat is to be ugly; (c) to be thin is to be happy, to be fat is to be denied the possibility of happiness; (d) the good are thin, the immoral are fat; and (e) to be fat is to be lazy, to be thin is to be fit. In North American culture we are expected to suffer to overcome our femaleness through diet and exercise (Wooley, 1994). Styles of fashion over recent years have intensified the need for control of the body, as they reveal much more than was common in the past. As well, fashion no longer serves to disguise perceived flaws (Seid, 1994). Wooley notes that with the increase in pornographic images, "*we are able to see through clothes, past them*" (p. 41, italics in text). The standardization of clothing sizes serves to send the message that people should come in sizes that fit the clothes rather than the clothes being sized to fit the people (Gutwill, 1994). Through messages such as these, body image and self-esteem have become inextricably linked for many women in our society (Bordo, 1993). The thin body has achieved the status "of a god" (Gutwill, 1994, p. 2) and the achievement of the thin body is seen "as a truly magical solution to a myriad of felt problems" (p. 2) by many Western women.

One of the primary vehicles through which these messages are conveyed is the media (Kilbourne, 1994). According to Kilbourne, it is in the interest of both the corporate world and the media for us to feel inadequate about our physical appearance. We can then be offered a variety of products which, if they work at all, do so only temporarily. A predominant message presented through the media is that a woman can choose to have whatever body type she might wish. However, only a very specific body type is presented as desirable (Bordo, 1993). By offering us the illusion of control,

women are positioned like gerbils on a wheel, or perhaps runners on a treadmill. We chase after an unattainable goal, all the while being told that it is within our grasp. To quote Kilbourne: "It is profitable for women to feel terrible about themselves" (p. 416).

Thus, the "female body is revealed as a task, an object in need of transformation" (Bartky, 1990, p. 40). Rothblum (1994) reviews the literature and concludes that there are a number of consequences meted out to those who fail to present a slim and trim body. Such women are subjected to an accepted form of discrimination from those with whom they interact. The result is that they tend to be downwardly mobile. Rothblum asserts that while many believe that "*poverty causes obesity*, ... in fact research suggests that *obesity causes poverty*" (1994, p. 58, italics in text). If a woman refuses to remake her body as required by society, she faces "the refusal of male patronage" (Bartky, p. 76) and subsequently, "desexualization" (p. 77). As a woman is still largely defined by her sexuality, her very existence is challenged. Freeman (1986) reviews studies which show that women perceived as beautiful go on more dates, are more likely to marry up the social scale and are treated better by others as they go through their lives.

I will conclude this discussion of the contributions of theory to the understanding of our complicated relationships with our bodies with an overview of a recent article by Fredrickson and Roberts (1997). Based on a review of the literature, the authors developed the concept of objectification theory, which describes some of the possible implications for women of living in this society. Throughout the paper, the authors acknowledge that all women do not have the same experience of sexual objectification.

Sexual objectification occurs when a woman is reduced to and responded to primarily as a body that has the purpose of being used by another. This occurs via the

media and interpersonal interactions. The consequence of this pervasive experience of objectification is that women are socialized to see "*themselves* as objects to be looked at and evaluated" (Fredrickson & Roberts, 1997, p. 177, italics in text). Women also learn to view other women with the same gaze. Women are taught that their primary currency is their appearance, and therefore strive to control how they look and thus how others respond to them. The authors postulate that this has wide ranging implications for individual women.

The act of continuously comparing one's body to the bodies presented as ideal and finding oneself inadequate, can lead to the experience of shame. Shame interferes with a woman's ability to act and think, leading her to focus on her perceived shortcomings and her desire to disappear from view.

Second, the constant surveillance of the body in response to the objectifying gaze precipitates anxiety. This can be related to a woman's concerns about her appearance -- looking right, ensuring that clothes are adequately in place. As well, women are primed to feel anxiety about their safety, and are placed in the difficult position of being expected to be attractive, yet potentially held responsible for their own sexual victimization.

Another area affected by self-objectification is the experience of "peak motivational states" (Fredrickson & Roberts, 1997, p. 183). These are states in which an individual is completely focussed in creative and challenging activity. Such experiences are hampered when others bring attention to a woman's body, as well as by her own self-awareness, which serves to prevent complete absorption in an activity. The authors warn that this can decrease the quality of a woman's life.

Last, Fredrickson and Roberts (1997) observe that, perhaps as a result of ignoring bodily experiences, such as hunger, in the name of dieting, women are less attentive to the messages their bodies give them than are men. Alternately, this decreased awareness may be the result of focussing the majority of their attention on their outward body, thereby limiting the energy accessible that can be used to attend to the internal body.

Although the authors go on to explore some of the implications of objectification theory in women's mental health concerns and its implications over the lifespan, I have chosen not to relate these details. My aim in presenting this work is to provide some context for the world in which women, both therapists and clients, live.

Empirical research shows that many women have negative opinions about their appearance and weight (Cash & Henry, 1995). Several studies reveal that a woman's body image can change under different circumstances (Grogan, Williams, & Conner, 1996; Haimovitz, Lansky, & O'Reilly, 1993; Kalodner, 1997; Ogden & Munday, 1996). Thompson and Hirschman (1995) found that consumers believed their body conveys numerous messages about themselves as people. Theoretical work points to the possible role of patriarchy in developing the complex relationship many Western women have with our bodies (Bartky, 1990; Brown, 1985; Brownmiller, 1984; Chernin, 1982; Fontaine, 1991; Hutchinson, 1985; Orbach, 1978; Wolf, 1990). The media is often cited as one of the vehicles through which women develop beliefs about ourselves and our bodies (Bordo, 1993; Fredrickson & Roberts, 1997; Kilbourne, 1994). According to Fredrickson and Roberts, many women constantly monitor their bodies to assess how they measure up, and experience deep shame for perceived failures. Those of us who do

not live up to the ideal presented in the media may find ourselves alone (Bartky), poor (Rothblum, 1994) and blamed for our own victimization (Rothblum).

Female therapists are also subject to the mandates of society about the appearance and behaviour of women. To engage empathetically with women who starve themselves is to observe some of these cultural mandates played out to an alarming degree (Bloom & Kogel, 1994). This experience has the potential to have a significant impact on therapists. I will now proceed to explore literature about work with women with eating disorders.

Therapy with Women with Eating Disorders

When we look in horror at her emaciated body might we not be looking, horrified, into the soul of a patriarchal and misogynist culture? She is the living embodiment of what this kind of culture can do to women. She ferociously takes up the cultural vision for acceptable femininity and paradoxically turns it into its antithesis: She cannot and will not participate in adult female life and sexuality, no matter what her age. (Bloom & Kogel, 1994, p. 62)

...we have learned that therapeutic work with eating disorder patients may become a fruitful training experience in developing patience, frustration tolerance, perseverance, and flexibility. And it cures you of omnipotence fantasies...(Vanderycken, 1993, p. 16)

A number of authors point to the challenges inherent in work with women with eating disorders. This can be a result of the particular dynamics of the presenting problem (Frankenburg, 1984; Hughes, 1997; Vanderycken, 1993), or the interaction between the therapist and the client, often discussed under the rubric of

countertransference (Frankenburg; Piran & Jasper, 1993; Wooley, 1991). Sometimes the feelings brought up in the therapist are about body and body image (Piran & Jasper; Rabinor, 1995).

Several authors speak of the challenges of working with women with eating disorders. Impaired cognitive functioning as a result of physical illness (Vanderycken, 1993) makes it difficult for clients to engage in intense psychotherapeutic work (Frankenburg, 1984). Another challenge is that clients often deny that there is any problem with their eating (Vanderycken). The type of illness, with such an obvious "cure" -- just start eating -- can easily lead to a futile focus on weight gain, which can replicate the dynamics a client has with her parents, and serve no therapeutic purpose (Frankenburg). Therapists may find themselves feeling on some level that the problems are self-induced (Brotman, Stern, & Herzog, 1984). In addition, the client frequently maneuvers herself into a position in which positive change (in the eyes of the therapist) is synonymous with defeat (in the eyes of the client) (Frankenburg). Extreme resistance is common (Vanderycken). Often clients appear to engage in treatment plans, only to sabotage them later (Hughes, 1997). Anorexic women seem to need people to be engaged in trying to help them, but "can rarely bear to allow [helpers] the satisfaction of success" (Hughes, p. 264). The energy required of therapists can cause them to feel anorexic clients are "like emotional black holes, absorbing seemingly infinite amounts of energy with no remaining trace" (Wooley, 1991, p. 260).

Countertransference is defined by Piran and Jasper (1993) as "...all the experiences stirred up in the counselor through her interaction with the client" (p. 164). Wooley (1991) describes it as "all the therapist's responses to the patient, occurring at

varying levels of awareness, to all of the patient's verbal and nonverbal communications" (p. 255). In her discussion of the issue, Wooley distinguishes between the reactions of male and female therapists, as well as to clients with anorexic, as opposed to bulimic symptoms. Her professional experience with therapists who work with women with eating disorders has led her to the conclusion that women tend to have more difficulty working with anorexic women than do males. She attributes this in part to the "curtailment in relational growth" (p. 258) exhibited by women with anorexia nervosa. It is her contention that anorexia nervosa is an extreme form of deviance from the normal trajectory of female development, and thus presents a great challenge to female therapists. Wooley herself speaks of finding solace in "people, food and intense feeling" (p. 258) at times, in reaction to her work with eating disordered women. She notes that if a woman has difficulty with her own appearance and body, she may find work with anorexic clients particularly challenging. Hughes (1997) observes that clients may induce anxiety in those around them by their public acts of self starvation, while at the same time not experiencing anxiety about their desperate circumstances.

Female therapists may also find themselves experiencing a sense of competition with their clients who have eating disorders (Frankenburg, 1984; Piran & Jasper, 1993). Piran and Jasper comment that work with these women may be particularly salient, bringing up the feelings a therapist has about her body. They remark on feeling "subject to harsh scrutiny and competition" (p. 167) at times. As noted by Gutwill (1994), both client and therapist are immersed in the larger social context in which eating and women's bodies are imbued with multiple meanings.

Based on her experience “as a psychotherapist and a ... supervisor of clinicians treating disordered eating and body image problems” (p. 90), Rabinor (1995) discusses some of the challenges that she has observed female therapists are faced with when working with women with eating disorders. She focuses on the experience of shame that can be triggered in the therapist. It is her contention that a therapist may experience three kinds of shame. To begin, she may feel shame as a result of her own body dissatisfaction. Second, she may feel she is an impostor offering therapy to clients about eating and body issues. Last, she may find early experiences of having her “body devalued because of her gender” (p. 90) triggered, leading to both unconscious and conscious shame. Rabinor notes that a female therapist will likely identify to some degree with her client’s dissatisfaction with her body, because for both therapist and client, in this society, “looks count” (p. 93). She concludes by observing that by witnessing the pain of their clients, therapists are made vulnerable to their own pain. In a patriarchal society, in which girls and women are traumatized as a result of their sex (Brown & Gilligan, 1991, as cited in Rabinor, 1995), this pain can be deep.

I have found three studies that explore how professionals react to work with women with eating disorders. Shisslak, Gray, and Crago (1989) surveyed 71 professionals (58 female, 13 male) in the health care field about how they were affected by their work with clients with eating disorders. The study focussed on respondents’ perceived changes, rather than objective behavioural measures. No distinctions were made between the responses of females and males. Twenty-eight percent of respondents (18 female and 2 male) stated that they had been “moderately to greatly affected by their work” (p. 692). Those who were affected spent a greater proportion of their working day

engaged with clients with eating disorders. They also read more about eating disorders and had a greater history of dieting. As well, they revealed an increased awareness of food and healthier eating habits. Their body image improved, they reported increased awareness of their weight, physical status, their feelings surrounding their body, and greater awareness of their appearance and how they dressed. The length of time people had worked in the field was not related to the impact reported by respondents. The authors noted that the study is limited by the low return rate (41%), and the focus on subjective rather than objective reports of change. However, it indicates that exposure to eating disordered clients can have an impact on professionals, particularly in their relationships with their bodies.

A 1988 study by Sansone, Fine, and Chew focussed on nurses (12 staff, mean age 40.0 years) who began working on an in-patient unit with eating disordered clients and compared them with nurses beginning work in other areas (11 staff, mean age 33.5 years). The sex of the participants was not reported. It is likely that a majority, if not all, were female. Nurses with a reported history of an eating disorder or who were significantly overweight were excluded. Both groups were followed for 13 months and assessed for depression; attitudes towards eating, their patients and their job; and changes in their weight. Nurses in the eating disorder programme reported more satisfaction with their job, although less positive attitudes towards their patients than nurses working in other areas. Their attitudes toward eating were less distorted and their weights were lower. They were at no higher risk of eating or mood disturbance. The authors postulate that many of the differences can be attributed to the dynamics of the particular unit, in which learning was valued, staff actively involved in programme and

treatment planning, and there was a strong interdisciplinary team approach. These findings show that work with eating disordered clients had an impact on how participants related to their bodies and indicate that their work environment may also have influenced their reactions to these clients.

Brotman, Stern, and Herzog (1984) used a questionnaire to assess the emotional reactions of first year residents in the fields of medicine, pediatrics and psychiatry towards hypothetical anorexic, obese, and diabetic patients. Sixty-three percent of residents responded: 9/12 in psychiatry (5/9 female), 14/24 in medicine (4/14 female) and 6/10 in pediatrics (2/6 female). The results showed that all groups experienced more negative emotion when imagining work with an anorexic patient than either of the other two patient types. However, these results were not statistically significant. Psychiatric residents reported more awareness of how their emotional responses may affect the care they give. Due to small numbers, the authors were not able to break down the difference between male and female respondents. The authors hypothesize that the increased negative reactions to anorexic patients may be a result of the perception that the illness is self-inflicted.

These three studies indicate that work with women with anorexia can have an impact on professionals. They may experience changes in body image, eating habits, and appearance (Sansone, Fine, & Chew, 1988; Shisslak, Gray, & Crago, 1989). Some may also experience negative emotions when interacting with these women, with the potential to affect the care given (Brotman, Stern, & Herzog, 1984). The work environment in which individuals find themselves may influence their reactions (Sansone et al.). Literature on the nature of therapeutic work with women who starve themselves points to

a variety of challenges presented to counsellors. This can be the result of countertransference (Frankenburg, 1984; Piran & Jasper, 1993; Wooley, 1991), the nature of anorexia nervosa itself (Frankenburg; Hughes, 1997; Morgan, 1977; Vanderycken, 1993), and the pertinence of body concerns to female therapists (Rabinor, 1995).

Vicarious Traumatization/Compassion Fatigue

What is specific to the concept of vicarious traumatization is the recognition that the exposure of persons, other than the victim, to the specifics of trauma material or the reenactment of traumatic experiences transmits the emotionally laden aspects of the original violence and thus is a source of emotional arousal and distress for those persons. In turn, this emotional arousal can have parallel effects on the biological processes of the receiver as the prolonged arousal has on the victim (Hartman, 1995, p. 176).

Research and theoretical explorations into the effect of exposure to clients' traumatic material on therapists are relatively new. The primary authors who have initiated this discussion are Figley (1995a, 1995b), Pearlman and Saakvitne (1995a, 1995b), and McCann and Pearlman (1990). It has been called variously secondary traumatic stress disorder (Figley, 1995a), compassion fatigue (Figley, 1995a, 1995b), and vicarious traumatization (McCann & Pearlman; Pearlman & Saakvitne). Pearlman and Saakvitne explain the difference between Figley's two synonymous concepts and vicarious traumatization. They note that secondary traumatic stress disorder is derived from the medical model, with PTSD (DSM IV, 1994) serving as its foundation. In contrast, the focus of vicarious traumatization is on how therapists create meaning out of

their experiences. For the purposes of this discussion, I have opted to use the term vicarious traumatization as it is the more inclusive one, taking into account both symptoms, such as those described in Figley's work, and the making of meaning and process of adaptation (Pearlman & Saakvitne).

