WHAT’S HUNGRY?
ROBOT LIVING AND THE ABDUCTION OF INNOCENCE:
A WOMAN’S JOURNEY INTO THE UNDERWORLD OF EATING DISORDERS

by

TARI LYNN WEBBER

A clinical case study
submitted in partial fulfillment
of the requirements for the degree of

DOCTOR OF PSYCHOLOGY IN CLINICAL PSYCHOLOGY

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This clinical case study has been accepted for the faculty of the
Meridian University by:

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Carolyn Shoshana Fershtman
Clinical Case Study Advisor

____________________________________________
Melissa Schwartz, Ph.D.
Academic Dean
I dedicate this work to my aunt, Laurie Jenson, who is a nurse and Jin Shin Jyutsu practitioner. She took me in when I was an adolescent. It was from her attentive loving guidance in daily living and the practices of Jin Shin that I gained the internal cohesiveness and quiet which allowed me to explore the world and to begin to create a soulful life and make my place in the world. My aunt’s careful, devoted work with me over time inspired my work in the field of psychology. In turn, my hope is that my work in the world will provide safe harbor and healing experience for some of those souls fragmented by our complex and increasingly depersonalized world.
ABSTRACT

WHAT’S HUNGRY?
ROBOT LIVING AND THE ABDUCTION OF INNOCENCE:
A WOMAN’S JOURNEY INTO THE UNDERWORLD OF EATING DISORDERS

by

Tari Lynn Webber

This study explores the dynamics of eating disorder in relation to trauma, loss, and unmet needs through the case of a 23 year-old woman who sought treatment in an intensive outpatient eating disorder program. She was referred for therapy following hospitalization for suicidal ideation and acute depression and was diagnosed with Anorexia Nervosa with episodes of binge eating and purging. This study tracks the client’s consequent therapeutic journey.

The literature reviewed and referenced herein surveys resources from Biological, Cognitive Behavioral, Psychodynamic, Sociocultural, and Humanistic perspectives, and Imaginal Approaches to the topic of eating disorders. Included is an overview of relevant research and theory on trauma, family relationships, perfectionism, and self-damaging behaviors. Marion Woodman’s discussion about the tendency for women to seek perfection related to body image is a significant key principle in this study. Also important are Donald Kalsched’s discussion on trauma, Kim Chernin’s thinking about mother-daughter relationships and hunger, and Angela Favarro’s view of the relationship between rape and eating disorders.

The therapeutic process assisted the client in addressing the suppression of life force and compulsions for perfection and self-deprivation that dominated her daily living.
She discovered hidden, denied parts of her psyche that had driven her to suicidal thoughts and physical collapse. Using cognitive behavioral, narrative, somatic, and art therapy methods, we journeyed together to the murky inner depths where hopes and dreams were buried in fear and shame.

Major learnings were related to identifying that the client denied herself love, food, nurturing, acceptance, and awareness of her deeper feelings which in turn created an insatiable hunger. She had been trapped by internal survival defenses against trauma and loss. Her body hungered for nourishment, her heart for love, and her soul for expression. This disconnect was initiated by two traumatic incidents which brought about abrupt endings to childhood innocence as she became isolated in silent suffering with shame and guilt as her companions. While her heart recoiled from love and its potential for pain, her body languished from lack of food and the vital emotionally energized connection to her soul.

This study concludes with reflections about the client as well as the topic. The client’s compulsive, robotic lifestyle signified the urgency of her need for safety through relentless control of her internal and external environments. She needed to reconnect the separated parts of herself in order to transform the unbearable and dangerous dynamics of her life. Her journey called on both mothering and fathering capacities of the therapists to establish a safe container for this painful process and the guidance and direction necessary to support the retrieval of the soul.
ACKNOWLEDGMENTS

There are many people without whom this work would not be what it is. My client’s incredible spirit, courageous tenacity, fragile vulnerability, and resilience have opened my heart. My site supervisor’s gently supportive and perceptive guidance nourished my hungry soul.

Had I known what Hermes the Trickster was getting me into, I might never have taken on the daunting tasks of Imaginal Inquiry nor found the gold in this powerfully transformative journey.

My loving husband and dearest friend, Troy, and our son Tre and daughter Ashlian have my deepest gratitude for always reminding me what is important.

My friends and family members were greatly impacted by my dedication to this project. Though the hours, days, weeks, months, and years apart are irreplaceable, their unfailing love and support have strengthened our bonds and deepened our friendships. Without them I could not have done it.

