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*Chapter 9*

# THE ART OF SUPERVISION IN THE TREATMENT OF EATING DISORDERS

***Edith Mitrany*** [***]
Training and supervising psychoanalyst, Israel Psychoanalytical Society and International Psychoanalytic Association
Formerly Head of the Department of Child and Adolescent Psychosomatic Medicine and Department of Eating Disorders, Sheba Medical Center, Tel Hashomer, Israel

## Abstract

In eating disorders as in other psychopathologies, the twofold purpose of supervision is to provide learning for the supervisee and to optimize the service for the patient. This chapter addresses supervision in the treatment of eating disorders from two vantage points: case management and psychotherapy proper. With regard to case management, issues of hierarchy and leadership may influence the cohesiveness of the team and its therapeutic effectiveness and in this respect a structured eating disorders program has an advantage over an ad-hoc operation of private caregivers.

With regard to psychotherapy, although cognizant and respectful of alternative and even more ubiquitous models of psychotherapy, the author has chosen to address the supervision of psychodynamic psychotherapy, congruent with her own orientation. The contemporary supervisory stance has parted from the previous purely didactic approach and recognizes the centrality of counter-transference. Unmotivated for change and difficult to treat, patients with eating disorders arouse in the therapist strong counter-transference reactions which reverberate in supervision: both therapists and supervisors are prone to experiencing frustration, anger, loss of value and confidence in their professional effectiveness. Traditional psychoanalytic devotion to the process, while delegating secondary attention to the symptoms is not realistic in eating disorders, notorious for their mortality risk. Artful navigation between activism and neutrality is one of the many challenges for both the therapist and the supervisor engaged in the endeavor.

**Keywords:** eating disorders, psychoanalytic psychotherapy, psychodynamic psychotherapy, supervision, counter-transference

[***] E-mail address: edmitran@netvision.net.il

## INTRODUCTION

The treatment of eating disorders is composed of a number of simultaneous multidisciplinary interventions, undertaken on a secondary or tertiary care level.

Eating disorders are potentially severe, life threatening mental and physiological conditions. Anorexia nervosa (AN) alone has a high mortality risk (1, 2) including suicide, which is a common cause of death among these patients (3).

The front line intervention is therefore geared toward physiological stabilization, restoration of weight, normalization of alimentation and of aberrant eating habits and removal (or at least reduction) of the obsession with food and weight. The current core multimodal treatment protocol includes medical, pharmacological and dietetic management, rehabilitation and psychotherapy. The latter might be individual, family, or group therapy, long term psychodynamic, or short term crisis intervention, psycho-educational, supportive, cognitive-behavior therapy (CBT), interpersonal (IP), expressive-art therapies, etc. Each of these psychotherapies has its own merits provided they all abide by the basic principles of team collaboration and ongoing medical supervision. Treating anorexia single handedly is not a conceivable option (4).

The Merriam-Webster Dictionary (5) defines supervision as an act of overseeing, "a critical watching and directing of activities or a course of action" According to the Roget's Thesaurus (6) supervision is a synonym to (partial list): overseeing, surveillance, to inspect, scrutinize, contemplate, examine, to have control over, to manage, to direct, to conduct.

## SUPERVISION

The following text will address two aspects pertaining to the supervision of treatment: case management and its supervision on one hand, and psychotherapy supervision on the other hand, with special emphasis on the unique dilemmas confronting the therapist vis-à-vis a patient suffering from an eating disorder

### Team Work and Case Supervision

Less severe cases of eating disorders are usually treated in the community, in private or public care, while patients with more severe eating disorders are hospitalized. The optimal care is usually provided by specialized eating disorders programs. At all levels of intervention, professionals working as a team is preferable to a number of professionals working in parallel (7, 8, 9).

Eating disorders programs, in hospital or outpatient settings, are hierarchically structured and consist of a department head and representatives of the different disciplines present (medicine, nursing, nutrition, psychotherapy, education, etc.) organized in one or several teams each led by senior professionals who function as case managers and treatment supervisors.

Team work is not an improvised, ad hoc partnership of several professionals working in tandem in pursuit of a common task but rather a group activity with its own particular

dynamics and interactions. According to Yank (10) if properly invested, it will operate efficiently.

> "The crucial property of teamness"--the key set of intangible phenomena that allow a team to function synergistically as more than the sum of its parts, and with a sense of team identity… Leadership activities promote team cohesiveness and boundary maintenance"(p.250) ".