Observing that little attention has been paid to the impact of trauma work on therapists, Figley (1995a, 1995b) has developed a theoretical concept which he terms compassion fatigue. It is his contention that it is natural for therapists to be affected by empathetic work with an individual who has been traumatized. He conceptualizes the impact as being similar to that of PTSD (DSM IV, 1994). That is, the sufferer experiences the same symptoms as an individual diagnosed with PTSD, however, the traumatic event in question did not actually happen to the sufferer. Rather, he or she was exposed to the traumatic material via the helping role. Figley (1995b) notes that in the description of PTSD, there is acknowledgment that those close to traumatized individuals can also be traumatized. Figley (1995b) asserts that while therapists are vulnerable to compassion fatigue, the effects are not necessarily permanent.

Figley (1995a) lists several factors he believes increase an individual's susceptibility to compassion fatigue. As mentioned earlier, it is his contention that merely being in an empathetic relationship with a traumatized individual puts a caregiver at risk. While empathy enables the caregiver "to understand the person's experience" (p. 15), it can also traumatize the listener. He also contends that an experience of trauma in the caregiver's past increases susceptibility to compassion fatigue. If this trauma is unresolved, it can rise to the surface as a result of hearing about another's trauma.

Viewing oneself as a rescuer is a risk factor (Figley, 1995b). Trauma experienced by children can also be particularly difficult for caregivers.

Vicarious traumatization (Pearlman & Saakvitne, 1995a) differs from compassion fatigue by being a more encompassing concept. The authors developed this theory from their observations of trauma therapists (1995b) and a small body of empirical research (1995a). Vicarious traumatization is not the result of one specific therapeutic relationship, but rather is a cumulative occurrence, a consequence of time and numerous therapeutic contacts with different clients. Vicarious traumatization encompasses the negative consequences of trauma work and is a by-product of affective empathy. Like Figley (1995a), Pearlman and Saakvitne (1995a, 1995b) assert that it is a natural response to trauma work.

The authors distinguish their theory from Figley's (1995a, 1995b) concept of compassion fatigue, by observing that "vicarious traumatization emphasizes the role of meaning and adaptation rather than symptoms" (Pearlman & Saakvitne, 1995a, p. 280-281), such as the list of symptoms used to diagnose PTSD or compassion fatigue. Pearlman and Saakvitne acknowledge that therapists may experience symptoms of PTSD, as well as depression, anxiety, and other disturbances. However, vicarious traumatization is a larger concept than compassion fatigue, and its effects can filter deeply into an individual's being, altering how she or he understands and lives in the world.

According to Pearlman and Saakvitne (1995a), a trauma therapist can experience disruptions in a number of areas. These changes will in turn have an impact on other aspects of a therapist's life. One of the most significant changes is to the therapist's "frame of reference" (p. 282). Pearlman and Saakvitne define this as the way an

individual “views, experiences and interprets his [sic] world” (p. 282). The authors contend that an alteration in any aspect of an individual’s frame of reference affects all aspects of self. A person’s frame of reference is conceptualized as being composed of three elements: identity, world view, and spirituality. All can be disturbed by work with trauma victims. In addition, an individual’s ability to maintain self-esteem and a consistent identity may be disrupted. One’s “ego resources” (p. 288), the capacity to develop and preserve boundaries, may also be altered. Pearlman and Saakvitne list various psychological needs, which can be disturbed by trauma work. These are: safety, trust, esteem, intimacy, and control. Changes in this realm can reverberate in interpersonal relationships. Therapists may also experience intrusive imagery and unwanted bodily experiences.

The authors (Pearlman & Saakvitne, 1995a) list a number of mediating factors that influence a therapist’s experience of vicarious traumatization. As mentioned previously, the specific kind of empathetic engagement is significant (affective empathy presenting a higher risk than cognitive empathy). The feeling of being overwhelmed by a client’s needs in a multitude of areas can lead to feelings of inadequacy on the part of the therapist. Also distressing is the social context in which a therapist exists. Pearlman and Saakvitne note that when working with sexual abuse survivors, “it is unnerving and enraging to treat survivors of sexual assault all day, and to see violence against women touted as family entertainment on television and movie screens at night” (p. 305). Other factors include the therapist’s work context. Therapist autonomy is significant. Can she work with clients as she would like? Does he have control over his caseload? Does she have a sense of isolation, or does she feel supported while doing this difficult work?

There is a small body of empirical research about vicarious traumatization. Chrestman (1995) surveyed therapists who were members of the International Society for Traumatic Stress Studies, the American Association of Marital and Family Therapists, and the International Society for the Study of Multiple Personality and Dissociation. The number of respondents was not given. Participants completed "a variety of questionnaires designed or selected to assess personal and professional history, psychological symptoms, cognitive schemata, coping behaviors, and behavior changes" (pp. 30 - 31). The tools used to assess respondent's trauma symptomology were originally designed to measure symptomology in trauma survivors. Chrestman found that therapists who worked with trauma victims experienced more symptoms of trauma (primarily symptoms of avoidance and intrusion) than those who did not, although the symptoms were not in the clinical range. Trauma therapists' cognitions were not more negative than those who did not work with trauma victims, as assessed by the World Assumptions Scale. That is, these therapists did not report more negative beliefs about the world. However, they did engage in more behaviour designed to minimize their risk of exposure to danger, which "may represent an increased awareness of true danger" (p. 33). Mediating factors were clinical experience (more experience, fewer symptoms), increased income and opportunities for additional training. Chrestman concludes by suggesting that it may be helpful to vary professional activities (engage in other than exclusively clinical tasks) and to pay careful attention to self care and stresses in ones' life.

One hundred psychotherapists who were trained at the graduate level and worked with sexually traumatized clients completed a self report questionnaire for Kassam-

Adams (1995). Results showed that this work produced PTSD symptoms in these therapists. A personal history of trauma, particularly in childhood, was linked both to increased PTSD symptoms and more exposure to clients with sexual trauma. Kassam-Adams hypothesizes that it is possible that therapists with a history of trauma may be more likely to select to work with traumatized clients. As well, these therapists may be more susceptible to their client's reports of trauma. The results are limited by the small number of male respondents ($n = 25$). Some positive results of the work were reported by respondents, including "personal growth, spiritual connection, hope and respect for human resiliency" (p. 46).

Pearlman and Mac Ian (1995) studied 188 self-identified trauma therapists using the TSI Belief Scale, and the Symptom Checklist-90-Revised. Information about the therapists' work with traumatized clients, personal trauma history, and psychological functioning was also collected. The authors found that therapists with a personal history of trauma experienced more negative symptoms as a result of their work than those who did not report a personal history of trauma. The authors conclude by suggesting that more training should be provided for trauma therapists. As well, supervision should be available to all trauma therapists, and those therapists with a personal history of trauma should receive additional support.

Schauben and Frazier (1995) gathered information from 118 female psychologists and 30 sexual violence counsellors on their experience of vicarious traumatization. Questionnaires were used to gather data about their exposure to sexually victimized clients, personal history of sexual trauma, psychological functioning, and coping strategies. Findings showed that higher levels of professional exposure to sexually

victimized clients was linked with more symptoms of vicarious trauma, PTSD and disrupted beliefs about the world, for example, about peoples' goodness. Of interest, however, is their finding that this type of disruption was not related to personal history of victimization. The authors do not speculate as to why this might be, except to note "that the counselors' experiences of sexual violence symptoms do, indeed, appear to be vicarious" (p. 61). This finding contrasts with the findings of Pearlman and Mac Ian (1995) and Kassam-Adams (1995). Schauben and Frazier suggest that training for therapists about sexual violence is needed, given the incidence of traumatized clients.

A personal perspective on the issue of vicarious traumatization comes from Astin (1997), a therapist who works with survivors of rape. She explains that this work has affected her more profoundly than her work with other traumatized clients. She hypothesizes that this is because she cannot convince herself that she will not be so victimized herself. As a result, she struggles not to blame the victim for not running, screaming, or somehow preventing the attack, even though she is intellectually aware that this is unreasonable. She explains her experience in cognitive terms, stating that she makes a point of reviewing her cognitive assumptions on a regular basis and challenging them if they are unrealistic. She concludes that her experience of vicarious traumatization has enabled her to appreciate the experiences of her clients better.

A therapist who has specialized in work with Vietnam veterans describes how he has been transformed by his work in the article "Therapist in the combat zone" (Tick, 1995). He explains that he began this work as a pacifist and an antiwar activist who had been prepared to enter a conscientious objector plea to bypass the draft. However, the process of engaging empathetically with veterans challenged him deeply. Through a

series of nightmares over a number of years, he came to understand how and why people kill in combat situations, and to accept the killer within him. It was his insight that people do not kill out of rage and vengeance, but out of terror and absolute fear for their lives. After coming to this realization, he stopped having nightmares, and it is his belief that he became both more assertive and less moody. As well, he was able to engage with his clients more fully, to help them to recognize the terror that motivated their behaviour, and to reconceptualize themselves as frightened young men as opposed to murderous killers.

Other authors discuss how they have been altered by the work they do with their clients. For example, Perlstein (1997) who works with dying clients, describes her increasing appreciation of the ordinary things and activities of life. As a psychologist working with traumatized individuals, Pachter (1997) developed an understanding and respect for peoples' ability to cope and even thrive under adverse circumstances. She believes this has enriched her life. Hauer (1997) discusses how helping a client through her grief over the death of her mother enabled Hauer herself to grieve her own mother's death and to become stronger herself. Growing up with the expectation that she should be happy all the time limited Cole's (1997) ability to experience a range of feelings. She believes her work as a therapist has enriched her life by facilitating her ability to experience a wider range of human emotions. Through this work she feels she has become a more whole person. Hill (1997a) reflects on 22 years of work as a therapist and notes that she is more compassionate and open to the different ways people live their lives and deal with difficult circumstances. She has also developed faith in her ability to cope with traumatic loss as a result of seeing the strength and courage of her clients.

Some authors discuss methods of mediating the impact of vicarious traumatization on therapists. Williams and Sommer (1995) suggest that it is important for trauma therapists to acknowledge their vulnerability to vicarious traumatization, and to try to "use themselves in a manner which maximizes the healing and minimizes the hurting, both for their clients and secondarily for themselves" (p. 232). They continue by listing a number of ways trauma therapists can do this. They assert that therapists should use an ethical framework to guide their practice. They should also work from a sound knowledge base and engage in ongoing educational activities. If they have been traumatized themselves, they should have their own trauma issues largely resolved. They should get therapy to do so if necessary. People interested in entering the field of trauma therapy should reflect on what has led them to this particular field. Once in the field they should be careful to match their therapeutic strategies with the needs of the client. It is important to "examine constantly the toll that conducting the work takes on the self" (p. 240), watching for triggers of vicarious traumatization. The authors also note that therapists should watch for alterations in their personal schemas, as outlined by McCann and Pearlman (1990). In addition, therapists should be conscious of the methods of self-soothing they choose, and consider their efficacy. Williams and Sommer recommend involvement in a support group composed of others doing this work.

Catherall (1995) also emphasizes the importance of interacting with peers. He asserts that "the therapist's professional peer group has the power to dilute the impact of secondary traumatic stress, to normalize the disturbing reactions, and to help the therapists maintain the therapeutic connection with clients despite his or her personal upheaval" (p. 81). A support group composed of peers can: provide resources; provide

counsellors with an opportunity to be listened to and accepted; "correct... distortions in the therapist's assessment of his or her behaviour and responsibility in regard to disturbing cases" (p. 84); help reframe a traumatic event; provide empathetic support. He continues by listing a number of group norms that enable healing to occur.

Based on a review of the available literature, Munroe (1995) suggests that all trauma therapists, regardless of their level of experience and education are susceptible to the effects of secondary trauma. He asserts that as a result, they should be warned about the possible impact of doing this work. He provides a sample informed consent form, which could be used by an organization for this purpose.

To summarize, it appears that the act of engaging in an empathetic relationship with a client has the potential of changing therapists in both negative (Chrestman, 1995; Figley, 1995a; Kassam-Adams, 1995; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a; Schauben & Frazier, 1995) and positive ways (Cole, 1997; Hauer, 1997; Hill, 1997a; Pachter, 1997; Perlstein, 1997; Tick, 1995). The affects can be far reaching, altering how an individual understands her world, and experiences her life. It appears that a history of trauma may increase a therapist's susceptibility to vicarious traumatization (Figley; Kassam-Adams; Pearlman & Mac Ian; Pearlman & Saakvitne). Other possible factors include work environment (Pearlman & Saakvitne), the social context in which a therapist exists (Pearlman & Saakvitne) and as well as the personal relevance of the issues a client brings to therapy (Astin, 1997). There are a number of ways the experience of vicarious traumatization can be mediated (Catherall, 1995; Williams & Sommer, 1995).

Just as engaging in an empathetic relationship with a trauma survivor has the power to have a profound impact on the life of a therapist, it was my suspicion that empathetic engagement with women who starve themselves could have an affect on female therapists. I wondered if such therapists would have difficulty distancing themselves from the issues their clients bring into therapy. I suspected that body image dissatisfaction would likely be personally salient for many therapists. The parallel to trauma work may go even farther, as some authors assert that women are traumatized by growing up in this society (Brown & Gilligan, 1991, as cited in Rabinor, 1995). If it is the case that those who have experienced trauma in their past are more susceptible to vicarious traumatization (Figley, 1995a; Kassam-Adams, 1995; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a), women traumatized by their culture may be vulnerable to changes in their experience of their bodies and the world as a result of their work with anorexic women.

Conclusion

The world of the therapist is a complicated one. She is inevitably changed by what she sees and hears in her office (Hill, 1997a & b). The literature on vicarious traumatization suggests that the act of empathetic engagement with an individual who is processing traumatic material can have a significant impact on the lifeworld of a therapist (Figley, 1995a, 1995b; McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a). Other literature points to the life altering aspects of work with all types of clients, not just those who have been traumatized (Cole, 1997; Hauer, 1997; Hill, 1997a & b; Pachter, 1997; Perlstein, 1997). Literature on therapeutic work with women with eating disorders highlights the difficult nature of this work, in particular

for women (Frankenburg, 1984; Hughes, 1997; Piran & Jasper, 1993; Vanderycken, 1993; Wooley, 1991). This may be a result of the particular dynamics of eating disorders, the multiple messages women receive about how we are to look and behave in our society (Bartky, 1990; Bordo, 1993; Orbach, 1978; Ussher, 1989; Wolf, 1990) and the relevance of clients' issues for therapists (Rabinor, 1995). It was my hope that through a phenomenological study of female therapists, I would learn more about how their experience of working with women who starve themselves affects and changes them, as women and as therapists.

Chapter Three

Methodology

Method Selection

An exploration of the lifeworld of female therapists in professional relationships with women who starve themselves, is a study of meaning and experience. This is the territory of phenomenological research (Giorgi, 1975; Kvale, 1983; van Manen, 1984). Rather than a specific question to address, I had a phenomenon to investigate. My interest in this phenomenon was derived from my own experience, a common starting point for researchers selecting this particular methodology (Osborne, 1990).

... phenomenological research does not start or proceed in a disembodied fashion.

It is always a project of someone: a real person, who, in the context of particular individual, social, and historical life circumstances, sets out to make sense of a certain aspect of human existence. (van Manen, p.40)

Phenomenology is an appropriate methodology to select when attempting to capture a previously unexplored phenomenon (Colaizzi, 1978). It is congruent with my beliefs as a feminist, as it is derived from my personal experience and is collaborative (Worell & Etaugh, 1994). Indeed, Osborne refers to interviewees as co-researchers to emphasize their importance in the phenomenological process. As well, it is a method complementary to counselling (Osborne), which uses many of the skills central to humanistic approaches to counselling (McLeod, 1994).