My writing partners Julie Puffer, Henry Kaiser, and Donna Minkel embodied for me the Father Principle, and their long, careful hours of editing, ceaseless inquiry, good humor, and personal support brightened long days and kept me on track. Finally, thanks to my Advisor, Shoshana Fershtman, for guidance and support that got through the last leg of this journey.
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CHAPTER 1

INTRODUCTION

Clinical Topic

The increase of eating disorders has serious physical and emotional consequences for many young women today. Many are dying from medical complications of anorexia and bulimia. These women tend to suffer silently while they physically deteriorate from extreme efforts to fit into an idealized body image influenced by our culture. In my work with my subject client and my research on the topic of eating disorders, I discovered that underlying my client’s eating disorder was a deep hunger rooted in basic unmet human needs.

A look back in time will help provide the context for understanding what is meant by the concept *eating disorder* as well as types and subtypes of eating disorders. According to Diane Yancey, an eating disorder is a habit of binging and purging first described in ancient Roman times when citizens forced themselves to vomit in order to prolong their enjoyment of a very heavy meal. Later, physicians and others began to make detailed observations, which Yancey traces as follows: In 1874 English physician, William Gull wrote of a young woman whose symptoms included loss of appetite, constipation, slow pulse rate, and cessation of menstrual periods. Gull concluded that his patient was suffering from simple starvation, and coined the term *Anorexia Nervosa*. In 1903, French psychiatrist Pierre Janet was the first to publish the description of *bulimia* by describing a patient that binged and purged but never lost her appetite. An American
physician, Albert Stunkard, an expert on obesity, isolated the symptoms of bulimia in 1959 but for many years, the illness was still considered clinically to be a variation of Anorexia Nervosa. The American Psychiatric Association did not recognize bulimia as a distinct disorder until the 1980s and applied the term Bulimia Nervosa in 1987.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) an eating disorder is defined by severe disturbance in eating behavior with two specific diagnoses, Anorexia Nervosa and Bulimia Nervosa. The essential features of Anorexia Nervosa include refusal to maintain a normal body weight, an acute fear of weight gain and obesity, and a significant distortion in perception of the shape or size of one’s body. Bulimia Nervosa is characterized by repeated binging on food followed by compensatory behaviors, such as self-induced vomiting, excessive use of laxatives, fasting, and/or excessive exercise. As in Anorexia Nervosa, there is also a distortion in perception of body shape and size.

The next chapter provides a Literature Review in six sections. First, the Biological Perspective on Eating Disorders explores literature that informs about medical treatments often needed and addresses relevant biochemical disturbances caused by binging and/or purging as well as restricting behaviors. There is discussion of numerous factors that influence the development and maintenance of anorexia and bulimia as well as treatment for eating disorders which must include health and safety precautions because disordered eating patterns can be, and often are, fatal. Among these are Bessel van der Kolk who discusses trauma and Post Traumatic Stress Disorder, as well as Angela Favaro, Sylvia Ferrera, and Paolo Santonastaso discussion of self-injurious behavior. Also mentioned are Holly Clemmens, Dennis Thombs, R. Scott Olds, and Karen Lowry Gordon
observations that many anorexics and bulimics suffer from long term, sometimes permanent physical damage such as heart problems, osteoporosis, severe dental issues, and even kidney failure.\textsuperscript{9}

In the next section entitled Cognitive Behavioral Perspective on Eating Disorders, the lens used to examine the etiology of eating disorder focuses upon issues of cognition and behavior as they pertain to the treatment of eating disorders. Research from this perspective emphasizes identifying and changing maladaptive cognitions to correct harmful behavior, rather than addressing the causes or underlying dynamics of the disorders. Key theorists in this section include Christopher Fairburn and G.E. Wilson Key who explain the application of cognitive behavioral therapy to bulimia. Another significant source is Richard Stein, Justin Kenardy, Claire Wisemen, Gennifer Zoeller Dounchis, Bruce A. Arnow, and Denise E. Willfley who contribute to the understanding of the drives and root causes of binge eating disorder.

In the Psychodynamic Perspective on Eating Disorders, literature from the Psychodynamic Perspective indicates that early childhood experiences and family dynamics contribute to the manifestation of eating disorders. The nature of one’s relationship to primary caregivers or parents plays a particularly key role. In this section exploration of theory from a number of authors who do not necessarily speak about eating disorders helps to bring deeper understanding to this disorder. Among these are Sigmund Freud who describes pleasure principle and the transference process, as well as Donald Nathanson who writes about shame and Heinz Kohut about healthy narcissism. Additionally, Geneen Roth brings insight regarding eating disorders and intimacy.
Next, the Sociocultural Perspective on Eating Disorders examines social and cultural factors in the evolution of psychological problems and disorders. This literature emphasizes the impact of cultural and peer influences on ego development, and demonstrates the relationship between the sense of self and one’s interactions with cultural and social norms. Important theorists considered here include Mary Pipher who speaks to the cultural oppression of young girls today and Yancey who describes ways that that distorted body images skew development for young women. Caroline Knapp considers the relationship between female identity and the culture.