Butterill (11) calls attention to possible team dysfunction caused by

> "…poorly defined accountability, a lack of leadership, communication breakdowns, and boundary violations. Suggested interventions are education of team members about organizational theory, open discussion of contentious issues, and reinforcement of boundaries…."(p.370)

Team leadership in institutional programs is a pre-assigned function, emerging from a hierarchic system. Heads of department or chief psychologists are appointed, not democratically elected. The department head designs the treatment plan and delegates authority to the team leaders to oversee its implementation and coordinate the therapeutic activities, to supervise the management of the cases, their progress and vicissitudes.

There is a clear distinction between case management/supervision versus therapy supervision, whereas the former is service oriented and its purpose is to survey the diagnostic process and the accuracy and execution of the ensuing dispositions, the latter is focused on the psychotherapy process per se.

In ad-hoc settings, as opposed to structured eating disorder programs, the situation is quite different. Patients with eating disorders (or parents of an afflicted minor) who approach a private individual mental health professional will hopefully be advised to also see a dietician. Even in the fortunate but infrequent case where several basic disciplines (medicine, nutrition, psychiatry, psychology, social work) are actively collaborating, still, without a clear treatment algorithm, experience with previous shared cases and commonly agreed upon leadership, this format is not yet an eating disorders team. Individual care givers might initiate either sporadic consultation or regular supervision with a "specialist" in his, her own field, but this is an individual resource, outside the team. The mutual updating of treatment progress among the peer care givers – if there is any - has definite merits but still remains a default substitute for cohesive team work, case management and supervision as they are practiced in accredited eating disorders programs.

The following clinical case reflects underlying issues of hierarchy in leadership and interpersonal conflicts of such a "non-team" caregivers.

## Case vignette 1

Anna, 16 yrs of age, began psychotherapy and dietetic counseling following a severe weight loss diagnosed as AN-RestrictingType. At some point, a psychiatric intervention was requested by all parties involved (parents and therapists) on account of suicidal thoughts and obsessive-compulsive manifestations. All three therapists from different disciplines worked in private practice and had no previous collaboration. Their involvement in this case was parallel and not interactive. At one point, the psychiatrist heard from the patient's mother that the dietician suggested day hospitalization. Surprised by this unshared initiative, the psychiatrist

contacted the dietician who denied having made the recommendation. It was suggested that the family is manipulative and deceptive. The psychiatrist, a senior psychoanalyst himself, monitored medication while meeting with the patient every six weeks and exchanging by phone occasional update impressions with the psychologist and dietician. This psychiatrist experienced a certain frustration at carrying the bulk of the clinical responsibility while in effect filling only a marginal role vis-à-vis both patient and colleagues. This latent annoyance turned into overt vexation when, a few months later, the patient reported that she will be seeing a substitute psychologist for a while, since her therapist is about to take maternity leave. The surprised psychiatrist expressed disagreement with this recommendation and the same evening approached the psychotherapist to complain about the lack of communication and collaboration. "How is it possible that you have not informed me and consulted with me?" The reaction was: "it is your fault! You should have been more active in initiating collaboration between us and least of all share your disagreement with the patient." The psychiatrist protested that it was the therapist who took one-sided initiatives, that a 3 month (the length of the maternity leave) substitute new therapist might not be such a good idea, versus the more logical alternative of increasing the frequency of the visits with him, a known figure to the patient and an experienced therapist in his own right. The psychologist insinuated that both patient and parents would not feel comfortable with the psychiatrist as an alternative therapist. It was not said whether this was therapist's own inference or a de-facto communication by the patient. After a while, the patient declared herself sufficiently recovered and in no further need of professional help.

This is an example of a dysfunctional team, or in effect, a non-team, but rather a number of otherwise esteemed professionals who instead of collaborating, worked in parallel, competing for autonomy and leadership, and thus inadvertently collided along the way. In a "Solomonic Judgment" in reverse, the patient flew into health, relinquished both "parents" and regretfully dropped out of therapy while still in great need of treatment.

## Supervision of Psychotherapy[†††]

Of the plethora of practiced models in psychotherapy, this paper will address psychotherapy and its respective supervision from a psychoanalytic perspective, the author's area of expertise.