Personal Assumptions and Bracketing

What follows is a description of my experience with the phenomenon I have studied, and a discussion of my resultant assumptions. This process is referred to as

bracketing, and serves several purposes. As the researcher in this phenomenological study, I was the “‘instrument’ through which data were collected” (Rew, Bechtel, & Sapp, 1993, p. 300). It is impossible for a researcher to completely separate or remove herself from her own experience (Beck, 1994; Colaizzi, 1978). To attempt to ignore the impact of one’s person on research allows for the possibility of presuppositions sneaking into research without the researcher’s awareness (van Manen, 1984). By exploring my own situation and beliefs, I hoped to reduce my unconscious bias when approaching the data I encountered (Baker, Wuest, & Stern, 1992; Colaizzi). One purpose of self reflection then, was to facilitate my ability to look beyond my experience (Beck, 1994; Kvale, 1983; Osborne, 1990). This process also serves to alert researchers to the possible experiences of their co-researchers (van Manen). Furthermore, making explicit my reflections allows the reader to take them into account when reading the data and the subsequent conclusions (Osborne; van Manen).

Having professional contact with women with eating disorders has led to significant changes in my life. I experience my body and my world differently than I did prior to having intimate, empathetic interactions with this particular group of women. My contact with these clients occurred when I worked as a nurse in an in-patient psychiatric hospital setting. This involved working with clients for eight or 12 hour shifts. I worked with two women per shift, with a total of four in the programme at any given time. I was required to eat with them, administer to their physical needs, engage in therapeutic work (both individual and group), and function as part of a multidisciplinary team. Clients on the unit were severely ill as a result of anorexia nervosa, bulimia or a

combination of both bulimia and anorexia. They were admitted to the hospital for an intensive three week stay for the primary purpose of re-feeding and medical stabilization.

I did not enter this work expecting to be changed by it. I had worked in the field of psychiatry for some time already, and although I had found it challenging and interesting, I had not been shaken as I was by my work with this particular group of women.

As I reflect on my experience, attempting to articulate what occurred for me, several incidents and thoughts flit through my mind. I remember talking to a young male medical student who asked me what could be done about the terrible tragedy of eating disorders. My response was to tell him to "eat with lust and gusto." This I did myself, in a defiant effort to show that I was not like the women with whom I worked. At some point after beginning this work I started to wear large, solid shoes and endeavour to celebrate my size and the space I took up on this earth. I began to look at fashion magazines with different eyes. I stopped thinking that there was something deeply wrong with me for not matching the images I saw on the glossy pages. Instead, I found myself thinking that there was something wrong with the images, and with a society that promotes ill health and an infantile appearance in women as signs of beauty. I began to be drawn to images of women who were normal or large sized and gloried in their defiance of societal norms. I also started to exercise, not for weight control but for fun, for the enjoyment I got out of using my strong, solid body.

The uniting theme running through these anecdotes is of being released from shame. Unbeknownst to me, over the course of my life I had taken on a sense of shame about my physical appearance. I felt shame for being too wide in the hips, for taking up

too much space, for being tall, but not lithe, for experiencing hunger and being unable to control my need to eat, nor my enjoyment of food. I felt angry and ashamed when I went to clothing stores and did not fit the clothes on the racks because I did not match a personally unattainable norm.

The process of working with women who were literally trying to disappear, who were embodying to an extreme degree this type of shame, caused me to view it with different eyes. I was able to recognize it as a tragic artifact of our society, rather than a unique flaw of my own. This did not mean that my experience of bodily shame completely disappeared, but rather that I was able to enter into a dialogue with it. I began to make choices about how I would respond to it and how much power I gave it in my life. I found myself undertaking acts of defiance, refusing to try to be small, waif-like and barely visible.

Sometimes I still feel wrong, particularly when I shop for new clothes and am unsuccessful in finding anything that fits me correctly. However, more often I feel comfortable in my body and with my appearance. I enjoy eating, and do so publicly (something I did not do comfortably in the past). I feel delight when I am strong and fit. I deliberately make efforts to use my body for pleasure by hiking, biking, and cross-country skiing.

It can be difficult to be in this new place, as I have lost the dream of magical transformation that comes from believing in the promises of the diet and fitness industries. Rather, I am constantly challenged to accept who I am, to learn to live with, and celebrate what I am as much as I can. I have an uneasy relationship with fashion and make-up. I do not want to buy into societal expectations of beauty, yet I like to feel

attractive. I try to assert both to myself, and to society, that I am okay as I am right now. I am no longer waiting for some mythical future time when I will be slimmer or fitter. The repercussions of these changes in my perception and outlook continue. This is not a static process, and I anticipate that the changed meanings that occurred for me as a result of my work will continue to reverberate throughout my life.

Upon reflection on my circumstances, I had three primary assumptions about the experiences of the women in the study. I anticipated that they would be aware of, and feel, or have felt, in some way, that they did not meet the expectations of womanhood placed on them by society. As Fredrickson and Roberts (1997) explain, "the sexual objectification of the female body has clearly permeated our cultural milieu: it is likely to affect most girls and women to some degree, no matter who their actual social contacts may be" (p. 177). I also expected that they would have been affected in both positive and negative ways by the empathetic counselling relationships they had had with their clients (Hill, 1997a). Third, I anticipated they would have an awareness of the dissonance between the societal demands for womanhood and their work as therapists. In this work, they are opposing societal injunctions by striving towards their clients gaining voice, gaining presence and sometimes even gaining weight. I anticipated therefore, that they might have some reactions to this experience of cognitive dissonance.

I expected that these reactions would play themselves out in a variety of ways in their lives. I imagined that they might have an altered understanding of the society they inhabit and the expectations placed on women. Perhaps they would have become politicized or angered. It was possible that they would view their body and how they adorn, feed and use it, differently. I thought they might also have an altered perspective

on the bodies of their partners, children, and friends. These women might be less accepting of patriarchal norms of society. They might strive to create different types of relationships with the men in their lives as a result. It was possible that they might have developed some unique coping skills to manage these altered meanings and experiences.

In spite of my personal experience and the assumptions I have articulated, my goal was to be open to what my co-participants would teach me about their experience. Throughout the research process I endeavoured to monitor my own assumptions and beliefs. According to Kvale (1983), "the task of the interviewer is to focus upon, or guide towards, certain themes, but not to guide the interviewee towards certain opinions about these themes" (p. 176). As this is phenomenological research into a new area, I was not testing a hypothesis. Rather, I was seeking to encounter the experience as related to me by co-researchers (Osborne, 1990; van Manen, 1984).

Participants

According to Baker, Wuest, and Stern (1992) there is "only one legitimate source of data: informants who have lived the reality being investigated" (p. 1357). Participants were required to reflect on their experience of working with women who starve themselves. Therefore, co-researchers were selected based on their ability to express themselves and their possession of relevant experience (Colaizzi, 1978; Osborne, 1990). I sought women who, as a result of their jobs, had been in an empathetic relationship with women who were starving themselves. This needed to be a significant area of focus in their work. I wanted to meet with women who had an "interest in illuminating the phenomenon" (Osborne, p. 82). I anticipated that suitable co-researchers might come from a variety of the helping professions, ranging from counselling, to psychiatry, to

nursing. To ensure that they had sufficient experience working with women who starve themselves, they were required to have worked in the field for a minimum of two years. So that they were able to reflect on their experience from not too great a distance, therapists could not have been out of the field for more than two years. I interviewed the first five respondents who met the research criteria, with the goal of focusing deeply on the experience of each individual (Baker et al., 1992). As delineated by Osborne (1994), data collection was considered complete when patterns or themes began to reoccur throughout different people's stories. That is, when no new themes were emerging, there was no need to continue to seek out more data from additional co-researchers.

Procedure

Phenomenology is not a straightforward procedure where step A leads to step B, which leads to step C, and so on. Rather, the steps of a phenomenological study may be revisited and revised numerous times throughout the process (van Manen, 1984). According to van Manen, phenomenology can only be understood by engaging in the process. In spite of the inherent difficulty in explaining phenomenological research, I will endeavour to elucidate the process followed during this study.

I began by using van Manen's (1984) outline to structure my work. He delineates four primary activities which compose phenomenological research: "Turning to the Nature of Lived Experience;" "Existential Investigation;" "Phenomenological Reflection;" and "Phenomenological Writing" (p. 42). These occur throughout the research process. The details of data analysis were guided by the method delineated by Colaizzi (1978).

Turning to the nature of lived experience.

Turning to the nature of lived experience involved identification of a phenomenon I wished to explore, an “experience that human beings live through” (van Manen, 1984, p. 43). This occurred when I became curious about female counsellors’ personal and professional experience of their work with women with anorexia. The next stage was the development of a question that asks what the identified experience is like for those who live it. As stated earlier, the question I used is as follows: What is the experience for women therapists of working with female clients who are starving themselves? It was the essence of this experience that I sought as I carried out this study (van Manen). I was curious about what it was like for other women who are/have been in therapeutic relationships with women with anorexia nervosa. Once a phenomenon has been identified and a question formulated, the researcher then must go through a process of reflection to examine what is already “known” by the researcher. Much of this has been described in the literature review found in the previous chapter.

Existential investigation.

Van Manen (1984) suggests that the phenomenologist use his or her own experience as a “starting-point” (p. 51). This can serve as an initial map when delving into a phenomenological study, as personal experience offers clues to the nature of the phenomenon under exploration (van Manen). My attempts to do this are described in the section entitled personal assumptions and bracketing.

There are a variety of other sources of information that can be plumbed for phenomenological research, from literature to language (van Manen, 1984). In this study, I derived information from the professionals I interviewed. Colaizzi (1978) describes this

process as “contacting [the] phenomenon as people experience it” (p. 57). Van Manen states that “the point of phenomenological research is to ‘borrow’ other people’s experiences and their reflections on their experiences in order to better be able to come to an understanding of the deeper meaning or significance of an aspect of human experience” (p. 55).

Participants were recruited in a variety of ways. To begin, I recruited via word of mouth in the community, as I have some contacts in the field. I invited colleagues to inform suitable individuals about my study, and to have those interested contact me for further information. I also posted notices where they might be seen by professionals (Appendix A). As these efforts did not generate a sufficient number of suitable co-researchers, I sent letters to therapists who work with women with anorexia nervosa (Appendix B).

Interested individuals were screened by phone to determine how well they met the research criteria, prior to booking an appointment for an interview. Eight women expressed interest in the project. Two of these did not meet the research criteria, and one agreed to be interviewed, but later cancelled for personal reasons. In the end, five women participated in the study. During the initial telephone contact I informed the women that interviews would be audio taped and transcribed to aid with data analysis. At this point a suitable time and private location was selected for the interview.

Before beginning any type of data collection, it was imperative that I establish rapport with each co-researcher and inform her of the purpose and method of the study (Osborne, 1990) and that participation was voluntary. She was given a copy of the informed consent form to read and sign (Appendix C). I endeavoured to make the co-

researcher comfortable, and began with an orienting statement (Appendix D). Once rapport was established, the bulk of the interview took place. Throughout the interview, I used basic counselling skills such as attending, listening, empathy, and probing (Egan, 1990). Four of the interviews took place at the participants' place of work, and one in my home.

The focus of the interview was the lifeworld of the co-researcher, with the aim of illuminating central themes (Kvale, 1983). The focus was not the details of each woman's story, but the themes central to her experience of working with anorexic clients (Kvale). Throughout the process, I attempted to understand the meaning of these themes (Kvale). Each interview was open-ended and largely unstructured, although I was prepared with a list of questions to facilitate the exploration of topics raised by the participants (Osborne, 1990) (Appendix E). Questions were derived from my self-exploration (Colaizzi, 1978). They proved useful in some of the interviews, as they provided a focus for, and deepening of, the participants' explorations. As suggested by van Manen (1984) throughout the interview process I asked for specific examples of the women's experiences, so as to understand what they "experience[ed]and [felt], and how [they]act[ed]" (Kvale, p. 175). The amount of direct questioning required varied from individual to individual.

As researcher, it was important for me to focus the interview on the topic at hand. As well, I needed to allow for ambiguity, as it is possible that an individual's experience may contain contradictory elements (Colaizzi, 1978; Kvale, 1983). Attempts were made to clarify these contradictions, but they were allowed to exist when they were indeed present. I also endeavoured to enter into each interview with an openness to whatever my

co-researchers might tell me, by putting aside my own experience as much as possible, and focussing deeply on that of the participant (Kvale). As described earlier, I attempted to bring my experience into my conscious awareness through the process of self reflection. According to Colaizzi, this facilitates objectivity. "Objectivity, then, requires me to recognize and affirm both my own experience and the experience of others" (p. 52). Interviews were considered complete when co-researchers felt they had nothing more to add. Due to time constraints, one interview lasted for an hour. The rest ranged from 90 minutes to two hours. To facilitate the development of effective phenomenological interviewing skills, a transcript of the first interview was reviewed by my faculty supervisor, who is experienced in phenomenological research. The feedback received was then used in subsequent interviews.

Phenomenological reflection.

Following each meeting, the taped interview was transcribed verbatim. When all transcriptions were complete, I used the seven step guideline provided by Colaizzi (1978) as a rough template for the analysis process. As Colaizzi suggests, initially each interview was read over, so as to acquire a preliminary sense of it. Following this, the transcript was reread and "significant statements" (p. 59), be they sentences or phrases, were highlighted. Each transcript was read several times.

I then met with my faculty supervisor, to discuss my impressions thus far. During this meeting, seven preliminary themes were developed. Next, I returned to each transcript, rereading it and coding it to identify statements supporting each theme. This allowed me to determine whether all of the themes were present in all of the transcripts. I subsequently moved from an analysis of individual transcripts, to what Osborne (1994, p.

172) terms an “across persons analysis.” In this stage, I paraphrased significant statements from individual interviews, and categorized them under individual thematic headings. Following this, I wrote a description of each theme. Throughout the process of describing each theme, I returned repeatedly to the initial transcripts, so as to ensure that the original meaning was not lost (Colaizzi, 1978). It must be noted that this entire process was very organic. Some of the initial themes were kept, while others collapsed into each other, and some were reconfigured into new themes. The next step involved returning the themes to each co-researcher and interviewing her again. This process is described in greater detail in the reliability and validity section of this chapter. The final product, represented in chapter four, details five themes.

To conclude this section, a word about phenomenological reflection. Van Manen (1997) suggests four “lifeworld existentials,” which I found helpful as I attempted to unearth the essential themes: “*lived space* (spatiality), *lived body* (corporeality), *lived time* (temporality), and *lived human relation* (relationality or communality)” (p. 101, italics in text). While I meditated upon the experiences related to me by my co-researchers, I endeavoured to keep in mind these four lifeworld existentials as loose guides for the interpretive process. Two of van Manen’s lifeworld existentials seemed particularly relevant as I immersed myself in my co-researchers’ words: lived body and lived human relation.

As noted earlier, there may be ambiguities and contradictions in the themes, and Colaizzi (1978) observes that “what is logically inexplicable may be existentially real and valid” (p. 61). Kvale (1983) echoes this point, observing that contradictions may accurately reflect the lifeworld of the co-researcher. The feelings the women sometimes

had about their bodies, which are described in chapter four, provide an example of such a contradiction. My goal in the thematic description was to accurately represent this, as I believe it is an important element of these women's experience as therapists who work with eating disordered clients.

Phenomenological writing.