The Humanistic Perspective on Eating Disorders focuses on personal self-worth, self-actualization, and development of the whole person. From this perspective the suppression of emotions can result in compensatory eating behaviors, including restrictive eating, binging, and purging. A goal of Humanistic therapy is to bring underlying emotions to awareness and to develop a more authentic relationship with the self. Considered in this section is thinking from Carl Rogers about positive self-regard and Virginia Satir about self-worth.

Finally, Imaginal Approaches to Eating Disorders draws from many psychological perspectives to view the whole person and their life experience through the archetypal lens of the soul which Aftab Omer has noted expresses itself in images. Healing and transformation is accomplished by engaging the imagination in understanding the structures, dynamics and underlying protective purposes of symptomatology. Also included in this section is Anita Johnston’s discussion of the use of food to substitute for love and security. Marion Woodman’s discussion of the imbalance
between feminine and masculine is a significant resource considered in this section. Kim
Chernin focuses on female identity and what she calls the hungry self.

A brief summary of some significant sources will help define the clinical topic.

Though he does not write specifically about eating disorders, Robert Bly says that both
competitive and self-damaging behaviors are symptomatic of a deeper loss and
connectedness to one’s soul.11 Eating disorders could certainly be considered to be
among those symptoms of loss of soul. According to Bly, the breakdown of the family
along with spiritual and moral values in the culture means that young people lack
adequate resources that would enable them to face life’s traumas.12 It is not surprising,
then, that studies on self-injurious and self-destructive behavior by Angela Favaro, Sylvia
Ferrera, and Paolo Santonastaso found that both abnormal eating patterns and compulsive
self-injurious behavior, particularly bulimia, are common among young women who have
suffered negative sexual experiences such as rape.13 The authors determined that eating
disorders are comprised of compulsions which develop or emerge to alleviate anxiety and
to control untenable emotional states including depression, loneliness, and de-
personalization, rather than to provide gratification. The compulsive behaviors may also
be a means of self-punishment in an effort to avoid negative feelings. Given that trauma
often predates the development of an individual’s eating disorder, the work of Donald
Kalsched helps build understanding of eating disorder. Kalsched found that trauma and
overwhelming experience can seriously damage one’s ability to process and integrate
experience.14

Given that those who suffer with eating disorders are predominantly women, it
could be that there is some common trauma that women experience. Marion Woodman
helps in this regard with a look at the relationship between “addiction to perfection” and the loss of connection in a woman’s relationship with the feminine.\textsuperscript{15} Woodman asserts that women with this addiction tend to suppress their female energies which otherwise naturally support the fullest expression of their feminine nature.\textsuperscript{16} This suppression undermines a woman’s capacities to be intuitive and to nurture her sense of self. Woodman observes that in today’s society women are embracing masculine attitudes in order to survive in an energetically male system of thinking.\textsuperscript{17} Women today are responding to the cultural pressures to compete and drive themselves to achieve male forms of physical and emotional perfection.\textsuperscript{18} Woodman suggests that women have lost their connection to the archetypal Goddess within.\textsuperscript{19}

Kim Chernin’s work with eating disorders emphasizes an inter-generational pattern in which women symbolically “give birth” to their mothers.\textsuperscript{20} Wanting to live her own life differently, the daughter may disown aspects of herself which mirror those particularly unfavorable aspects of her mother but when she is unable to resolve internal conflicts about her mother’s life choices, the daughter’s unmet needs can result in eating disturbances.\textsuperscript{21} Chernin holds that when a mother’s death results in the daughter’s emotional needs being neglected, the daughter’s feelings about her mother’s failures become frozen and projected upon significant others in her life.\textsuperscript{22}

Anita Johnston claims that one can transform one’s relationship with food through myths, metaphors, and story-telling.\textsuperscript{23} Johnston suggests that what is experienced by people with eating issues as insatiable hunger is a metaphor for the deprived or disowned soul’s longing for love. Johnston further maintains that food can eventually become the external symbol for comfort, warmth, and even security.
Though not specifically mentioning eating disorder, Omer’s thinking about the dynamics of inner psychological life is helpful. He says that women (and men) are influenced by the culturally imbedded archetypal tyrannical father who functions as a driven, performance-oriented gatekeeper. Omer holds that we need an internal balance of both the archetypal Mother and Father in order to support the development of healthy peer relationships internally and in the world. Omer also asserts the need for the internal Friend to help identify and ameliorate the gatekeeping which restricts experience and inhibits our natural passion and vitality. When there is inadequate internal Friend, gatekeeping contributes to the development of imaginal structures which are “assemblies of sensory, affective and cognitive aspects of experience constellated in images which both mediate and constitute experience.”