As psychotherapy itself, supervision of psychotherapy is a vast issue, informed by a great number of publications, subject of numerous theoretical and technical currents and controversies. (7) Addressing it in full would be way beyond the scope of this chapter.

A few salient points with regard to psychotherapy supervision per se will be briefly summarized, prior to shifting the focus to supervision in the treatment of eating disorders.

**In the pre-qualification stage**, supervision of psychotherapy involves trainees from various disciplines: psychiatric residents, clinical psychologists, clinical social workers, psychoanalytic candidates, etc. As a requirement of professional training, the supervision process is in many ways a close application of the above-mentioned Webster definition: the supervisee undergoes a learning experience through orientation and constructive criticism, and the patient benefits from "critical watching", both processes enabled by the supervisor. The task of supervision is to facilitate and develop learning. The supervisor can be

[†††] psychoanalytic psychotherapy and psychodynamic psychotherapy are used interchangeably

experienced as a reliable mentor, someone to identify with, but he also can be considered judging and controlling. (12)

The subjective experience of the supervisee during the training phase of his/her career varies according to a number of factors, all orbiting around the three dyads involved: therapist-patient, therapist- own therapist (assuming that the supervisee is still undergoing personal therapy), supervisor-therapist, and their respective matching personalities. Addressing the way supervisees evaluate their supervisors, Beinart (13) refers to the findings of D.R.Green (author of "Investigating the Core Skills of Clinical Supervision", unpublished D. Clin.Psych. dissertation, University of Leeds-1988):

> "using a qualitative research methodology Green found that special knowledge, credibility and integrity were terms used by trainees to describe influential supervisors." (p.42)

Some congruence of theoretical orientation between supervisor and supervisee is necessary for a good working alliance of the supervisor-supervisee dyad, although one may argue that exposure to diversity in theoretical paradigms enhances the learning process of the trainees.

The spectrum of the supervisory stance in psychoanalytic psychotherapy may vary from a didactic approach, at one end, which altogether avoids dealing with counter-transference, to an equally extreme position advanced by Balint (14) at the other end sustaining that the ideal supervisor would be the supervisee's therapist himself. The great diversification in psychoanalytic theory and practice has generated over the years a multitude of supervisory models in-between the two above mentioned poles.

**In the Post-qualification stage** a less motivated trainee might discontinue the supervision once his/her formal training requirements have been fulfilled, even though the case progress might still benefit from additional guidance.

At the opposite end, a dedicated therapist, although already formally qualified and even with years of experience, will unequivocally request supervisory assistance from a senior or peer and profit from it. Solnit (15) claimed that supervision, like psychoanalysis, is interminable.

In many institutional programs, supervision of psychodynamic therapy is mandatory even for qualified therapists

**Setting**: Psychodynamic therapy in eating disorders is often a complex proposition which in many respects cannot fully abide by the golden rules of practice. Public inpatient care has been increasingly shortened by heath policies, and unless there is a consecutive spectrum of daycare and outpatient service available, in many such settings the stay is too brief to allow for more than crisis intervention. If available and feasible, psychotherapy will better be supervised, for the benefit of all parties involved. According to Eckstein, R., and Wallerstein (16)

> "The supervisor is directly related to the student but has a quasi-indirect relationship to the patient. On one hand his responsibility is to teach psychotherapeutic skills to the student, but there is an additional responsibility in maintaining clinical standards and seeing that patients benefit from the service." (p.12)

One distinct characteristic of supervision of psychodynamic psychotherapy in an eating disorder program – assuming that this option is not definitively extinct- is the inability to

maintain the mutual anonymity of the supervisor-patient dyad as practiced in private psychotherapy. In most eating disorder centers the psychotherapy supervisors perform additional functions (psychiatric care, group therapy, etc) and often are otherwise involved with their supervisee's patients. However, there are settings that adhere to a more canonic stance and "import" the psychotherapy supervisors. Those are not members of the staff, hold no organizational functions and usually meet the supervisees in their own offices, away from the clinic.