Van Manen (1984) emphasizes that the work of phenomenology does not end with the analysis of the data: It continues with the writing of the final product. The acts of research, writing, and thinking are deeply entwined. "Interpretive phenomenological research cannot be separated from the textual practice of writing" (van Manen, 1997, p. ix). To write about a research project is to think deeply about it and to be challenged to express these thoughts on paper. Indeed, van Manen (1997) goes so far as to contend that only through writing can a person know exactly what she knows. The author must be self-reflexive during this process. She is trying to convey the lived experience, some part of the world, of another individual or group of individuals. This is done in part by presenting anecdotes and quotes from the interviews, which exemplify the themes being discussed (van Manen, 1989).

Van Manen (1984) suggests a variety of ways to organize the final phenomenological description. I chose to use a thematic approach. The various themes are presented individually, thus providing the structure of the piece. These themes then form a description of the phenomenon being discussed. "Phenomenological description is an example composed of examples" (van Manen, p. 64). As phenomenological research is not a finite process, writing and rewriting has been required (van Manen, 1984, 1989).

Reliability and Validity

Phenomenological research does not allow for traditional tests of reliability and validity (Colaizzi, 1978; Osborne, 1994). For example, due to the nature of the research, it is impossible to determine test-retest reliability. Returning to the same individuals after a period of time for a fresh set of interviews could lead to a different set of themes. My co-researchers and I change with time and likely have been altered as a result of being involved in this process. However, the goal of phenomenology is not to capture the truth of a phenomenon, but rather “to describe the world-as-experienced by the participants of the inquiry in order to discover the common meanings underlying empirical variations of a given phenomenon” (Baker, Wuest, & Stern, 1992, p. 1356).

As a way of establishing validity, I selected to return to the co-researchers for a second interview (Colaizzi, 1978). The aim of this interview was to ensure that the themes resonated with each woman’s experience (Osborne, 1994), a process Osborne (1990) refers to as determining the “goodness of fit” (p. 87). Each participant was given a copy of the themes to read and contemplate prior to our second interview. When we met we discussed the themes, in particular, her sense of whether or not each individual theme described an aspect of her experience. We also discussed the participant mini-biographies. Each interview lasted for up to an hour. According to Colaizzi, new information arising from such interviews should be incorporated into the data presented. The feedback received was editorial in nature. For instance, one quote was used twice, a repetition which was subsequently deleted. All of the women reported that they felt accurately represented in each of the themes. However, different themes resonated more powerfully with different women, in accordance with their unique experiences. The co-

researchers were also interested in learning about other women's experiences their work with anorexic women, and often said they felt validated by reading about the other therapists. For example, one therapist stated she felt extremely validated to discover that she was not alone in finding this work very challenging.

I have also made my personal position explicit in this thesis, to allow readers to determine the validity of the work. My musings, in combination with the data presented, should help to enable readers to understand how I arrived at my conclusions, whether or not they would arrive at the same conclusions (Giorgi, 1975). I have also worked to "present ... coherent and convincing arguments" (Osborne, 1990, p. 88) in the thematic descriptions.

Ethical Considerations

In a discussion of ethical issues in nursing research, Burns and Grove (1995) itemize four areas of concern. I will list each, and the measures that I took to address them. The first is the right to self-determination. The authors explain that all people should be "treated as *autonomous agents*, who have the freedom to conduct their lives as they choose without external controls" (p. 368, italics in text). This means that researchers must inform participants about the study being undertaken. This I did through the use of an orienting statement (Appendix D) and an invitation to ask questions about the study. As well, individuals must be allowed to choose whether or not to participate. In this study, interested individuals were invited to contact me for information about the study and could make a choice whether or not to participate. All participants were adults working as mental health professionals, and as such were cognitively capable of making such decisions independently. Last, participants must be

able to withdraw from the study at any time if they wish, with no penalty. This right was written into the informed consent (Appendix C), which was reviewed with each co-researcher.

Second, Burns and Grove (1995) discuss the right to privacy. This is described as “the right to provide or prevent access of others to their records” (p. 372). In this study, co-researchers provided me with the information they chose to reveal. The audio tapes used were kept in a safe location, and participants selected a pseudonym that was used in all written transcripts. Brief biographical sketches were approved by participants prior to being included in the final report. Therapists were reminded not to refer to clients by name, nor to reveal any identifying information about clients during the interviews.

Third, participants have the right to fair treatment (Burns & Grove, 1995). This means that “subjects should have been selected for reasons directly related to the problem being studied and not for their easy availability, compromised position, manipulability, or friendship with the researcher” (p. 375). The individuals who participated in this study were selected based on their possession of relevant experience. Close friends were excluded from the study.

Finally, Burns and Grove (1995) cite the importance of protecting research participants from discomfort and harm. They clarify that this can “be physical, emotional, social, and/or economical” (p.376). The risk of discomfort and harm can range from “no anticipated effects” “to certainty of permanent damage” (p. 376). I do not believe that this study caused participants any discomfort or harm. As this study did not require participants to complete a questionnaire or answer specific questions, they were free to determine for themselves what they were comfortable revealing. At no time

during the course of the interviews did any individual become visibly distressed. Had this occurred, my counselling skills would have been used to manage the situation. However, I was not prepared to offer counselling to an individual myself, but if necessary, would have discussed appropriate avenues an individual could take to aid in further exploration. Had an individual expressed suicidal or homicidal ideation, confidentiality would have been broken (as delineated in Appendix C) and appropriate interventions would have been undertaken to maintain the safety of those at risk. A final ethical safeguard was the review of the study by the Behavioural Research Ethics Board at the University of British Columbia. Ethical approval of the research protocol was received prior to beginning data collection.

Chapter Four

Results

Introduction

To begin this chapter, a summary of the characteristics of the participants as a group will be provided. Following this is a brief description of the individual participants, which has been approved by each woman. Subsequently, the common themes derived from the analysis of the interview transcripts will be presented. The themes described detail these counsellors' experience of therapeutic work with women who are starving themselves.

Participants

All of the women interviewed for this study are mental health professionals working in the Greater Vancouver Area. They have worked with women with anorexia nervosa in a variety of environments, ranging from private practice to institutional settings. Their professional experience in the area ranged from two and a half to 12 years. Four are heterosexual and one is lesbian. Two are single, and three are in committed relationships. Two are parents. Two were born in other Western countries and moved to Canada as adults. The rest are Canadian. None of the women have a personal history of an eating disorder, although one woman described dabbling with eating disordered behaviour in her late teens. All appeared to be within the normal weight range.

Barb. Barb is a 39 year old Caucasian woman. She has worked in mental health for over 10 years, and for the past two and a half years has worked with women with eating disorders. She did not have any specialized training in the area prior to beginning

to work with this client group. She is looking for work with other populations. In the past she has worked with forensic sex offenders and in a general out-patient department. She has often focussed on group therapy in her previous work.

Rachel. Rachel is a 48 year old Caucasian woman. She has worked with women with eating disorders for just over four years, and has no specialized training in the area. She has worked in mental health for 14 years. Prior to working specifically with women with eating disorders, she worked with women with a variety of mental health concerns, including some with eating disorders. She has also worked with the dying, with adolescents and in the area of drug and alcohol treatment.

Margaret. Margaret is a 39 year old Caucasian woman who has worked in the field of eating disorders since completion of her professional schooling. During her education she specialized in work with women with eating disorders and chose to continue in this area upon graduation. She has worked with women with eating disorders for eight years.

Sandra. Sandra is a 37 year old Caucasian woman who has worked in the area of eating disorders for six years. She had no specialized training in this work prior to beginning in this area. She took a two year break from her work to pursue a graduate degree in another field. She has worked in mental health for 14 years. In the past she has worked in the area of drug and alcohol treatment.

Simone. Simone is a 33 year old Caucasian woman who has worked in the field of eating disorders for 12 years. She wrote her Master's thesis on eating disorders. She made a deliberate choice to work with women with eating disorders, and since completion of her professional training she has done so in a variety of different settings.

She has done both individual and group work, and has worked with adolescents as well as adults.

Common Themes

Five themes common to each co-researcher have been derived from the process of data analysis. They represent commonalities in the lived experience of these therapists who work with women who starve themselves. These themes describe the women's sense of heightened awareness, sense of vulnerability, increased sense of responsibility, sense of altered relationships, and need to develop coping strategies. I will begin by discussing the experience of heightened awareness of societal influence on women's self-perceptions and behaviours. It is presented first, as it seems to be an overarching aspect of the experience of the participants and it appears to inform all of the other themes identified in this study.

The sense of heightened awareness

A theme essential to the participants' experience of working with anorexic clients involves a sense of heightened awareness of the powerful influences that shape the self-perceptions and behaviours of women in North American society. Through their work with women with anorexia nervosa, these counsellors became more acutely aware of societal pressures on women to fit an unrealistic standard. This heightened awareness filtered through every interview. It is present in many of the other themes that will be discussed later, where some of its nuances will be explored in greater detail. For some co-researchers, the experience of heightened awareness developed as they worked with women who were starving themselves. For others, an already existing awareness was accentuated and kept alive as they engaged in their work. Everywhere around them,

these participants saw evidence of cultural and societal messages directed at women. They noticed it in the media and in celebrities. They looked to see how it was manifest in female friends and strangers. The women reported having a variety of feelings in reaction to what they observed.

Counsellors who participated in this study described seeing the world from an altered perspective. Said one, "You put on a different pair of glasses and you see the world differently ... with a focus being on food and body image." Another explained that she was always aware of women's issues and commented that her work "keeps [her] vision focussed or tuned, or keeps [her] hearing tuned." Yet another said, "I'm more aware of the constant pressures on women to fit a certain ideal, and it's something that I think about regularly, and I'm always aware of and I'm in tune with it every minute of the day." A different woman conceptualized anorexia nervosa from a framework of emotional starvation and denial, and reported seeing evidence of this all around her. As the participants carried out their daily activities, they contextualized what they saw from the perspective of someone who had come into contact with the "worst case scenario." They were conscious that most women are affected to some degree by societal forces that perpetuate a troubling view of women.

Consistent with this sense of heightened awareness, the participants perceived the media differently. They took note of the body sizes of female actors and models, of those who serve as role models for young women, of diet commercials and lingerie advertisements. One therapist stated that "the images of these women in the magazines are like red flags showing us that there is something really wrong here." She went on to say, "The really emaciated models, they look sick and repulsive to me, it's like circus

freaks or something.” The metaphor of a film technician was used to explain another co-researcher’s experience when she described looking at models and magazines. “It’s a bit like being a film technician who does special effects ... every time you see a film you can see how it’s all done.” This “spoils the fun of it ... [as she] can’t engage in the fantasy in the same way a lot of women might be able to.” She was conscious of the artifice of such images and noted, “It doesn’t make me yearn for it in a way that maybe some women do. I see beauty in other things, I don’t consider that to be beautiful, I genuinely don’t.” She expressed frustration that others did not have “insight” into the role of the media in making people feel inadequate, as “it seems so obvious.”

These therapists also looked at the women they saw around them, as they carried out their daily activities, through the lens of heightened awareness. One counsellor explained it this way. “I’m more aware of feminist issues ... just seeing a woman walking down the street and seeing a woman who takes up space, or seeing a woman who doesn’t take up space, or watching how people interact.” Some women referred to observing female strangers and assessing them for the possibility of an eating disorder. If they saw a thin woman walking down the street, they often thought she was anorexic. However, they realized that this assumption might be incorrect, as they were aware that their perspective might be “skewed,” such that they saw what might not actually be there. While discussing this phenomenon, one described her experience this way:

If a thin person was to walk in the room now, ... I would look at her and assume she has an eating disorder. I wouldn’t believe that she could be just naturally thin. So I tend to, especially women, I tend to see thin women as having, I would think

that there must be something going on there and I'm not sure how true that is really, because I expect some people are naturally thin.

She continued, explaining that she looked at large women from a critical stance as well.

"Similarly with heavy women, I tend to see the issues walking around there."

The women in the study frequently noticed behaviour they understood as representative of women's concern about their bodies. These therapists were conscious of less extreme manifestations of the cultural drive toward slenderness. Said one woman, "I see it everywhere, and I feel ... super aware of people's low grade eating disorders." One therapist, who reported that in large part her awareness of these concerns developed after she began her work with women with eating disorders, stated, "I hear it all the time now, like I'm standing in a line at a take out, two 22 year olds are asking, 'Is there any fat in that?' and I'm going, yeah, there it is, I recognise it." Another stated, "I'll walk by someone and hear someone make a comment ... and I'll say, 'Oh there it is.'"

Some co-researchers commented that they saw their friends and acquaintances from an altered perspective; that they were on the lookout for anorexic behaviour in those around them. This was in part because of their heightened awareness of the prevalence of restrictive eating patterns among women. These therapists repeatedly stated their belief that all women have concerns about their bodies. They felt that those who denied this were simply not acknowledging their concerns, either to themselves or to others.

For some participants, their awareness of societal pressures to fit a particular standard extended to men as well. One noted that men in the gay community are particularly vulnerable to such pressures, while another commented that her heterosexual

male friends were very preoccupied by concern about their bodies. These women observed that while pressure to conform to a bodily ideal continues to affect women more powerfully, the gender gap is narrowing, "and not in the direction of equality."

To conclude, the female counsellors interviewed in this study reported that they lived with a heightened awareness of societal pressures on women, particularly those related to body image and food. Many counsellors found themselves taking note of evidence of women's concerns about meeting unrealistic standards everywhere around them. They noticed it in women walking down the street and in overheard tidbits of conversation. They looked at popular culture with critical eyes. Some were aware that men are similarly affected by body image concerns.

The sense of personal vulnerability

The participants all experienced their work with women who starve themselves as being infused with a sense of their own vulnerability. They spoke of the commonality of their clients' issues for all women, and they expressed an awareness that most women are vulnerable to many of the same pressures and concerns as their clients. The counsellors themselves felt influenced by societal mandates regarding body, beauty, and feminine behaviour. Some were conscious that they shared some of the personality characteristics they commonly observed in their clients. A number of co-researchers discussed personal changes they had experienced as a consequence of this awareness.

The women in this study felt that the issues faced by women with anorexia nervosa encompass the essence of being a woman in North American society. They commonly found themselves reflecting on their own femininity. One woman described her clients' struggles this way:

... wondering can I say no, ... do I always have to be nice, can I tell you what I think, can I say what I feel, can I be a mother and have a career, is it okay if my body develops, is it okay if I don't want to do what such and such says, is it okay if ... I'm really sensitive and get hurt if my family members say something to me, and to me, that is all the stuff that embodies being a woman.

Another participant described therapy with women who are starving themselves as, like looking in the mirror and seeing our tendencies amplified as women, a tendency to self sacrifice, a tendency to starve ourselves, a tendency to value ourselves in terms of beauty only I'm reminded of that more so than anywhere I've ever been, ... work, in peer groups, even in adolescence ... you're not exposed to that extent.

One therapist reflected on "working with ... women ... who are trying to push away their femininity." She stated that she believes she has become more comfortable with her femininity as a result of doing this work. She explained that to her, this means she does not have to be "assertive and powerful" "the way that men do it." She commented, "If I had chosen law or ... even another sub-speciality, I don't know if I would have figured that out." She concluded that, "When I was younger, I think I wanted ... to be a male, but now I want to be a woman."

These therapists also observed that it was not as easy to distance themselves from women with anorexia nervosa as it might be with clients with different concerns. They were often conscious of their own vulnerability to concerns similar to those faced by their clients. One commented that, "these are everyday people, ... I see professionals ... and there but for the grace of God, that could be me." Another woman said that in her

experience, “working with these women ... kept [her] own issues very alive.” However, she concluded by commenting that, “I would say it’s not so much that I work with eating disorders that has affected me, it’s that I’ve been dealing with all these issues that just happen to be expressed through an eating disorder.”

The awareness that they too had incorporated societal beliefs about women’s appearance into their own view of women was a new realization for some of the participants; an awareness that was distressing at times. One co-researcher began to recognize her own vulnerability to societal beliefs about beauty while losing weight for health reasons.