The subject client for this Clinical Case Study is “Mary Jones” (pseudonym), a 23-year-old young woman whose struggle with eating disorder involved pushing herself beyond her physical capabilities while suppressing and denying an ever increasing hunger for fuel in the forms of food and love. She herself called this style “robot living.” I chose eating disorder as my topic because professionally I have developed an interest in further understanding and developing my work with people who are suffering from eating disorders, and because Mary presented with feelings and symptoms with which I was personally familiar. I am motivated to help young women grapple with the underlying disconnections and losses, which I also suffered as an adolescent. The experience of adolescence and the feelings that accompany this vulnerable period of physical and psychological development can be filled with vitality and passion, but also depression, anxiety, trauma, and grief. Mary’s circumstances drew me in clinically as well as
emotionally as I tuned into her loss of connection to herself and her hopes and dreams
and underlying needs. I could also feel an inner force in her that wanted to fight for her
needs and desires but did not seem to know how. I was excited at the prospect of helping
another find ways to live life in connection with her true self. I very much wanted to
provide a loving, therapeutic environment and the guidance and support that might help
this young woman safely navigate the tumultuous waters of self examination.

More broadly, I am acutely aware of a lack of community resources for the depth
and scope of work that is required for young women to heal from eating disorders. I am
fascinated with how to support feelings of self-worth in women in the complex, male
orientation of modern culture. In my observation and experience, disordered eating
patterns mirror one’s internal relationships with one’s self as traumas and unmet needs
unveil themselves in the progressive symptoms.

**Exploration of the Subject/Topic**

The psychological aspects of eating disorders have been of interest and concern to
me for a long time. While I received a Masters of Psychology degree in 1996, I have also
worked for over 20 years in a gym as a fitness trainer as well as in a school of performing
arts as a modeling and personal development instructor. In these arenas, I was exposed to
a culture of young women who were engaged in a constant and painful struggle with a
world that held them to unrealistic physical standards. Early on in this environment, I too
tried to obtain the perfectly sculpted body in order to be the best trainer/teacher. But I
began to see that as women, we fought internally with ourselves and externally with each
other. The primary conflicts were constellated around body image, competition, and
envy. It appeared that our confidence was connected to how we compared to each other. It also seemed that a thin body and attractive appearance brought a false sense of self-worth while failure to achieve such an appearance resulted in a greatly diminished sense of self-acceptance. I often sensed that the young women were never at peace as the fitness, modeling, and performing arts milieus seemed to magnify environmental influences and pressures on young women. The extreme dissatisfaction that women tend to feel about their bodies as they attempt to fit into a cultural mold of unrealistic thinness surfaces in these environments. Given the nature and scope of my work and in order to be more effective, I have worked to bridge between the health and fitness industry and the profession of psychology.

Through my personal struggles and quest for a soulful life, I have also felt called to help women awaken and develop love of self. Accepting and loving myself as I change and grow is my own perpetual quest. My childhood weekends at home were rife with violence. My father was a Viet Nam war veteran filled with bitterness at the world who turned to alcohol for comfort at the end of each work week. His alcoholic rages put my mother, sister, and I in constant danger of attacks. At times he threw heavy objects, furniture, or hot food. I dreaded the weekends when my dad would bully my mom until she hid cowering in a corner of the closet or ran to neighbors in fear. When Mom hid in my sister’s and my bedroom closet, sometimes pulling us in with her, I remember her hands shaking. I never felt safe or protected but instead felt responsible for my mother’s safety. Gradually, as I entered adolescence, I buried my pain, fear, and outrage under a tough bravado and soon, I became a target of my father’s rage.
In addition to the ongoing challenges related to my father, one event had a huge impact on my life. At age eight, my best friend was killed while I was with her and her family on a vacation at Lake Tahoe. While she and I were out in the neighborhood playing, we noticed a full-size candy vending machine that was situated on a hill at a nearby church. One day, my friend and I watched teenagers pushing and shaking the machine to get free candy. We wanted to try and so ran up the hill and began pushing at the machine. While I stood dumbstruck, the heavy machine slid and began to tip over. My dearest friend was standing next to me one moment and was dead the next, her little body crushed. I ran to get help but it was too late. She was dead and I was still alive, not comprehending why I was still here. I was scared and I did not feel safe.