**Team Interaction and Supervision:** Eating disorders programs traditionally hold group teaching activities in the format of case presentations either at the evaluation level (the so called "intake meeting") or as a treatment review. In addition, there are study groups either at peer level or led by a senior professional, local or imported, for the purpose of either consultation or continuous case supervision. This group of people, the "staff", by the mere virtue of working together will develop its own dynamics whether they sit in a circle in the meeting room or by themselves in their respective offices. Issues, to mention a few, such as achievement ambitions, competition, envy, exhibitionism, shame, passivity, control but also idealization and love, will emerge in the discussion, and are not exclusively related to the material presented. Patients with eating disorders present common characteristics such as chronicity, repeated relapses, lack of compliance, self destructive behaviors including suicide attempts which in the long run wear out the care givers. It will be incumbent on the supervisor to determine the demarcation line between group supervision and group therapy, a perennial challenge in all forms of psychotherapy supervision. A not uncommon occurrence is counter-transferential (supervisor vis-à-vis the group) causing the supervisor too to feel inadequate or ineffective, short of providing rescue solutions and subject to controversies as illustrated in the following case.

## Case Vignette 2

Sally, 42 years of age, suffered from chronic AN-Purging Type since age 15. At present she was in her second year of twice weekly psychotherapy with Dr M. Due to a severe relapse of the anorectic symptoms, Sally needed urgent hospitalization and the only available eating disorders facility for the adult population in this country was headed by Dr. M. During her hospital stay, Sally, like the rest of the patients, was treated by a multidisciplinary team. The psychotherapist assignment presented a dilemma: on one hand it seemed inappropriate for Sally to continue therapy with Dr. M. (whose policy, as head of the department, was to refrain from seeing patients in the ward on an individual basis) but, on the other hand it made little therapeutic sense to assign Sally to a new psychotherapist, for the short period of expected hospitalization.

After serious staff debates it was decided to make an exception in this case and allow Sally to continue her twice-a-week sessions with Dr. M. Unsurprisingly, this decision put Sally in a special position vis-à-vis other patients (envy, sibling rivalry on their side, a sense of entitlement, bullying and acting out, on hers). The "special position" transpired to some members of the staff, in particular individual therapists and nursing personnel, all under Dr. M's leadership. By virtue of projective identification with other patients, displacement of envy and rivalry with regard to her special relation with Dr. M. and splitting, Sally became the focus of intensive preoccupation and debate.

During the few months of her hospitalization Sally captured many staff meetings and group supervision during which Dr. M. found herself overtly or covertly attacked, and deep inside deploring almost everything: the imperative inpatient admission, this particular eating disorder service under her chairmanship being the sole available resource, not having had temporarily discontinued psychotherapy, or not having assigned Sally, while hospitalized, to another colleague. Dr M was conscious of confronting negative countertransference feelings not only toward Sally but also toward her own team, vis-à-vis whom she fulfilled a supervisory function.

As an epilogue to this dilemma it is of interest to note that after the discharge and upon renewing the psychotherapy with Dr. M. on a private basis, Sally although recovered from the set back in her nutritional status and eating behavior, became a very resistant patient who eventually entered a negative therapeutic reaction which led to an insoluble impasse and ultimately discontinuation of treatment. Sadly, Sally had a life long difficulty in retaining her "good objects". During the following years, Sally had several relapses which required hospitalization in the same eating disorder setting, although without dilemmas with regard to the identity of the therapist since Dr. M has in the mean time retired from the service.

## Supervision of Individual Psychotherapy of Patients with Eating Disorders

The overall effectiveness of the various forms of psychotherapy in eating disorders remains controversial, the dropout rate is high and randomized controlled trials are extremely rare (17). Compared with briefer and symptom-oriented modes of therapeutic intervention, long term psychoanalysis is currently a rather uncommon treatment recommendation for eating disorders. Its next-of-kin, psychoanalytic psychotherapy, less rigorous in practice although founded on the same principles of analytic listening and empathic, but neutral in its nondirective exploration remains a worthy option and can be greatly beneficial to many such patients (4).

Individual psychodynamic oriented psychotherapy and its parallel supervisory process are not essentially different in eating disorders as compared to other psychopathologies, but they do possess specificities worthy of investigation.

The paramount dilemma of a the psychotherapist-supervisor pair informed by a psychoanalytic orientation vis-à-vis a patient with an eating disorder is how to artfully navigate between therapeutic neutrality dictated by one's own theoretical frame of reference, and the activism imposed by the unique vital necessities of a biologically endangered patient. This compromise is facilitated by the axiomatic rule of never operating as a single handed caregiver, which means that in all eventualities, the medical and nutritive situation is being monitored by the collaborating team members. Although not forcefully totally abstaining from addressing the weight and eating issues, the therapist need not necessarily focus on these preoccupations.