I always thought I was detached, I was immune to the whole body image thing, and I came to realize that I wasn’t, I looked at my body and how I valued beauty, big breasts, small breasts, big bum, small bum and ... I had many of the old ideas and beliefs.

Being thin as a young adult had “relieved” a different therapist “of the social burden of having to be preoccupied with [her] body” and left her with the impression that she was not vulnerable to the same pressures and concerns as other women. However, during her years of working with women who starve themselves, she came to realize that being “skinny” “freed [her] from having to be preoccupied” with her body, “but in fact [she] wasn’t free ... [she] could relax, but [she] was still obviously influenced by the social norm.”

Body issues were prominent in the lives of many of the participants. Some were aware that they had gone through periods of time when they were vulnerable to the same preoccupation with issues of body, eating, and weight as their clients. One therapist was

about the same age as many of her clients when she began to work with anorexic women.

She stated,

I felt the pressure of it, I wasn't immune to it at all, ... so working with girls and women who were very thin ... brought up a lot of body issues for me and made me feel insecure, and it was very hard when I first started, to not have stuff come up for me, it totally triggered feelings in me.

Over time she came to understand that "it's not about food," that food is a "non-issue."

She explained that body issues became less of a concern as a result of this realization.

The feelings commonly experienced by women when they gained weight appeared to be troublesome for these counsellors. Most of the women stated they were very opposed to dieting. They struggled with how to respond to weight gain when it occurred.

You think, well, I'm treating people with eating disorders and I'm trying to get people not to focus on their weight and their bodies, but the reality is that most of us are thinking about it at some time, and how do I reconcile that it's bothering me, but I'm trying to tell people not to let it bother them.

They were relating to their bodies both in terms of their position as women in this society and as therapists. For these women, there were no simple solutions when they experienced feelings of discomfort about their bodies. Conflicting feelings about their bodies appeared to be something the women became more comfortable with over time. One interviewee said she had become more comfortable with feeling "ashamed" of her body, as she was able to put her feelings into a cultural context and did not expect herself to be beyond her culture.

Sometimes these counsellors spoke about going through a process of evaluating whether or not their behaviour and thoughts were similar to those of an individual with an eating disorder. One co-researcher discussed beginning an exercise routine. She found herself wondering if she was vulnerable to the compulsive exercise behaviour she had seen in her clients. She asked herself, "Can you catch this, where does it start?" noting that, "Often in the history you'll hear, 'Well, I was at a vulnerable time and I began to diet and then I began to exercise' and then it takes off." She was relieved to discover that she had no desire to exercise compulsively. For another woman, a weight gain of 10 pounds led her to reflect on the thoughts and feelings she experienced. Upon weighing herself, she had "some pretty self critical voices in my head, which [she knew her] clients had a lot." "I really did look at it quite carefully and I thought, it's okay to be having these questions, ... this is not anorexic stuff, it's not to do with work, this is normal, ordinary, it's not a crisis, I really tried to disengage it from work."

As described above, many of the women in the study were conscious of their own vulnerability to the same pressures and concerns as their clients. One co-researcher reflected that she was not concerned about the possibility of developing an eating disorder. However, she worried that she

could become involved in a culture like [she] sees so many women getting involved in, where you become overly focussed on your appearance and how you look, and putting those pressures on yourself and losing that perspective, ... it would be easy to ... do some of that thinking and to waste precious brain energy on it.

Other participants were conscious of their vulnerability to engage in perfectionistic thinking similar to that they observed in their clients. In the words of one co-researcher who saw herself as vulnerable in this way: "I recognize how ... ruthless a person can be with oneself who has a perfectionistic streak." She realized she needed to look at herself with compassion in spite of her imperfections. She explained that when her clients were particularly "stuck," sometimes she felt that as their therapist, she was "supposed to be leading them out of this stuck place." She commented that, "it challenges [her] perfectionism" and that she "needs to have this sense of compassion for [herself] for not being perfect enough." Another explained that her clients' "fear of letting go of rigidity" resonated with her, and was something she has "had to challenge in [herself] all along."

One woman was aware that she was vulnerable to the same pressure as her clients to deny her emotional and physical needs. She explained:

There's a piece of all of those things within me that I struggle with on a daily basis. When I'm reminded of that, I try to tell myself, try not to have self deprivation cognitions in my mind, to say, it's okay to have needs, it's okay.

Another woman in this study believed that "anorexia is a lot about denial of self, and denial of being weak" and was aware that in the past she had been vulnerable to societal and familial pressure to deny herself in this way. She described her "adulthood as ... a process of letting go of all of those layers that pushed my natural instincts down, and now I'm more comfortable with what comes naturally, which is really a very celebratory approach to life." She reported that she was conscious of celebrating life's sensual pleasures, "and that includes sex and food and any kind of physical sensation, and to

enjoy it as much as possible,” “which is the polar opposite of that aesthetic of denying yourself.”

To summarize, the lives of the women who participated in this study were infused with a sense of their own vulnerability to many of the same concerns as their clients. They struggled with feelings of dissatisfaction with their bodies and appearance. Some were also aware that they shared personality characteristics with their clients, such as perfectionism and rigidity. It appears that they often looked at their vulnerable spots and used this awareness as an opportunity to challenge themselves and engage in personal growth. For some, there were positive changes in their lives as a result.

Increased sense of responsibility

Each of the women interviewed reported an increased sense of responsibility in their lives, which was expressed in three different ways. They felt responsible as therapists to their clients with eating disorders. They also spoke of being responsible to themselves. Last, they discussed their sense of being responsible to counter, as best they could, the prevailing ideology present in our society that they believe contributes to the development of eating disorders.

All of the women in this study expressed a deep sense of responsibility in their role as therapists. It was common for them to discuss the importance of their own readiness to work as therapists. “The therapist is the tool for therapy,” said one, “so my thing is always -- is the tool ready to be effective?” Participants often commented on their belief that they must be comfortable with themselves and their own vulnerabilities to work effectively with eating disordered clients. Explained one counsellor, it “is not ... that none of us should have issues, we all have them, but that we should know and make

some sort of peace with them before we tackle this population.” This was in part because of the particular nature of their work with women who starve themselves. As one co-researcher said:

Working with women with eating disorders ... makes us examine our beliefs as women, our views about our own bodies in terms of our own beauty, it taps into our own vulnerabilities, our insecurities, our own stuff from our own childhood around food.

For one woman, her eating patterns as a young woman caused her to reflect on her fitness to work with women who starve themselves. In her late teens she had “flirted around the edges of an eating disorder ... but ... wouldn’t make a commitment.” She recalled that earlier in her career, she had felt uncomfortable about her uneasiness about her body. She “did a lot of soul searching about, for [her] is this, even ethically, is this a place where [she] should be.”

These therapists often spoke of their feelings of responsibility to act as role models for their clients, although this meant different things for different women. Sometimes this had an impact on how these therapists ate. Most stated that they would never go on a diet. Sometimes these women struggled with their feelings of dissatisfaction around their bodies, as well as with their sense of responsibility to not engage in the same behaviour they discouraged in their clients. For one woman, skipping meals was a particularly salient issue.

I’m constantly telling people not to skip meals, so I never, where before I would skip the meals when you’re an eating disorder specialist it doesn’t just become

anymore, oh I skipped a meal Ethically I couldn't live with it, if I was ... treating people with eating disorders and I was doing some weird stuff with food.

Another counsellor struggled with conflicting feelings about her responsibility to "role model healthy eating" while eating with clients, versus her responsibility to herself. At one point, she was on a special diet and could not eat exactly the same food as the clients. She observed that when she was away from work, she would feel proud of following her diet and caring for her health, while at work she would "feel guilty for refusing food" she could not eat because of her health concerns. She explained that "it almost felt like a betrayal to the clients ... that here I was losing weight and changing my lifestyle and they were having to do the opposite." She chose to tell her clients about the reasons for her food choices. "I don't disclose my private life, but because there was an issue around food, I was very open ... to try to take away any of the secrecy around it." She also wondered about the benefits of shielding clients from people who are dieting.

My argument has always been that when they go out there they will be sitting at a dinner table with people who are on a diet, ... so to insulate them from that reality is doing them a disservice, anyway, rather than working with it.

Some therapists reported they felt strongly about acting with integrity in accordance with what they saw as central to the issue of self-starvation. For example, one therapist framed anorexia nervosa in terms of an existential dilemma acted out in the form of an eating disorder. She had not resolved her own existential questioning, and as a result there were times when she struggled with feeling "like an impostor" as she worked to help clients. However, rather than dwelling on this, she tried to role model "that it's possible to hold a dilemma in your hands and not hurt yourself ... that you can

live with the anxiety of unresolved conflict without hurting yourself.” She felt a responsibility to present herself as authentically as possible, which meant not “representing oneself as knowing answers and being not human.” This did not mean that she disclosed to clients about her struggles. “I think we all read between the lines of what people are saying and doing and I think they can ... read that about me.”

Several of the participants spoke about their responsibility to live full lives in the face of the deprivation in their clients’ lives. Being pregnant was an example one therapist used. She “felt good about it ... like a good role model.” She contrasted her life at that time with that of her clients: “They have a dried up little life and the therapist has this rich, leaking, fat life, full.” Another woman in the study, believed she should “really experience life to the fullest” “in the midst of [societal] disapproval.”

These women also spoke of the responsibility they felt to themselves. For one, this meant being true to some dietary choices she had made years before, even when it was a challenge to honour them while eating with clients. Another woman discussed the importance of caring for her health. She reported being much more aware of the role of nutrition in the maintenance of good health. She had seen “the devastating effect of starvation ... so [she was] aware of what [her] nutrition [did] for [her] body and now [she was] taking multivits and so there’s more of a body awareness and less depriving [her]self.” Another co-researcher struggled to sort out her responsibility to herself and her wish to challenge cultural mandates toward women regarding food and eating. She said, “With my professional background I find it really hard to not eat fats and not to eat anything I want.” However, occasionally she had to examine her behaviour to determine whether or not it was beneficial for her, regardless of the political implications. She was

aware that there were times when “maybe [she was] stuffing some feelings, maybe [she was] being self destructive.” She was challenged to “depoliticize” eating and exercise and to evaluate their importance for her personally.

This leads to a discussion of the final aspect of this theme; the women’s sense of responsibility to fight back against society. These counsellors were careful not to perpetuate certain societal attitudes. They would not reinforce their female friends’ concerns about weight and appearance. A lesbian participant went through a process of evaluating what she found attractive in a woman, and felt “ashamed” to discover that she was drawn to women “with all the physical attributes that the media promote.” This led her to become more conscious of the ways she conveyed her attraction to her partner. “I’m also more aware of the message I send ... to communicate attractiveness to my partner, like what’s beautiful.”

One woman recalled speaking to teenagers in high school about eating disorders. As a result of her own attractive appearance, occasionally the students would challenge her. “At the end of it, one of them would stand up and go, ‘Easy for you to say, just look at you.’ ” She would use her own experience to challenge their belief in the power of beauty. “I would say, ‘Some people look at me and think that I have no problems, or that I’m never unhappy, never lonely, never sad, never frightened,’ ” explaining that her appearance did not shield her from such experiences.

Sometimes co-researchers struggled with their sense of social responsibility. One woman described an incident that occurred while she was shopping for lingerie in a department store.

At the top of the escalator there was a huge poster of the most emaciated, horrible, anorexic looking model in a bra and panties, right as you come up the escalator, in my face, ... I talk about it to myself, ... like it's truly an obsession in our culture ... the first thing you see in the lingerie department I bought what I needed to buy ... and I was half way home and I said ... why didn't I go to the manager ... and say, "I take offence to that poster because it represents an unattainable idea for most women," and I was mad at myself.

She explained that she did not have "freeing women from obsessions with their body obsessions" as a "cause," but sometimes "blatant" examples such as this made her wonder if she should take action.

To summarize, the participants in this study were conscious of the choices they made in their personal and professional lives. They were conscientious about their role as therapists, and about their readiness to do such work. It was important for them to live in congruence with what they encouraged for their clients, as best as they could. This meant different things for different women. They also felt responsible to themselves. As well, they were aware of the role they could play in perpetuating destructive attitudes toward women and experienced a sense of responsibility to counter these attitudes in a variety of ways.

A sense of altered relationships

The women interviewed in this study described alterations in their experiences of relationships based on their work with anorexic clients. They sensed changes in how they experienced their intimate relationships with partners, friends, and family. Some co-researchers were aware that their friends also experienced their relationships with them

differently. As well, their relationships with their bodies, food, and their understandings of the same were altered.

A number of the counsellors interviewed spoke of changes in their relationships with friends. They brought to their friendships a different understanding of issues around body, weight, and dieting. One therapist who experienced this quite acutely explained that she felt "out of sync" with her friends. She stated:

I get stuck a lot in my friendships, because I'm so politically anti-diet and being surrounded by people who ... give lip service to the idea that it all doesn't matter, but will still on a day to day level fret about fat content and exercise ... so I find on a personal level I get stuck between my strongly held political positions and the reality of the world and not wanting to sit in judgement of the people around me, my friends.

This has been "very painful" and she commented that it has sometimes led to a distancing in her friendships. She believed her friends felt "betrayed" at times. She hypothesized that she puts her friends into a position in which they could look at their own body issues, when they might not be prepared to do so. As well, she does not engage in what is often perceived as supportive behaviour with friends who want to lose weight. For example, she never encourages a friend to lose weight by offering to go to the gym with her.

The women also spoke of viewing their friends differently. As a result of her awareness of the prevalence of restrictive eating patterns among women, one therapist said she observes her friends closely. "I'm watching to see if they have an eating disorder. And I never did that before, or to see if there is a beginnings of an eating disorder." She was conscious that many of her clients were able to hide their illness until

they became very sick, fooling those around them. As well, she was aware that health professionals are not immune to developing these types of eating patterns. "A lot of my friends are health care professionals, so it's made me more aware, ... given me cause to think, do I have a friend who has an eating disorder I'm not even aware, and how would I help them." She added that "maybe [she was] looking too hard," as her fears had not come true.

Some of the women also commented that they had sensed changes in their friends' interactions with them. Sometimes friends did not seem to know how to discuss their concerns about their bodies. As one interviewee noted, "It touches people in such a vulnerable place, but very few people want to go there." Friends either did not bring up these issues, or else did so very apologetically. Knowing the kind of work these women did, their friends appeared to feel uncomfortable discussing diets, perhaps fearing the assumption that they might have an eating disorder. Several of these therapists commented that their friends would never tell them if they were dieting. One woman sensed that her friends were often aware of some of the issues involved in women's concerns about their bodies, and thus seemed to feel that they were "supposed to rise above" them. This woman explained her friends' perspective this way, "Not only am I ashamed of my body but I'm ashamed of being ashamed of my body, because I'm supposed to know better."

Another participant stated that she had found herself in the role of "truth sayer," noting that "because [she is] in the field it's [her] obligation to set the situation straight." She added, however, that she consciously chooses when to speak and when to remain silent. She gave an example of a conversation with someone who had recently lost

weight due to emotional distress. The woman was feeling empowered by her new, slender body. The therapist described her response:

I'm like, okay, do I do it or don't I, do I chose to go into it or not? And I chose to, I chose to go in to help her see, so how hooked in are you to your self esteem being tied up to this skinny body you now have ... we talked about it and ... it was a useful thing for her.

As indicated by the previous points, the kinds of conversations co-researchers had with those around them were influenced by their heightened awareness of women's concerns about their bodies. One woman had an acquaintance who was constantly trying to lose weight and "wanted to talk about it in a girlie way ... I was very turned off by that and ... I asked her not to do that." She suspected that she "must come across as a bit of a fascist sometimes if I don't allow anyone to mention it." Another woman noted that she "socially [had] no tolerance for talking about just whatever it is some women talk about."

