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"If I See Somebody Therapist or Anything, I'll Immediately Scope Them Out": Anorexia Nervosa Clients' Perceptions of Their Therapist's Body

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Abstract

Although people with an eating disorder are known to observe and assess body related stimuli, research has yet to explore these behaviors in the therapy room. Consequently, practitioners do not know if their body is having an impact on their client or the therapy process. This lack of knowledge is problematic given the poor recovery rates and high levels of drop out in eating disorders treatment. Using semi-structured interviews this study investigated the beliefs and experiences of 11 women diagnosed with anorexia nervosa or bulimia nervosa with a history of restricting who had received counseling from a female therapist. Results derived from a thematic analysis suggested that the women not only observed, speculated and made assumptions about their therapist's body but also that their assumptions and speculations had the potential to influence both their beliefs about the therapist's ability to help them, and their willingness to engage in therapy.

Keywords: eating disorders, information processing, qualitative, therapist appearance, therapist eating, treatment resistance

“If I See Somebody Therapist or Anything, I'll Immediately Sort of Scope Them Out”: Anorexia Nervosa Clients' Perceptions of Their Therapist's Body

When a body meets a body, no formal introductions are made ... As therapists, we focus on words but our bodies also speak Yet most accounts of therapeutic process mention very little of what the bodies mean to each other (Petrucci, 2008, p.237).

Although people with an eating disorder (ED) are known to observe and assess body related stimuli (Lowell & Meader, 2005), and some therapists working with ED clients have reported feeling that their appearance was being “monitored, examined or evaluated” (Warren, Crowley, Olivardia & Schoen, 2009), very little is actually known about ED clients' thoughts regarding a female therapist's body size and relationship with food. This is problematic for two reasons. Firstly, the limited empirical and theoretical evidence that is available suggests that a therapist's body may be an important factor in work with ED clients (Orbach, 2003, 2004; Petrucci, 2008; Vocks, Legenbauer & Peters, 2007; Warren et al., 2009). Secondly, practitioners currently have little guidance regarding the ways in which their body might be perceived by their clients and the possible impact their clients' perceptions might have upon the therapy process.

This lack of knowledge is also troublesome in light of evidence suggesting that client expectations and preferences might influence their willingness to engage in, and be influenced by, their therapist and the therapy process (Arnkoff, Glass & Shapiro, 2002). Without knowing what clients actually think, it is difficult to know if the poor ED recovery rates (Berkman, Lohr & Bulik, 2007; Fichter, Quadflieg & Hedlund, 2006; Löwe et al., 2001; Steinhausen, 2002, 2009) are related in any way to clients' preferences and expectations regarding their therapist's body going unmet.

Given that a fundamental part of ED sufferers' intra- and interpersonal experience is that of feeling invisible, unheard and worthless (Reindl, 2001; Shelley, 1997), it is important to give voice to their views. Consequently, the current study was designed to redress the lack

of research and knowledge in this crucial area by exploring female ED clients' beliefs about a female therapist's body size and relationship with food.

Method

Participants

In order to enable the identification, analysis and reporting of patterns (themes), similarities and differences within the data, whilst simultaneously being able to give voice to each interviewee, Braun and Clarke's (2013) recommendations for sample size were followed. Accordingly, participants were 11 women from the UK diagnosed with either anorexia nervosa (AN), or bulimia nervosa (BN) with a history of restricting, who saw themselves as either recovered or 'on the road to recovery' and had received counseling for their ED from a female therapist. Participants ranged in age from 18 to 50 years (mean 31.5 years) and the duration of their ED ranged from 2 to 28 years (mean 13.3 years). When asked how recovered they saw themselves on a scale from 0 to 100% their responses ranged from 40 to 100% (see Table 1). All interviewees had received some form of treatment for their ED from the UK National Health Service and all had at least one experience of working with a female therapist. The study was advertised through 'beat' (a UK nationwide charity providing information, help and support for those affected by EDs), and through regional counselling services and support groups in the South-West of England. Ethical approval was received from the UWE Health and Life Sciences Faculty Research Ethics Committee.

[Insert Table 1 about here]

Data Collection

A semi-structured interview format was utilized and interview questions focused on female therapists' body weight and shape, and relationship with food. Interviews were audio-recorded and lasted between 59 and 103 minutes. The first author conducted all interviews and transcribed them for analysis.