Mitrany (4) stressed:

> "The more symptom-oriented the psychotherapy, the more reluctant the patient is to cooperate and become coerced into a project geared towards an unwanted quest for change. Precisely for that reason, non directive psychotherapy, addressed to subjective feelings and preoccupations rather than to symptoms per se, might be perceived by the patient, for whom one of the central conflicts lies in a precarious sense of autonomy, as less intrusive and threatening, and thus more acceptable**."** (p. 201)

Bechar (18) emphasizes the unique contribution of self-psychology to the treatment of eating disorders.

"Three main issues exemplify the opportunities and dilemmas that this new development in psychoanalytic theory brings to the fore in the treatment of eating disorders:

[1] Empathy with deeds and attitudes of the patient that the therapist finds difficult to empathize with;

[2] Empathic understanding "from within" from an experience-near stance vs. experience-distant interpretation "from without";

[3] Self, selfobject relations with food and as a result of progress in therapy, with human beings." (p 147)

In their comprehensive paper on "Supervising the therapy of patients with eating disorders" Hamburg and Herzog (7) address in detail characteristic features of this endeavor and the replication in the supervisor-supervisee couple of certain currents (splitting, boredom) present in the therapist-patient pair.

Among the themes reviewed one finds the exaggerated need for control as well as a basic fear of being intruded upon, which are characteristic of the anorectic/bulimic patient. A too strenuous effort on the part of the therapist to obtain early revelations of the patient's hidden secrets with respect to both eating behaviors (vomiting, use of laxatives) or past and present possibly shameful life events (stealing. sexual assault, infidelity etc.) could be intrusive and needs to be intercepted and interpreted by the supervisor. The reverse situation, in which the therapist totally ignores endangering patterns could reflect a form of collusion between patient and therapist vis-à-vis an authoritative object impersonated by the supervisor. This interaction illustrates the role responsiveness reaction as conceptualized by Sandler (19) and warrants an urgent intervention by the supervisor. As already mentioned above, characteristic to the work with these patients is compromising between therapeutic neutrality on one hand and proper attention to the symptom, on the other.

## COUNTERTRANSFERENCE

Among the issues emerging in all supervisory processes, perhaps the most salient is counter-transference. This concept gained a new dimension half a century ago owing to Searles (20), Eckstein and Wallerstein (16) who introduced the notion of a parallel process, meaning the interwoven interaction between patient, analyst, and supervisor.

Regarded from different perspectives, transference and counter-transference gained more attention and controversy than any other subject within the psychoanalytic domain. Until less than three decades ago counter-transference in supervision was avoided rather than accepted and utilized. For most supervisors the supervisee's counter-transference seemed to be a Pandora's Box they feared to open, out of concern that they may, from their position of authority, inappropriately intrude into the personality and inner life of the supervisee and turn supervision into psychotherapy. Over time, the initial trend of seeing these phenomena as pathological processes and impediments to therapy radically changed to considering transference and counter-transference normal components of all conscious and unconscious interactions. Wiener (21) wrote:

> "… although we may be in agreement that transference dynamics are alive and well in supervision, more difficult to assess is whether they are fostering or hindering the task of supervision." (p.53)

Far from claiming that counter-transference should be the sole subject matter of supervision, authors like Hunt (22) nevertheless relegated considerable weight to counter-transference emotions,

> "Supervision which lets in the counter-transference is the most helpful kind because it goes to the core of the therapist-patient relationship." "(p.370)

As applied to eating disorders, countertransference has been widely addressed (8,23,24 etc.), focusing on the impact -on both therapy and supervision –by typical phenomena on such as the tedious maintenance of boundaries, over identification or the opposite, frustration and exasperation with the patient.

The long and weary treatment of patients with eating disorders, described as unmotivated, unable to gain insight and enter transference inevitably reflects on counter-transference. The most common identified responses on the part of the therapist range from frustration and even a sense of failure at one end to narcissistic rage at the other, both endangering, with emotional depletion. Quoting Chessick (25)

> "any therapist who works with eating disorders must have ample independent sources of emotional supply and empathy in his personal life and must be free of the temptation to turn to his patients for gratification, soothing, or narcissistic massage."