This awareness of issues related to eating disorders caused one interviewee to be very careful about the kinds of messages she sent out to her friends about weight. She stopped asking friends questions about their weight.

My friends say to me something like, "Are you losing more weight?" or whatever. I don't ask those questions anymore, I don't know if that's good or bad, but it doesn't feel right to ask those questions anymore, because I wonder what message I am sending.

Jokes were sometimes censored as well, again keeping in mind unintended messages that might be portrayed. One woman who enjoys humour in her relationships was aware she monitored what she said. "I'm more careful of what I joke about now, especially back to

physical appearance ... whereas that used to be fair game, but I'm more sensitive to that now." Even a joke at her own expense was not seen as a good idea, as "that can still convey a message to somebody else, if I make a joke about my own weight, that still conveys a message that if they're the same size as me, then they can think, 'What are you saying?'" Thus, it appears some spontaneity had been lost in her interactions with friends.

For one participant, social situations were difficult. As she explained, many people were interested in her work. "It touches on nearly everyone's lives in some way." "Everyone's got their own story to tell, whether their sister was anorexic or they were." However, she did not want to discuss the topic outside of work. This was, in part, because of her desire to separate her professional life from her personal life. As well, she believed that people often "have a voyeuristic, sensationalist idea about anorexia" and she did not feel it was respectful of her clients to discuss the illness in this way. In addition, she believed she had very little understanding of anorexia nervosa. "I don't really have any answers, the more I'm in the field, the less I understand it."

Some of the participants reported being more selective about the types of people with whom they made friends. For example, one woman said,

I just don't seem to have jock friends ... I mean serious, like, triathlon stuff... and I used to hang out with people like that ... quite a bit, but not, I just couldn't stand hearing that kind of talk outside of work now.

Another co-researcher explained that she was careful not to get into relationships "with women who were very competitive about their looks." One counsellor was very discriminating in her relationships, so as to ensure she did not find herself acting in the

role of therapist to her friends. She clarified that she did not mean there was no room for vulnerability in her relationships, rather, she did not want to counsel her friends. She agreed that this might be a result of working in mental health in general and not necessarily be specific to her work with clients who starve themselves.

Some of the women mentioned positive changes in their relationships with friends based on their work with anorexic clients. With intimate friends, sometimes conversations about women's issues and concerns took place on a much deeper level than they otherwise might. One therapist commented that her work had led her to appreciate women more. She explained that it was her perception that women are "stronger and more interesting than men," in spite of the fact that they appear to "outwardly struggle more."

These counsellors also discussed changes in their romantic relationships. A single woman commented on her dating life. She noted that the men around her were "incredibly conscious of their own bodies and their weight" and she found herself looking at men to determine how comfortable they were "with their own bodies." "If there's a morality around food and weight and exercise, if there's a moral tone there," she would not pursue a relationship with them. She noted that if they had that approach toward themselves, they would likely apply it to her and "find [her] wanting, and then we're in trouble." When this occurred, it was a painful and difficult experience.

I'm completely, I'm split between my political stance and my own vulnerability because, if I find a man judging me because of my weight, there's a part of me that agrees with him. "He's right, I really should lose weight, ... I'm gross and disgusting," that's all there, it just is. ... I'm aware of it, I don't listen to it, but in

a vulnerable moment when I'm worried about, does this guy really like me, if that comes up, that nerve is going to get touched. So that nerve gets touched and then there's the political side, and then there has to be a battle inside of me, so it's not as simple as just saying, "He's an idiot." I have to fight my way through.

She found it difficult to find men in the dating world who were not affected by cultural pressures regarding physical appearance. Sometimes she struggled to sort her way through her personal vulnerability and her political beliefs.

Other participants spoke about changes in their long-term relationships. As with friendships, the topic of weight and body was often taboo. One woman had struggled in her relationship with her partner as, "he's very into working out and very fat grams conscious and calorie conscious." She had to make it very clear that she did not want to discuss these concerns with him.

I can't stand seeing him do it or hearing him talk about it, and I come back from a day of working with these women and he's, "Say did you know that a tofu wiener has four grams of fat in it?" and I just want to throw it at him.

Another woman recounted how she "chose to marry" her husband. It was important for her to marry a man who was non-traditional in many ways. He also needed to be "someone who was not stuck on cultural ideas of beauty." She described this as "a big thing," and commented that "even before we got married he would talk a lot about how for him the ideal body type is not emaciation." It appears she needed to have congruence in her romantic life with the beliefs that direct her work.

A lesbian co-researcher discussed differences in her intimate relationship. She was conscious that she talked about role distribution with her partner more than in the

past. "There will be one usually whose tendency is to be more in the classic, what we've come to define as a classic female role, and more self sacrificing ... I've found that I pick up on that a lot more, ... I'm more aware of it, wanting to combat that."

One woman in the study, who is a mother, discussed her awareness of the messages she sends to her child about beauty and bodies. She was conscious of conveying the idea "that beautiful women are all sorts of looks, all sorts of different women can be beautiful, and different people can be beautiful, and not to be derogatory about the body." She tries to be positive about her own body as an example. She was also very concerned that her child not place too much importance on physical attractiveness. "I guess you do really want your son or your daughter to feel a general sense of being okay physically and then to forget about it." When people have complimented her child's appearance, she has told her child, "It's nice that they say that, but the most important thing is ... how you're feeling inside and whether you're kind to people." She wondered if she was "more conscious of those messages than most parents would be."

Some of the women also described changes in their relationships with their bodies and food. They perceived that extra layers of meaning were added onto their bodies, and how they fed and cared for them. These counsellors experienced their bodies not only from the perspective of women subject to strong societal pressures, but also as therapists who had a heightened awareness of these pressures. Most of the women in this study described going through different phases in their relationships with their bodies over time. Some reported periods of preoccupation with their own weight and body size. One woman recalled her experience early in her career. "I remember thinking about my

weight more, and watching what I ate more and that kind of stuff.” At times these counsellors ate “for the clients.” As one explained, “I found that I was eating much bigger meals, and eating more frequently.”

Eating with clients, often a part of the job in institutional settings, was sometimes experienced as a challenge by counsellors. In this context, eating is a job task in which therapists are supposed to “role model healthy eating.” Some of these women described feeling terribly self-conscious during meals. “I know that they’re watching my plate, and if I’m enjoying the food I feel like a glutton for enjoying it, if I don’t want something then I feel I have to finish it.” This experience, along with pressure to keep the conversation away from the topics of food and exercise, often meant the meals were “not a very relaxing way to eat.” One woman found herself eating a lot at home in response.

The meals I would have at home, I would, ... I don’t know if you’d call them binges exactly, but I’d really nurture myself and overeat and put on lots of butter and ... do the things that I couldn’t do in front of the patients, not hold back.

For some, the acts of eating and exercising became politicised. As one counsellor explained, she went through a period in which she was “rebellious against anorexia and eating higher fat foods and exercising less.” She was defiant in the face of the resulting weight gain. “I didn’t care and it was ... kind of like, I’m going to do this and I’m going to be a big woman and I’m not going to be like them.” It is possible she felt a need to distance herself from her clients’ struggles. Some experienced confusion about what was normal and what was “anorexic behaviour” in this society. For example, one woman was unsure about the significance of refusing a piece of cake or checking the content label on a package of food. These acts appear to be imbued with extra meaning for the

participants when such behaviours are symptomatic of serious illness in clients. One woman described going through a process of having to reassess her eating patterns.

It feels like a feminist statement for me to be able to eat anything I want, ... but sometimes I have to reframe that and say no, actually I'm being self indulgent, ... I'm meeting my emotional needs, ... and take it outside the feminist model and look at it as more of a personal thing.

She described it as a "struggle" for her "to get the point where [she could] exercise healthily and also eat healthily." She explained that "there's no doubt some exercise makes you feel better and eating healthily makes you feel better, and eventually I had to come back to that knowledge for myself and not think of it as a sick thing."

The women interviewed experienced changes in their relationships that they attributed to their work with eating disordered clients. Their relationships with those around them were coloured by political nuances. They were often acutely aware of the possibility of an eating disorder in both strangers and friends. It was common for them to relate to their own bodies differently. Not only were these therapists subject to societal mandates about appearance, but they were also living with a heightened awareness of some of the troubling implications of these mandates. Sometimes they struggled to make choices that honoured their own health, given these circumstances.

The need to develop coping strategies

The women who participated in this study sensed a need to develop ways of coping with some of the challenges they faced as therapists working with women who starve themselves. It appears these counsellors needed to find ways to cope with aspects of their work, in particular the chronic and insidious nature of anorexia nervosa. Words

such as “draining,” “frustrating,” “upsetting,” and “frightening” were used to describe their work experience at times. One co-researcher said, “It’s like watching a wounded animal die, ... it takes a lot out of you.” These women also needed to develop ways of coping with their sense of heightened awareness of societal pressures on women, as well as with their sense of personal vulnerability. The details of these two experiences have been described earlier in this chapter. It appears that the women interviewed coped in a number of different ways. They spent time thinking about their clients and what might lead them to starve themselves. They developed therapeutic approaches to facilitate their work with anorexic clients. They engaged in self-talk to get through difficult times. Some decreased their contact with clients with anorexia nervosa. They tried to make time in their lives when they were less aware of societal pressures on women. These therapists were also mindful of caring for themselves.

I will begin this discussion of coping by detailing some of the challenges experienced by these therapists who work with women who starve themselves. Many of the women spoke of the length of time it takes to recover from anorexia nervosa, as well as the “repetitive nature of the disorder,” for which there is “no cure.” This sometimes left the therapists with feelings of “helplessness.” There were times when these counsellors “worked very hard, and then there appeared to have been a shift [in the client], and then [the client] backslid.” In the face of this, one woman “questioned [her] own competence.” She added, “anorexia is an insidious, insidious disease and you have to measure successes in tiny increments.”

Therapists also spoke of the challenges inherent in “wanting to help a population who has no idea how to receive it and wants to reject it.” One woman used a “food

analogy" to explain. "It's like someone who starved for so long, ... if you feed them a big banquet meal, they'll throw it up, they can't tolerate it." A different woman felt rejected on a "mother/woman kind of level, in the same way as a mother would feel if her child says that they don't want to eat your food." This point was echoed by another counsellor who stated, "with eating disorders, ... it challenges the fundamental instinct of eating food, which has huge meaning and significance for us as people."

Other aspects of their work with anorexic clients were difficult as well. One of the therapists was challenged by the "secrets and lies ... of anorexia" particularly in a group setting, as she did not feel adequately "trained" to "deal with" the conflicts that could occur as a result. Another woman commented that clients could be "very angry" and "very resistive."

It was common for these women to note that their work made them look at their own issues. One therapist commented that this work "pushes all your buttons and hits all your nerves." For some, these "buttons" related to the nature of being female in this society.

There's something unique about working with them, because it's everything in a package for women, you hit all the core stuff, body image, how we sacrifice ourselves emotionally, the need to be perfect, issues around shame ... how you view your sexuality, and all of those issues ... you get it all in one package with anorexia, and so it makes you look at yourself all in one package, whereas I think in other fields you can look at it more piecemeal, here you ... get the full mirror, you're looking at everything all at once, which is probably why it is a bit more draining.

For other participants, the particular characteristics of anorexia nervosa triggered their personal struggles with similar issues. As described in the discussion of therapists' sense of vulnerability, some of these counsellors observed that perfectionism and rigidity are common characteristics of anorexic clients. Therapists who shared these tendencies were challenged to examine themselves.

The theme of heightened awareness has been discussed earlier in this chapter and is of relevance in this discussion of coping. Women in this study experienced a variety of reactions to their increased awareness of "cultural pressures on women." They used words such as "frightened," "concerned," "scared," "sad," and "afraid" to describe their feelings. One therapist stated she felt "fury, pure, hot fury," however she did not know at what, or whom, to direct it. She described a feeling of "global frustration that the world is just so screwed up." Heightened awareness was experienced as a "loss of innocence" by one woman. She spoke about looking at her friends who did not have the same perspective and "almost wistfully thinking that was me." A different co-researcher described the experience of heightened awareness as "unnatural" and even "pathological." She commented that it was abnormal in a society which is actually "eating disordered," a society in which eating disordered behaviour is normalized.

The women interviewed used a variety of strategies to cope with the challenges they encountered through their work. It appears it was important for them to accept the lengthy course of the illness, as this helped them develop realistic expectations for improvement. The participants learned to "accept a long prognosis and not get sucked into the 'I need to see you get better' thing." They often acknowledged their powerlessness. "The individual has to make the choice about recovering from an eating

disorder, there's nothing magical that we can do." Another counsellor said, "I have to forever say I don't need to solve it for them, I don't need to cure it for them." One woman spoke of therapy this way, "The funny thing is they ... can't do it alone, but we also don't have all the answers, so it's a working relationship." A different co-researcher explained that she had to do "a lot of work around [her] ... rescuer coming charging in on a white horse." Some also spoke about putting the illness in perspective. It was important for one woman to recognise that "anorexia is, although it's a special, high intelligence thing, it's just another disorder." Another emphasized that "the issues underneath the eating disorder are universal."

Participants also discussed approaches to therapy that they used to facilitate their work. Repeatedly, the women spoke of ways to give control to their clients and to avoid becoming engaged in power struggles. "Handing the choice back to the client" was described by one co-researcher as, "better for the clients," and "easier" for the therapist. One woman stated that clients "are grown-ups and even if they are 60 pounds, they're still able to choose and to be responsible for themselves. And ... our job is to help them discover that about themselves." One of the women interviewed described herself as "a curious observer of [her clients'] dilemmas." This appeared to help her avoid entanglement in her clients' quandaries and becoming caught up in details. She used food issues as an example of such a detail. She later said she "understands the meaning [food] has for them, but [she] holds a space that there is more to life than that." According to her, it was critical not to "always be talking to the eating disorder," but to "find the person in the eating disorder." Indeed, a point of agreement amongst all of the counsellors was to avoid focussing on food in therapy, as this could serve as a distraction

from more important issues. Said one counsellor, "I used to think anorexia nervosa was all about food and it's not."

It was common for these women to discuss their framework for understanding their clients. Each of the therapists interviewed had developed some ideas about the reasons why a woman would starve herself. Often these ideas informed their interactions with their clients. It appears this increased the therapists' sense of efficacy as they did their work, and enabled them to cope with the stressors more effectively. It also helped them make sense of their clients' experiences.

Most of the women interviewed contextualized their clients' struggles, at least in part, by looking at the situation of women in North American society. Said one, "the issue of eating disorders ... encapsulates the oppression of women and women selling themselves short and not feeling good about themselves." Another placed the dilemma of women who starve themselves in the context of a culture in which women routinely deny themselves. Prior to working with these women, she had understood similar behaviour in other female clients from a paradigm of "interpersonal relationship dynamics," rather than "as a cultural, social issue." To her, anorexia is about "emotional starvation," "starvation not just of the body but of everything." For women who starve themselves, "food is the currency of exchange ... for emotions and relationships."

A different therapist hypothesized that women with anorexia are overwhelmed by the choices presented to them. To her, anorexia nervosa represents a "fear of adulthood." She went on to speak of femininity as "representing abundance" and "overflow." Another woman looked at her young clients from a developmental perspective. She explained,

When I work with these women ... I ... acknowledge their stage in life ... like I don't say to a 20 year old, "Oh get over it, stop being concerned with your appearance." That's not developmentally accurate, they're in a breeding game, ... they are trying to attract a husband."

However, this therapist found it much more difficult to "get a sense of why it would suddenly pop up in a person [in her] 40s or 50s."