Data Analysis

A thematic analysis utilizing Braun and Clarke's (2006) six-phase approach was conducted. In short this involved: familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report. The first author led the analysis and the second and third authors reviewed each phase of the analysis with the first author in order to finalize the developing codes and themes. Accordingly, the three authors worked together to maintain the quality and rigor (Morrow, 2005) of the analysis, and to develop the final three overarching themes.

Results

The three themes were: "Wearing eating disorder glasses," "You're making all sorts of assumptions as a client," and "Appearance matters." Taken together, the three themes highlight not only the women's tendency to observe, speculate and make assumptions about a therapist's body and relationship with food, but also the fact that their assumptions and speculations had the potential to influence both their beliefs about the therapist's ability to help them, and their willingness to engage in the therapeutic endeavor. Extracts from the interview transcripts are used to demonstrate the interpretative adequacy of the analysis and give voice to the interviewees (Morrow, 2005); words that have been added to clarify a quotation are in square parentheses and words that were stressed by interviews have been underlined. Although the study was primarily designed to explore ED clients' beliefs about an ED therapist's body and relationship with food, the interviewees also spoke about their beliefs in relation to other ED health professionals (e.g., psychiatrists, community psychiatric nurses (CPNs), dieticians, inpatient nursing staff). Consequently, the term 'therapist' is used for both ED therapists in particular, and when reference is being made to ED health professionals in general; when an interviewee referred to a specific health professional other than an ED therapist, the precise title they used for that person's role is given (e.g., dietician).

"Wearing Eating Disorder Glasses:" The Women's Observational Tendencies

This theme describes the way in which the women's observational tendencies seemed to be shaped by what Megan described as "eating disorder glasses." In particular, these glasses seemed to prime the women to automatically notice body-related stimuli – something that, in general, they seemed to be both aware, and accepting, of. As Sophie explained: "If I see somebody therapist or anything, I'll immediately sort of scope them out." Indeed Katie described the way in which speculating about a therapist's body shape and weight before seeing them for the first time was the "biggest thing" she and her friends (with an ED) talked about. The women's narratives suggested that they observed not only their therapist's weight and shape in general, but also specific parts of their therapist's body (e.g., her stomach and thighs). As Claire said: "I noticed she's [therapist] got a slightly rounded stomach when she sits down."

The women's narratives also suggested that they were aware of having an almost uncontrollable tendency to compare their bodies with the bodies of those around them. Indeed Hayley actually presented it as a normative part of having an ED – so natural that she felt it was "obvious" that a client with an ED would compare themselves to their therapist.

Similarly, the women also seemed to be aware that their perceptions of body size could be skewed or distorted and they seemed to accept this as a normative part of an ED. Sarah, for example, described how: "People with eating disorders don't see size, they see themselves as bigger and everyone else as thinner, so they don't actually see what's really there." For example, Sam, who saw herself as fully recovered, spoke of the way in which she had viewed her therapist during her ED treatment: "I can't picture her now as she was then because I probably saw her as thinner than she was, and myself larger than I was."

"You're Making All Sorts of Assumptions as a Client:" The Women's Assumptions about ED Therapists

This theme illustrates the women's tendency to speculate and make assumptions about their therapist based on the (sometimes distorted) observations they made of her. The essence

of the theme is encapsulated by Hayley's assertion that: "You're making all sorts of assumptions as a client about what's going on in terms of a-any-thing that's physically obvious [about your therapist]."

The women's assumptions about a therapist's body size clearly drew upon their understandings of the meanings and causes of both fatness and thinness. In particular, therapists who were perceived to be fat (this was generally seen as anything above a UK dress size 14/US dress size 10) were assumed to eat too much and to have "lost control" (Nina). The women also seemed to feel that fatness was intolerable and that fat therapists should "go on a diet"; as Sarah stated: "It's easy, how can you get overweight? You just throw your food up."