The following clinical example will illustrate how these themes reverberate in the parallel process:

**Case Vignette 3**

Ruth a mother of three, in her mid-thirties, applied for evaluation on account of a protracted eating disorder (since the age of sixteen) with bulimic and purging symptoms. The referral was prompted by an intensification of the symptoms as a result of which Ruth became severely underweight and hypokalemic. The evaluation led to hospitalization in an eating disorders program, where Ruth became stabilized and relatively free of abnormal eating behaviors.

After discharge, Ruth continued follow up with a dietician who specialized in eating disorders and began psychotherapy with a psychiatrist. With the bulk of eating problems apparently behind her, Ruth became cognizant of her many other problems, which, even if present before, were apparently masked by her eating disorder symptoms. She was anxious and insomniac, obsessive/compulsive about her chores, felt insecure, unworthy but at the same time demanding and armed with a strong sense of entitlement towards the surrounding objects. On the surface, Ruth seemed very compliant with the therapy, she wanted so badly to be well and praised, but somehow she failed this intent. The therapist who had developed a protective attitude toward the patient, as if she were a weak, somewhat handicapped child in need of special care, failed to decode her numerous subtle contradictory messages and when alerted by the supervisor, reacted defensively. He perceived the patient as desperate, avoidant, tormented by vague traumatic memories. His supervisor on his side, suspected that this

patient had a false self and behind messages of helplessness she was manipulative and in quest for exercising control.

At some point Ruth admitted having abruptly discontinued the medication without the therapist's permission. The therapist's main concern at this point seemed to be about the risk of withdrawal symptoms rather than the significance of the rebellious act itself. Shortly after, the patient began taking short vacations which incurred missing therapy sessions. The therapist continued to seem oblivious to patient's resistance and downright acting out, and sounded (again) protective of his patient (or of himself) vis-à-vis the supervisor. Only some time later, when the patient made a very important independent decision with regard to her career (or rather lack of) which also involved a very close tutorship by a coach with therapeutic ambitions, the therapist had a sudden change of heart: he felt furious, betrayed by the patient who had "pledged" loyalty to a rival, and impulsively confronted the patient with an ultimatum: "either me or him!"

The supervisor made a counter-transference interpretation commenting that the rage was in fact directed toward him rather than toward the patient, by a therapist who felt ridiculed and humiliated due to his compassionate naivety, caught in between a manipulative and dissimulating patient and a critical, unempathic supervisor. While cognizant of a sadistic temptation to declare: "I told you so!" the supervisor was also quite inclined to discuss the situation and even assume responsibility for forcing the therapist into a defensive identification with the so called attacked patient. This enactment could be seen as a manifestation of a projective counter-identification (26): the supervisor envied and reduplicated the supervisee’s ability for compassion, a capacity he apparently felt somewhat lacking in himself. In addition, due to a mechanism of splitting, the therapist and supervisor identified each with a different aspect of the patient's psyche: the therapist with the helplessness, the supervisor with the quest for control.

Indeed, one particular expression of countertransference is the mechanism of projective identification [Klein (27) Segal (28), Sandler (29), J, Ogden (30) and many others].

Waska (31) summarizes: " Projective identification is a dynamic mental mechanism that naturally engages the therapist's countertransference and attempts to make use of the therapist as a translator, toxic dump, or special reservoir for the unwanted, confusing, or threatened parts of the self " (p. 160)

Gabbard (32) compares projective identification with countertransference enactment (putting an experience into behavior).

Regarded from a contemporary intersubjective perspective, Berman (34) considers the supervision experience as a form of transitional space, within which contents of therapy and supervision overlap and create a fertile therapeutic triad,

> "A crossroads of a matrix of object relations of at least three persons each brings her or his psychic reality into the bargain, creating a joint intersubjective milieu."

The following supervisory experience will attempt to illustrate the way these psychic processes may impact the therapist post-factum, mediated by a supervisory experience.

**Case Vignette 4**

Rachel started psychoanalysis at age 19, prompted by symptoms of restrictive anorexia which developed a few months earlier, shortly after beginning her two-year military service. The commanders of the specialized elite army unit to which she was assigned, fully informed of her condition, encouraged the treatment and allowed her to leave the military base in order to attend three weekly analytic sessions. Apparently, owing to her performance, she was very much appreciated by her superiors.