Interestingly, the participants in this study did not understand female self-starvation exclusively as a product of women's situation in North American society. Our society was described as "eating disordered" by one woman, "in that food is so widely available and it's so false, like so much of it has been ... over processed." She continued, explaining that "we've lost touch with what food really is, and what eating really is, and what our needs are, and in a way anorexia is a rejection of a lot of that." She concluded that, "In some ways it's a political statement itself, a refusal of many things, but it's gone wrong." Women who "hook onto" eating disorders are "resisting" "the largess of the ... western world." Another co-researcher looked at her world and noted that anorexia exists in a society in which being "thin and fit" is as sign of moral superiority.

One interviewee described "anorexia as a fear based illness," in which "the fear becomes so great that they become paralyzed with it." She believed that the women with whom she works might each be afraid of something different, but their common perception was that "the world is a terrifying place." She saw many of her clients as being "terrified of who they could be" and afraid of "the monster in the closet," when in fact there was "no monster." She believed her role as therapist was to help clients open "the closet door," and face their fear. At the conclusion of the interview, she stated that

the issues faced by women who starve themselves “are really universal, we have universal themes and we’re human, we get scared, we’re sad, we’re all kinds of things and eating disorder clients ... are no different.”

For one counsellor in this study, anorexia nervosa is in large part about existential issues. “It’s ... their personal existential question ... acted out in the realm of their body and with food.” They are “using food as a kind of ... weapon, or something, of the battlefield.” She sees her clients as “struggling with authenticity for themselves, like they feel like they are struggling to be perfect.” This presents them with a dilemma, as “human beings have basic flaws, being human in a changing, impermanent, unpredictable and uncontrollable world.” For her, to be authentic to one’s humanity involves acknowledging this fundamental imperfection. Working from this framework enables her to approach her clients with “curiosity,” rather than “rejecting” her clients’ “struggles” and “feeling like it was making [her] work hard.” She reported she was able to interact with her clients with empathy and avoid many of the negative feelings she has observed other therapists experiencing.

As a way of coping with their sense heightened awareness, these therapists endeavoured to give themselves time during which they did not look at their world from this perspective. These women often experienced being “hyperaware” as “draining.” Upon taking a break from work to pursue other interests, one woman experienced a sense of relief that her awareness decreased. She reported that during this time she “felt more normal.” Some therapists spoke of consciously trying to minimize their focus on such issues while away from work. Explained one woman, “when I’m on vacation ... I try to shut that part of me off, I don’t notice it as much.” Another woman spoke of giving

herself permission not to talk to people around her about these issues when they arose, in spite of having relevant knowledge.

The women in this study also engaged in self-talk to help them cope with their work, particularly when they felt vulnerable. One said she tried to “be gentle on myself in terms of, this is a learning process for me and I’ll always learn about me.” She made this statement when discussing her experience of having personal issues around body image and attractiveness triggered by her clients. Feeling “hypocritical” was a struggle for one therapist when her vulnerabilities were brought to her attention during her work with clients. She explained that she “used to really be anxious about [her] own anxiety about [her] body, working with this population.” She felt she had become “more comfortable” when this happened, as she was able to acknowledge her vulnerabilities, while recognizing that they did not inhibit her from doing her work.

Several of the women spoke of the benefits of seeing a therapist themselves. This appeared to help these women cope with their sense of vulnerability. One woman believed that women “who have had therapy” while working as therapists “are better clinicians,” as those who have not had therapy “can’t go many places” with their clients. She said that as a result of her own therapy,

I never fear with a client where I’m going to go, what she’s going to ask me, what she’s going to say, what she’s going to challenge me and what vulnerabilities she’s going to hit because I feel equipped to deal with it.

For one therapist who worked in isolation, supervision was crucial. She described it as “ethically absolutely essential to keep [her] on track.”

Humour was a valuable tool for some of the therapists in coping with the realities of their work. In the words of one participant, joking with colleagues was a "way of coping with [her] frustrations and anxieties to do with the work." It was a "way of safely leaking off" "angry feelings ... towards the clients." Colleagues were also a source of support for some of the women.

To cope with the stress of their work, some of the women decreased their direct contact with anorexic clients. One woman said she had to "stop doing clinical work" for periods of time because she "felt burnt out." A couple of years off of work to pursue a degree was helpful for a different counsellor. Another was actively diversifying her client base. She described this as a matter of "managing fatigue." She also believed that it made her "a better therapist for ... people with eating disorders, because [she was] fresher, and [her] perspective was broader just by virtue of all of the other interactions." Another co-researcher moved into a position in which she had less direct contact with clients and more with other professionals. She felt this was "a good thing," as she had "lost quite a lot of patience ... for these women." One therapist was planning a move out of the field entirely, as she did not want to continue working with anorexic clients, in part because of the stressors she experienced.

These counsellors also discussed the role of their personal lives in coping with the challenges of their work. They mentioned the necessity of having a support network outside of work, and of having rich personal lives with friends and family and other interests. They often spoke with their partners and friends about their feelings. One said, "I talk with my friends, just about me, obviously not about an individual client, but yeah, I have to talk it out." Having a "very separate" personal life was important for another of

the therapists. In part this meant that she did not socialize much with people who work in the same field. Pursuing education in a separate field was extremely helpful for one woman. She explained that "education is really valuable ... it gives you something else, not just the subject ... it is a kind of a confidence builder." Having "another identity has "kept [her] sane."

These therapists were also conscious of the importance of caring for themselves while doing this work. Some reported they had struggled with this along the way. For a period of time one woman used "snacks and wine" to deal with "the toxicity of the day." Another "developed a really nasty chronic stomach problem" which she attributed in part to "internalizing" some of the stress of her work.

One woman went on regular "retreats." "I go on retreats, take myself away for a few days at a time about every two months, go rent a cabin somewhere on of the gulf islands and just disappear." She would return from these trips "feeling refreshed." Another participant was beginning to explore "spiritual" approaches, such as yoga and meditation, to manage her anxiety and relax at the end of the day. A different woman said she spent "a lot of time with [her] cat because she represents everything that's warm and loving and safe and good." Setting limits on work and commitments outside of work was helpful for these women. As one co-researcher explained, "when I'm home I don't want any responsibilities."

The women in this study reported being faced with many challenges in their work, and over the course of time, developed ways of managing these stressors. They learned about the nature of their clients' struggles, and developed therapeutic techniques that enhanced their sense of therapeutic efficacy. They used self-talk to help them manage

their feelings of vulnerability. They decreased their direct contact with anorexic clients as they felt necessary. They tried to dampen their heightened awareness when they were away from work. They spent time thinking about what might cause a woman to starve herself. It was also important for these counsellors to care for themselves. They spent time with friends, family, and pets, and found ways of managing their stress.

Conclusion

Information derived from the interviews conducted with these five female therapists was used to develop five themes, which describe their common experience of working with women who are starving themselves. These women spoke of being acutely aware of societal pressures on women to meet unrealistic standards of appearance and behaviour. They felt vulnerable to these pressures, much as their clients do. They felt it necessary to act responsibly in keeping with their role as therapist and their unique knowledge as specialists in the area of eating disorders. They sensed their relationships with those around them were altered, as well as their relationships with their bodies. Finally, they evolved coping mechanisms that they used to manage the challenges of their work.

Chapter Five

Discussion

Introduction

This study was designed to explore the lived experience of female therapists who work with women with anorexia nervosa. The research question that served to guide this study is: What is the experience for women therapists of working with female clients who are starving themselves? In this chapter, the findings derived from the interviews conducted for this study will be compared with the existing literature. This will be followed by an exploration of counselling implications, some thoughts about future research, and a brief conclusion.

Comparison to the Literature

Although the literature reviewed for this study gives one cause to suspect that female therapists working with anorexic clients might experience their work as affecting their personal and professional lives, no research to date has explored this. While this particular study only describes the common experience of five women who do this work, it represents a contribution to the literature on the experience of working as a therapist in a unique field. The therapist's experience of her work has only been explored in depth in the trauma field, under the rubric of vicarious traumatization.

The primary finding of this study is that the participants experienced their work as affecting their lives in numerous ways. Often this was a result of the women's sense of heightened awareness of societal pressures on North American women. The vicarious traumatization literature suggests that therapists can experience alterations in their perceptions of the world around them as a result of their work (Pearlman & Saakvitne,

1995a). However, this possibility is not discussed in the eating disorder literature. Pearlman and Saakvitne comment that an alteration in world view “leads us [trauma therapists] to experience what was once ordinary in new ways” (p. 286). That the counsellors interviewed for this study had a similar experience appears to be a finding unique to this study.

In response to their sense of heightened awareness, these therapists reported changes in a variety of aspects of their lives. They experienced alterations in how they perceived the world around them. They described changes in their relationships with their bodies, as well as in their relationships with friends and family. In addition, they discussed alterations in their sense of vulnerability to societal pressures. They also spoke of an increased sense of responsibility to counteract and challenge societal mandates. As well, they found themselves reflecting on their personal experiences of being a woman in this society. As one woman put it, this type of work “makes us examine our beliefs as women.” For example, they felt challenged to think about the role of beauty in their lives. Most stated that they had not been as deeply affected by work with other populations.

These women all felt they were vulnerable to many of the same issues and concerns as their clients. One area in which this was particularly salient was the co-researchers’ experience of their own bodies. Not only did the participants feel vulnerable to societal pressures, their experience was filtered through their heightened awareness and sense of responsibility to themselves and their clients. That these women felt vulnerable to some of the same concerns about their bodies as their clients is not surprising, given cultural expectations of the female body, and the complexity of most

North American women's relationships with their bodies (Bordo, 1993; Brownmiller, 1984; Cash & Henry, 1995; Fredrickson & Roberts, 1997; Thompson & Hirschman, 1995). Empirical studies indicate that work with eating disordered clients can affect how health care workers' experience their bodies (Shisslak, Gray, & Crago, 1989) and their awareness of food (Sansone, Fine, & Chew, 1988; Shisslak et al.). In discussions of countertransference in therapy with women who are starving themselves, authors commonly observe that a female therapist's feelings about her own body can be heightened by her work (Piran & Jasper, 1993; Rabinor, 1995; Wooley, 1991). Gutwill comments that every female therapist who works with anorexic clients is inevitably affected to some degree by societal pressure to meet an artificial bodily standard. Piran and Jasper observe that women therapists who specialize in the area of eating disorders can find themselves reflecting on their own feelings about their bodies. Rabinor notes that as a by-product of living in this society, it is likely that female therapists will sometimes relate to their eating disordered clients' unhappiness about their bodies. She states, "it is clear that the cultural mandate to diet and be thin tyrannizes most women" (p. 89). The extent to which these women felt vulnerable expands on the literature about therapeutic work with eating disordered women, which is primarily anecdotal and theoretical in nature (Gutwill, 1994; Piran & Jasper; Rabinor). By meeting with therapists who work with anorexic clients and allowing them to speak about their experience, this study provides some evidence to suggest that female therapists are vulnerable to the same societal pressure on their appearance as their anorexic clients. This research adds to the current literature by detailing the complexity of these therapists' feelings about their bodies.

An interesting finding of this study is that as a result of their complex feelings about their bodies, there were times when some of these women questioned their suitability to do this work. Sometimes they struggled with feeling that as therapists, they should not feel dissatisfied with their bodies. However, they came to the conclusion that their feelings about their bodies did not disqualify them from doing their work. They reflected on how, through this work, they became more accepting of themselves as women who are recipients of multiple societal messages about the female body. These therapists did not believe that it was possible for women to completely resolve their body issues, and rather sought to minimize the impact of their personal struggles on their professional practice. Rabinor (1995) echoes this point in her discussion on supervising therapists who work with women with eating disorders. She notes that it is common for therapists to wonder, "How can I help her [my client] accept her body if I have not really come to grips with mine?" (p. 90). For such women, "the role of healer may feel fraudulent" (p. 91). However, she contends that in this society, it is unrealistic for female therapists to expect themselves to be free of concern about their bodies. This contrasts with the trauma literature, which suggests that therapists should resolve their own trauma history, if present, to prevent harming their clients (Williams & Sommer, 1995). This research suggests that this is not necessarily possible for female therapists who work with clients who starve themselves, to completely resolve their personal concerns about their bodies. However, it must be mentioned that these therapists were very conscientious about their practice. Several stated that they felt responsible to keep clear boundaries around their personal issues and to work on these when they arose.

A significant finding of this study is that even though none of these therapists reported a history of an eating disorder, they experienced their work as affecting their lives in a multitude of ways. The possible impact of a past history of an eating disorder on the experience of a therapist is not addressed in the eating disorder literature. Most authors who write about vicarious traumatization contend that a prior history of trauma increases a therapist's susceptibility to vicarious trauma (Figley, 1995b; Kassam-Adams, 1995; Pearlman & Mac Ian, 1995). However, Schauben and Frazier's (1995) research disputes the role of prior trauma in the development of vicarious traumatization. One possible explanation for the co-researchers' experience is provided by Brown and Gilligan (1991, as cited in Rabinor, 1995). They posit that most women are traumatized as a result of being female in a patriarchal society. If, as some of the vicarious trauma literature suggests, past trauma affects experience, these therapists' sense of having been affected by their professional contact may not be surprising. If Brown and Gilligan are correct, these women are likely to have been negatively affected by societal mandates for women. Given the experience of the counsellors who participated in this study, it appears that it would be wise to view all female therapists, not just those who have had an eating disorder, as potentially susceptible to being affected by their work with anorexic clients.

While heightened awareness of societal pressures on women might be expected in this type of work, one particularly interesting finding of this study is that the participants experienced changes in their personal relationships. In large part, their relationships were altered as a result of their heightened awareness to societal pressures on women to meet an unrealistic physical standard. Their interactions with their friends and lovers were

altered. They were selective about the people with whom they spent time. Some spoke of a deepening of relationships and a greater appreciation for women.

While the eating disorder literature does not mention alterations in therapists' relationships, perhaps because of its focus on countertransference, the issue is addressed in the literature about vicarious traumatization. However, the reasons suggested for altered relationships are not the same for trauma therapists as for these therapists who work with women with eating disorders. Pearlman and Saakvitne (1995a) observe that "an awareness of pervasive human cruelty can lead to emotional numbing which, in turn, blocks feelings of intimacy ... with others" (p. 291). Figley (1995b) lists "detachment, estrangement from others" (p. 12) as symptomatic of secondary traumatic stress disorder. Schauben and Frazier (1995) found that some counsellors who work with trauma victims felt more distrustful of men, which would likely have an impact on their relationships. McCann and Pearlman (1990) observe that trauma work can disrupt a therapist's sense of trust in others. They also note that the confidentiality requirements of this work can interfere with intimate connections with people outside of the workplace and "may grow into a deep sense of alienation" (p. 141). Unlike trauma therapists, some of these women experienced an added richness in their relationships, as well as some challenges. Often these both of experiences had the same origin, an unwillingness to discuss issues such as weight, exercise, and diet. Sometimes this meant that conversations with those around them took place on a deeper level. On other occasions, these women's reluctance to engage in such conversations was a source of tension in relationships.

Consistent with the eating disorder literature, therapeutic work with women who are starving themselves was often experienced as challenging for the participants (Bloom

& Kogel, 1994; Piran & Jasper, 1993; Wooley, 1991; Vanderycken, 1993). There were times when they worked very hard and saw little movement in their clients. Sometimes they felt rejected by their clients. One woman described her work as "exhausting." Sometimes participants experienced powerful emotions in reaction to their work. There were times when they felt angry and upset about the terrible repercussions of anorexia nervosa on their clients' lives. The lengthy course of the illness was disheartening on occasion. These findings are not unlike those of authors who write about work with eating disordered clients. For example, Bloom and Kogel describe looking at anorexic women with "horror" (p. 62). Vanderycken writes about the frustration professionals sometimes experience when working with women with anorexia nervosa. Wooley notes that therapists can focus a great deal of energy on these clients with little evidence of results. The results of this study add to the current literature, which is primarily anecdotal and theoretical in nature. By detailing some of the therapeutic challenges experienced by these five women who work with clients who starve themselves, there is now some empirical evidence to substantiate theoretical discussions.