In contrast to the singular belief that fatness was both bad and the result of excessive eating, thinness was seen as positive and either "natural" and "biological", or as something that was achieved through food restriction. Although the women agreed about the existence of these two – competing – explanations for thinness, they disagreed about whether or not you "could tell" which explanation was true for any one therapist. While Amy felt that you "know intuitively" whether thinness is natural, others believed it could be "quite hard to tell" (Susie) or that "you wouldn't know" (Claire). The women's thoughts about the naturalness of a therapist's thinness were influenced at times by the presence of additional visual information such as race. As Nina explained in relation to her consultant psychiatrist: "She's Asian so in my head I know that well that's just her make-up I probably weigh more than her and that hasn't bothered me because I've just thought 'well that's just obviously how she is'."

In addition to using their observations of a therapist to make assumptions about the causes of her thinness or fatness, the women also made deductions about her relationship with food. Thus they often assumed that a therapist working in a specialist ED setting would have an ED history. Sam, for example, recalled a fellow inpatient telling her that the ED therapists had chosen to work there because: "They've all got their own issues with food." Additionally,

the women seemed to correlate body size with particular personality characteristics and relationships with food. Claire, for example, spoke about her thin dietician looking like “somebody who was very rigid and controlling about what she ate”; while Lucy decided that her “reserved” therapist had a similarly reserved relationship with food which meant she was “very strict with herself, [a] very controlled person” when she ate.

Similarly, “healthy”-sized therapists (generally defined by the women as someone with a UK dress size 12–14/US dress size 8–10), who appeared comfortable with themselves, were generally seen as having “a good relationship with food” (Lucy). Although neither Claire nor Lucy questioned their assumptions about the parallels between their respective therapists’ size, personality characteristics and their relationships with food, Hayley – who saw herself as fully recovered – did. Reflecting on the way that, during treatment, she had believed her psychiatrist had issues because she had a draw full of oranges, Hayley said: “You project that people that are thin or appear to be the low end or underweight don’t eat very much.” Similarly, Nina said her assumption about her therapist having no problems with food was: “What I needed to see in her, whether that was true or not.”

The women’s perceptions of their therapist’s size also seemed to influence their beliefs about her ability to help and understand them. Despite very few of the women actually having worked with a therapist they viewed as fat, it was clear that they were all concerned about such a therapist’s ability to understand them. Furthermore, the women also seemed to view fat therapists as personally lacking, “somehow inferior” (Amy) and, for Megan, over-eating was: “A weakness and I probably, totally honestly, would look down on them slightly thinking ‘just control yourself’.” In contrast, although therapists who were viewed as thin were not generally seen as unable to understand or empathize, Hayley worried that a therapist: “Who was naturally very thin wouldn’t understand and they’d just assume it [an ED] was about trying to be very thin.”

A further factor which seemed to influence the women's beliefs about a therapist's ability to help them was their perceptions of the therapist's body confidence – something they gauged from her body language and self-presentation. As Nina explained: “If you pick up that they've got a sort of doubt about themselves then that makes you think they can't help you.” In contrast, when a therapist was seen as being confident in her own body, the women felt she was then “equipped to make you feel that way [too]” (Sophie).

“Appearance Matters:” The Possible Impact of an ED Therapist's Appearance

This theme describes how the women's assumptions and speculations had the potential to foster both resistance to, and engagement with, therapy and recovery. More specifically, resistance to therapy and recovery seemed to be increased by a therapist being thin or fat. A thin therapist's body was variously seen as something to aspire to, as a source of envy and jealousy, and as endorsing undereating. Additionally, the women said that if a thin therapist asked them to gain weight it would feel “unfair” and “wrong” (Amy) due to the double standard of the therapist being “allowed” to stay thin. Furthermore, it appeared that working with a thin therapist made the women view themselves more negatively, and it seemed that the women assumed a thin therapist would view them negatively too. Claire, for example, said that she would feel “ashamed” if she disclosed her bingeing to her thin dietician as she assumed she would be: “Just as condemning of my greed as I am or even more so.” And Lucy spoke of feeling “inferior” when talking to her thin therapist who she believed had a strict, controlled relationship with food. Thus it was clear that the women experienced a broad range of potentially therapy-interfering feelings when working with a thin therapist – from jealousy, envy and unfairness, to shame, condemnation and inferiority.