Rachel was very committed not only as a soldier but as patient as well. She was punctual, verbal, associated freely, unraveled memories, fantasized and remembered her dreams. Sadly though, not only was there no improvement whatsoever in her anorexia, but gradually she developed depressive symptoms: a sense of emptiness, purposelessness and lack of worth. In the center of her preoccupation was her parents' marital crisis, prompted by her father's extra marital affair and her sense of having been betrayed by him even more than her mother.

The military service was limited to office hours and Rachel slept at the family home. One night, Rachel called the analyst at about two o'clock in the morning announcing that she had cut her wrists and was bleeding profusely. To the analyst's question whether the parents are at home, Rachel replied she believed they were asleep in their bedroom. The analyst wisely did not inquire why had Rachel called her on the phone rather than alert the parents down the hall, and instead prompted Rachel to immediately wake the parents up and rush to the emergency room.

The next day, for the first time in the year and a half since the beginning of treatment, the analyst received a phone call from Rachel’s father, requesting a meeting. The analyst was anxious to first meet with Rachel following the suicide attempt, and also to hear from her how she would feel about the proposed meeting with her parents. The analyst had promised to call the father back. Given all options: to oppose a meeting with parents, to accept and participate, or not participate, Rachel opted for the last. During that session, the analyst did ask the question:" why did you call me first?" Rachel couldn't find an answer and the analyst interpreted the guilt and the incumbent self-punishment over an otherwise unconscious forbidden oedipal (or primal scene) wish to penetrate the parent's bedroom. The meeting with the parents proceeded smoothly, they expressed appropriate concern, were not intrusive but rather offended that Rachel chose to call a "stranger" for help, while they were available to her, next door.

Now we come to supervision. The case was brought to an international forum of group supervision held in Europe. The forum included eight participants - associate members of the International Psychoanalytic Association- led by a senior training analyst. Some participants were adamant about the analyst meeting the parents, thus "corrupting" the neutrality of the analytic process and turning it into an "ordinary" psychotherapy with parental guidance. They would have opted for a different solution, such as referring the parents to a colleague for consultation or possibly couple therapy. Other participants joined the senior supervisor in commenting on the symbolic significance of Rachel's "cutting herself free" from infantile ties and thus dismissing her parents from their protective parental role.

The analyst, although appreciative of the different approaches and contributions, remained quite unsettled with regard to her so called "transgression" (meeting the parents). She also felt that the patient's message of loneliness had been somehow de-emphasized. The analyst could not help a feeling of being outvoted and categorized in a rigid and dogmatic

way. She left the supervision session feeling rather confused but upon further reflection, had a sudden insight into a late projective identification vis-à-vis the patient ("each of us was trying so hard and ultimately felt so utterly alone") and on second thought, considered herself redeemed by the supervisory encounter.

## CONCLUSION

Both psychotherapy of eating disorders and its corresponding supervision face issues basically similar to any other therapy/supervision endeavor. Here too, the supervisor-supervisee dyad faithfully echoes the therapist –patient saga. However, there are some unique features inherent to eating disorders pathology that merit emphasis. The main challenges facing both the therapist and the supervisor pertain to the psychotherapist's ability to function as a member of a team; to focus on the therapy process rather than on symptoms but in a way that balances therapeutic neutrality with concern for the patient's vital medical needs; to cope with issues of power struggle and quest for control as they emerge in the parallel process. Both the therapist and the supervisor may experience frustration, anger and narcissistic hurt vis-à-vis a resistant patient, unmotivated to change, and they are prone to a lessening of their sense of professional worth and personal value. This could be perceived as role responsiveness to the patient's unconscious malevolence.

In eating disorders as elsewhere, supervision is both an art and a métier. It could become a unique and memorable experience for a supervisory couple matched for personalities, theoretical congruence and transference/counter-transference sagacity. But it can also take a less profitable course and lead to impasse. Quoting Schlesinger (35):

> "There is art and science in facilitating learning through supervision. How to describe supervision that facilitates learning? To paraphrase Hippocrates, in the first place, it is important to do no harm."

The supervisory experience can be equally jeopardized by a supervisor's overly rigorous adherence to technique, too passive stance (which hampers learning), or activism and intrusiveness (which impair the supervisee's autonomy and creativity).

Supervision of psychotherapy does not mean interfering with the treatment, or outdoing the supervisee in his task. It is about being "there" and "with", but not "instead" of the therapist. As Winnicott (29) wrote:

> "Responsible persons must be available when children play; but this does not mean that the responsible person need enter into the children's playing"
> DYNAMICS AN

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