An important insight from this study is that these therapists who worked with anorexic clients were very aware of their need to find ways of managing the unique stressors and challenges of their work. Although the use of coping mechanisms by therapists has been explored in vicarious traumatization literature (Chrestman, 1995; McCann & Pearlman, 1990; Newman & Gamble, 1995; Williams & Sommer, 1995), it is not addressed in the eating disorder literature. It was not always easy for the participants to cope, and they sometimes struggled to find healthy ways of doing so. With this in mind, they examined both their personal and professional lives. They

modified their approaches to therapy, developing conceptual frameworks and intervention strategies, which they felt were effective for clients with eating disorders. They also were careful to tend to their private lives, and conscious of the need for self-care. This study affirms that work with eating disordered clients can be challenging for therapists. It adds to the current literature by describing these therapists' responses to such challenges. They responded by developing coping skills, which they applied both personally and professionally.

A significant finding of this study is that unlike the experience of vicarious traumatization, these therapists' experience was not exclusively negative. The contrast between these findings and the vicarious traumatization literature may be in part a result of the definition of vicarious traumatization. Pearlman and Saakvitne (1995a) define it as "a process in which the therapist's inner experience is negatively [italics added] transformed through empathetic engagement with clients' trauma material" (p. 279). Anecdotal literature indicates that therapists from a variety of specialties can receive personal benefits from their work (Cole, 1997; Hauer, 1997; Hill, 1997a; Pachter, 1997; Perlstein, 1997). The women in this study used their experience to grow and evolve as women. They became more aware of societal pressures on women, and thought deeply about how they should respond to them. Sometimes the self-denial embodied by anorexic women challenged these therapists to examine and alter their own behaviour. One woman became aware of her own tendency to deny her needs. She states that as a result, she is "more gentle on" herself, and gives herself permission to have needs. Some women reflected on their personal characteristics, such as a propensity towards perfectionism, and strove to accept themselves as imperfect human beings. These women

used their insights as opportunities for change and personal growth, which added to their lives, both interpersonally and intrapersonally.

Implications for Counselling

The results of this study provide some insight into the experience of female therapists who work with women who starve themselves. These findings may be particularly useful in the area of career planning and counselling. In addition, there are applications for the design of a supportive organizational environment for therapists who work with clients who have eating disorders.

An important contribution of this study is the recognition that female therapists may experience changes in their lives, which they attribute to their work with anorexic women. In some cases, these occurred in spite of extensive professional experience with other kinds of clients. Most of the therapists interviewed for this study reported that they felt less affected by their work over time. They were able to incorporate their heightened awareness into their lives, and they also developed some coping strategies to help them manage the challenges of their work.

Newcomers to therapeutic work with women who starve themselves may be well served by learning that it is normal to have reactions to this work. In particular, it might be helpful to discuss the experience of heightened awareness and its sequelae. As is the case with trauma therapists, women who enter into the eating disorder field may not do so "with a full understanding of the implications of their choice" (Pearlman & Saakvitne, 1995a, p. 279). Therapists new to the area would likely benefit from supervision in which they can safely explore their experience, with the knowledge that it is normal to have reactions to their work, and that they will not be judged (Newman & Gamble,

1995). Such therapists would also likely benefit from the support of their colleagues, as they learn about their work and incorporate their heightened awareness into their cognitive frameworks and personal lives. Experienced colleagues might be able to normalize the experience of therapists new to this work, and provide strategies they might use to cope with the particular stresses of this type of work.

The women in this study had experience working with anorexic clients in several different organizational settings. Some of these were described as supportive, others less so. There are a number of measures an organization might take to provide a supportive environment for therapists working with women with eating disorders. For example, organizations should strive to acknowledge and validate the experience of doing therapy with women who are starving themselves. Therapists should not feel that they are seen as less professional or less effective if they find themselves having personal reactions to their work. Participants observed that women with anorexia nervosa have many needs, and therapists can feel drained by this work. In an organizational atmosphere, therapists should feel free to share their feelings and coping strategies with each other. Regular team meetings might be a place where therapists discuss their feelings and experiences, as well as therapeutic challenges. Ongoing educational opportunities could be supported through the provision of funding and time. Education can help therapists develop a sense of efficacy in their work with clients, by enhancing their skills and knowledge. Many of these suggestions are similar to those in the vicarious trauma literature (Crothers, 1995; McCann & Pearlman, 1990; Newman & Gamble, 1995). Crothers also suggests allowing staff to take time off of work when "feeling overwhelmed," in the form of sick time or "mental health days," (p. 12) if provided for within the organizational structure.

Therapists who work independently are faced with the possibility of being isolated from their peers. This means, in the words of one co-researcher, that there might not be anybody to "case conference with, to debrief with." Under these circumstances therapists may be well advised to seek out supervision. One participant who was in private practice described supervision as "essential." In addition, such therapists may benefit from attending rounds or team meetings in organizational settings, particularly if there is a shared client base. Some participants who worked in a team setting received a great deal of support from their co-workers. Therapists in private practice might be encouraged "to tap into potential sources of support in one's professional network" (McCann & Pearlman, 1990, p. 145). One way of doing this is by developing support groups composed of therapists who do similar work. The vicarious traumatization literature provides some suggestions for the development of a safe atmosphere within which therapists can discuss issues and feelings (Catherall, 1995).

Many of the women in this study modified their practice to help them cope with the challenges they experienced. Some decreased time spent in direct contact with clients, taking on other tasks. One was trying to expand her client base to include individuals with other issues and concerns. Any therapist doing this work would likely benefit from diversifying her practice. It might be advisable for counsellors to work with clients who present with other issues, in addition to clients with eating disorders. It may be helpful for therapists to vary their activities within their practice, mixing in programme planning, public education, administrative duties and research, for example. Therapists may also benefit from engaging in educational activities, which serve to develop skills and knowledge, and also provide opportunities to interact with others in the

field (Chrestman, 1995). The therapists interviewed did not discuss educational activities directly, but appeared to discuss the same when they referred to the various therapeutic strategies they had developed over time. Part time work may be helpful for some women.

As observed by the participants in this study, therapists appear to benefit from having rich and diverse personal lives. They spoke of the importance of having strong support networks. It appears that it was often helpful for these women to shift their focus away from their heightened awareness to pursue other interests, for example, education or spirituality. One co-researcher was conscious of engaging in the sensual aspects of life, in dramatic contrast to the negative bodily experiences of her clients. Counsellors might be encouraged to develop a social circle that includes friends who do not work in the field of eating disorders. Involvement in a number of different social, creative and physical pursuits may help manage stress, affirm the richness of life, and connect therapists with the joys of the body. Pearlman (1995), a trauma therapist, observes that such recreational "activities balance ... some aspect of the helper/listener/nurturer roles we play in our work as trauma therapists" (p. 54). It is likely that the same would be the case for therapists who work with women with eating disorders.

I will conclude this section by suggesting that the ideas presented in the previous paragraphs may be of use to career counsellors working with counsellor/clients who are interested in, or working in, the area of eating disorders. An awareness of the impact of counselling women with anorexia nervosa may enable career counsellors to help their clients develop realistic career plans. Career counsellors could encourage therapists to examine the nature of the work environment. Are people encouraged to discuss their

feelings in a safe environment? Is supervision provided? If therapists are contemplating private practice, the issue of paying for supervision may be worthy of discussion. As well, the allocation of time spent working directly with clients who are starving themselves, versus time spent with other clients, or doing other tasks, could be examined. Career counsellors could also explore counsellor/clients' coping skills and the resources present in their private lives. Finally, it should be acknowledged that not everyone is suited to this work. In the words of one participant, "It might not be for you ... and that doesn't mean that there's something wrong with you, it doesn't mean that you're not good enough, it just might not be a good match. This field is not for everybody."

Recommendations for Future Research

The findings of this research are the result of an exploratory study in which five female therapists who work with women who are starving themselves spoke about their experience. In order to learn more about therapists' experience of this type of work, it would be helpful to interview a larger number of women. By interviewing more women, themes could be refined, or perhaps new themes would emerge. Factors that distinguish one woman's experience from another's could also be identified, such as age, length of time doing such work, personal experience with an eating disorder. As only two of the five therapists interviewed had specific training and knowledge in the area of eating disorders prior to beginning their work, it was not possible to draw conclusions about the impact of this on therapists' experience. A study of a larger group of women may provide information about this.

All of the women who participated in this study were Caucasian and born and raised in Western countries. As it happened that all of the women in this study were from

similar backgrounds, it was not possible to determine the role of race and culture in the experience of these therapists. There is some evidence that women of different racial and ethnic backgrounds do not experience their bodies in the same way as Caucasian women (Cash & Henry, 1995). A study that included counsellors from diverse backgrounds would help to discern if, or how, racial and ethnic background affects their experience of working with women who are starving themselves.

Based on the vicarious trauma literature, another variable that might affect a therapist's experience, is a past history of an eating disorder. As none of the participants reported such a history, I was unable to draw even tentative conclusions about the possible distinctions between the experience of therapists who have struggled with their own eating disorder, and those who have not. By interviewing women who have had an eating disorder, it may be possible to discern the role of such a history in the experience of female therapists.

The counsellors in this study made reference to having had different reactions to their work over time. Most felt that as time passed, their reactions decreased in intensity and that they developed more effective coping mechanisms. The therapist with the least amount of experience was planning to leave the field. A longitudinal study of therapists might uncover different aspects of women's experience over time and about the process therapists go through to develop ways of coping with their work. As well, it might provide insight about who chooses to stay in the field and who chooses to leave it to work with other clients.

Throughout this study I have focussed on the experience of working with women who are starving themselves, for reasons previously detailed. The experience of female

therapists working with women who binge eat, and thus represent the antithesis of the cultural ideal of slenderness, might be quite different from the experience of counsellors working with women who embody the ideal of slenderness. A study that explored the experience of such therapists could provide insights into the differences and similarities between women's experience of working with these two types of clients.

Finally, this study has focussed on the experience of female therapists. Co-researchers often spoke about reflecting on their own femininity, as they were faced with clients who were struggling intensely with the experience of being a woman in this society. In Wooley's (1991) discussion of countertransference in the treatment of women with eating disorders, she observes that male therapists often have different countertransference reactions than female therapists. Given men's different position in our society, an exploration of the experience male counsellor might help to determine the impact of gender on counsellors' experience of therapeutic work with women who starve themselves.

Limitations of the Study

Phenomenological research is limited by virtue of it not being representative of the population as a whole. Therefore, the results are not generalizable, although they may resonate with the experience of others. Although all of the participants were women, this does not imply that their experience is representative of all women in similar circumstances, nor does it imply that men's experience of this work might not be similar.

There were some limitations based on the methods selected to recruit volunteers. Undoubtedly, not all therapists who do this work in the Greater Vancouver Area were informed of the study. I interviewed the first five respondents who were suitable and

willing. As such, this study likely does not represent a cross section of female therapists who work with women with eating disorders in this locale. Given that the participants were volunteers, it is likely they chose to participate in the study because they found this work challenging. Those who had not been affected by their work with women who starve themselves were unlikely to volunteer to participate in such a study. As well, the recruitment notice (Appendix A) and letter (Appendix B) invited therapists to participate in the study for the purpose of discussing how they experienced and were affected by their work, thus limiting respondents to those who experienced their work as having an impact on their lives. This study was also limited by the geographical location of the participants. They were all from the Greater Vancouver Area. As well, as I do not speak a second language, only women reasonably fluent in English were interviewed. In addition, the results are limited by both my ability to interview, to establish trust, and to listen, and by my co-researchers' ability to articulate their experience. It was my hope, however, that my skills as an interviewer, as well as my co-researchers' interest in, and knowledge of, psychological matters would lead to rich material. Last, the quality of the analysis is limited by my ability to develop insight and engage in the phenomenological process with the information gathered through the interview process.

Conclusion

I would like to conclude this study by discussing my personal experience of doing this research. It represents an endpoint in a journey in which I unwittingly engaged several years ago, when I agreed to work as a nurse in an eating disorder programme. Although I was interested in the area, much of my motivation for accepting the job was to

avoid working night shifts. Little did I know that this decision would parlay itself into my Master's thesis.

Although I have not worked with women with anorexia nervosa for over three years now, I continue to be aware of the impact on my life of having done so. I have found it extremely validating to talk with other women about their experiences. It has been heartening to discover that I am not alone in the feeling that my world view has shifted as a result of doing this work. While I did not anticipate the specific themes that emerged, they make a great deal of sense to me.

Working on this project has been, much like my direct work with women who are starving themselves, an exercise in self-reflection. It has been fascinating and exhausting at the same time. My sense of heightened awareness has intensified at different times during this process, most notably during the data analysis. Sometimes I have felt quite overwhelmed by the complexity of my feelings about my body, my femininity, and our society. After such an intense experience, I feel that now I need to shift my focus away from these issues for the time being. Perhaps this is similar to the experience of the women I interviewed, who sought to create time in their lives when they were not focussed on the world of anorexia nervosa. However, I am grateful for the opportunity provided to me both by the clients with whom I worked and the therapists I interviewed.

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ConsentConfidentiality:

I agree to allow the audio tapes to be transcribed for the purpose of data analysis. I am aware that the information I provide will be analyzed for the purpose of identifying themes. Transcripts without any identifying information may be seen by other researchers. I understand that portions of my interview may be included in the final write-up of the study. I will be identified by the pseudonym I have chosen. Any identifying information about my clients will also be kept confidential. Transcriptions and audio tapes will be kept in a locked office at U.B.C. All information will remain anonymous and confidential except in cases where there is apparent risk of harm to myself or another person, in which case the researcher is legally and ethically bound to take appropriate action. After the study has been completed, the audio tapes will be destroyed.

I understand that my participation in this study is entirely voluntary and that I may refuse to participate, or withdraw from the study at any time.

I have received a copy of this consent for my personal records.

I, _____, agree to voluntarily participate in the study described above.

Participant's Signature: _____

Date: _____

Researcher's
Signature: _____

APPENDIX D

Orienting Statement

The following statement will be read by the researcher to all participants at the beginning of the first interview:

Very little research has been done into how therapists are affected by the work that they do. I am interested in how your work with women with anorexia nervosa has affected you personally, as a counsellor and as a woman. **The main question I am asking you is: What is your experience of counselling female clients who starve themselves/have anorexia nervosa?**

Please feel free to take as much time as you need to reflect on and answer this question. It may be helpful to think of both your professional and personal experiences, or an event which we can explore in detail. Or, you may wish to discuss your experience as if it were a story, with a beginning, middle and end, to describe how this work has affected you over the course of time.

During the interview I may ask you for more information or clarification about something that you have said in order that I understand your experience. You are not obligated to answer or discuss anything with which you feel uncomfortable.

Do you have any questions before we begin?

APPENDIX E

Interview Questions

General Research Question:

What is the experience for women therapists of working with female clients who are starving themselves?

Interview Question:

What is your experience of counselling female clients who starve themselves/have anorexia nervosa?

Additional Interview Questions:

- 1) Do you think your life has been affected by your work with women who starve themselves? How? In what ways?
- 2) In what ways do you think your work with anorexic women has changed your perceptions of yourself as a woman? as a counsellor?
- 3) Do you think that male counsellors who work with anorexic women would be affected in the same way as you were/are? Why or why not?
- 4) What if any effect has your work with anorexic women had on your relationships with other women? With men?
- 5) If you were to come up with a metaphor to describe the way you have been affected by working with this client population, what would that metaphor be?
- 6) If you were talking to another counsellor who was about to beginning working with this client population, what advice might you give her?