By contrast, the women were worried that if they worked with a fat therapist they would end up bigger themselves because fat therapists have: “Lost control so they're not gonna tell me when it's time to stop putting on weight” (Nina). Indeed, Amy's concerns were so strong that she felt her response to discovering that a therapist was fat would be to

manage the first session but never go back. A further issue raised in relation to fat therapists was that of their body being distracting. Megan, for example, said she had been so “hung up” by a fat psychiatric nurse who had co-run an ED group she was a member of that it had “got in the way” for her and prevented her from focusing.

In relation to a therapist's size, it appeared that the women saw the prospect of being asked to gain weight and eat ‘normal’ foods as more palatable if it came from a “healthy” sized therapist. They also seemed able to use a “normal” or “healthy” sized therapist as a kind of benchmark against which they could assess certain kinds of eating behaviors. Hayley, for example, felt that her “normal”, “healthy” sized therapist's disclosure about eating take-out once a week helped her to feel “okay” about the idea of eating take-out herself. “Normal” or “healthy” sized therapists who appeared comfortable with their own body were also seen by the women as modelling the way they could be if they recovered. An idea described by Claire as: “Not about learning from somebody else but you want to be able to take on a bit of what they have or instil a kind of sense of trust and a norma-, a sense of normality about food and eating.”

Finally, two women reported instances of their therapist eating in a session. Whereas Amy felt her therapist was testing her, Nina felt both jealous of her consultant psychiatrist (Nina believed that being able to eat in a session must mean that eating was not an issue) and a sense that her consultant psychiatrist was not concentrating on her (Nina simultaneously could not believe that eating was not an issue that required concentration). For Amy the anger was so great that she decided: “I just can't be doing with this.” Neither Amy nor Nina reported being invited to discuss their therapist's in-session eating.

Discussion

The results of this study describe a hitherto unexplored feature of ED treatment; namely, ED clients' tendency to observe and make assumptions about their therapist's body. The findings also highlight the possible impact of ED clients' observations and assumptions

on their beliefs about their therapist's ability to help them, and their willingness to engage in therapy. The fact that a therapist's body could have a negative impact upon a client's willingness to engage in therapy is noteworthy given the poor recovery statistics (Berkman et al., 2007; Fichter et al., 2006; Löwe et al., 2001; Steinhausen, 2002, 2009) and high drop-out rates from psychological therapy (Mahon, 2000; Wallier et al., 2009) in the ED field, and the ambivalence towards recovery (Williams & Reid, 2010) of people with AN in particular.

Consequently, it seems important that therapists working with ED clients think about how their body might be perceived, what messages it might be sending and the ways in which their clients might be interpreting their body size and speculating about their relationship with food. In doing so, practitioners will need to reflect on their own feelings about their bodies.

The main limitation that should be noted when interpreting the results of this study is the fact that very few of the women had actually worked with a fat therapist. Consequently, their responses were primarily based on their ideas about how they would feel if they were to do so and not on their experiences of having done so. A further limitation of the study was the relatively limited sample size which precludes generalization. In order to address these limitations future research could look at larger sample sizes and investigate the beliefs and experiences of clients who have actually worked with a fat therapist. Future research could also explore the beliefs and experiences of other samples. For example, the views of men with AN could be explored as it has been suggested that men face different issues in relation to EDs and that all-male treatment environments can be beneficial (e.g., Strother, Lemberg, Stanford & Turberville, 2012; Weltzin et al., 2012). Similarly, the views of non-heterosexual women with AN could be explored as it has been suggested that lesbians have higher levels of body esteem and are less concerned with dieting and 'thinness' than heterosexual women (e.g., Share & Mintz, 2002; Wagenbach, 2004).

Ultimately, it seems that appearance really does matter when working with ED clients. Accordingly, it appears important that practitioners in the field be both aware of this and reflect on the ways in which their bodies might be perceived and interpreted by their clients.

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Table 1

Age, Illness and Recovery Details for Interviewees

Name	Age (yrs)	Age at onset of ED (years)	Duration of ED (years)	Self-reported recovery (%)
Katie	26	11	15	no data
Sarah	32	16	16	<50
Alice	50	22	28	60
Megan	41	14	27	60
Sophie	19	13	6	60
Claire	33	12	21	50-80
Nina	34	30	4	70
Sam	18	12.5	5.5	95
Amy	42	19	16	95
Hayley	25	10	12	100
Lucy	25	16	2	100