My parents did not communicate with me about this event, or encourage me to say anything about it. Life went on as usual but I walked around in a fog. I was not allowed contact with her parents or to attend the funeral. I was told that this was because it would probably “be upsetting for everyone.” Without any supports to speak of, I toughed my way through the loss of my friend and the pain and confusion that followed. I did my best to forget it even happened, not letting myself feel any of it. I shoved it way inside hoping the pain, fear, and confusion would go away.

As I struggled with this traumatic experience as well as the ongoing trauma at home, I hungered to be held and hugged. I longed to have someone I trusted and felt safe with look into my eyes and see me, comfort me, love me. But in my family, neither love nor fear were acknowledged. I learned to hide my vulnerable sensitivities, wearing bravado as a protection because sensitivity or vulnerable feelings made me a target.
I was eventually blessed while still an adolescent, when my aunt took me into her home and wrapped her arms around me with loving kindnesses. She gave me my greatest gift, the opportunity and support I needed to find myself and the courage to enter into my life fully with a willingness to reach for my deepest desires and my highest aspirations.

I chose to study Mary’s therapy journey for many reasons. We both carry soul wounds imposed by our families, our culture, and our experiences of life in a woman’s body. Like Mary, I needed safe harbor from an unbearable, unsafe lifestyle and from my own mistrust of the world and need to be perfect in order to be accepted. We both felt the isolation of body and soul divided due to unattended trauma and experienced our tender feelings as dangerous. We were each intensely angry. I had acted anger outwardly in a rebellious lifestyle and Mary directed her anger at herself while maintaining a compliant face toward authority. I related to Mary’s sense of imminent danger and bids for safety through controlling her environment. Like Mary, I hid from vulnerability, worked hard to develop a mask of capability, and sense of safety in a harsh, cold world.

As I began my work with Mary, I hoped to pass on my aunt’s gift to me and I cherished the idea of sharing such an experience with Mary. As the work unfolded, Mary reminded me that I have spent my life learning to love and accept myself with all of my imperfections. I am a work in progress with gifts that are also my challenges. Today I am both hard on myself and very kind to myself. I have found that holding such contradictions is a key capacity in working with conflicting internal subjective experiences which underlie eating disorders. Personally and professionally, I am fascinated by these contradictions and challenged to understand their complexities.
Framework of the Treatment

Mary entered therapy in search of relief from the internal pressures of her eating disorder. I worked with Mary intensively for four months after she was referred by Herrick Hospital in Oakland, California. She had been treated there for Anorexia Nervosa with Bulimia subtype and episodes of binging and purging and had nearly died from medical complications of starvation. Acutely depressed, she had been having thoughts of suicide. It appeared that Mary had neither the capacities nor the guidance and support she would need to recover from the devastating effects on her psyche. True to the clinical symptomology of eating disorders, Mary emotionally distanced herself from other people, starved herself, and drove herself physically and mentally to comply with unrealistic standards for performance. Like others with eating disorders, she too carried a trauma history; she later disclosed that she had been raped as an adolescent and that her mother died just two years previously. A life strictly choreographed by physical and mental compulsions offered Mary means of escape from intolerable fear, grief, and shame while her soul suffered in silence, buried in the wreckage.

I provided Mary with therapy at Psych Strategies in Santa Rosa, California for five months in 2008. Psych Strategies is a full-service counseling program which employed over sixty psychotherapists and independent contractors and offering a variety of individual and group psychotherapy services. The agency’s services included two intensive out-patient group therapy programs, one of which was the Quest eating disorder program. In the Quest program there were three therapists, a program coordinator, and a nutritionist on staff. As the psychological assistant for the program, I attended every session with Mary and each of the other team members. Due to financial circumstances,
the Quest program was terminated only eight months after I began working at Psych Strategies. This program closure affected Mary in that her program was actually accelerated and intensified. Mary benefited from the addition of individual sessions, three hours in length, that were normally used for group work and she still had the typical one hour individual session with her therapist focused upon family and personal issues. However, with only about five months in the program, Mary was still shy a month of the programs normal six-month duration. Since Quest was ending, Mary also did not have the additional resource of a support group after graduation. She did enter individual therapy at Psych Strategies and was also referred to hospice for individual and group grief support. Finally, she continued to see her psychiatrist at Herrick who monitored her medications for anxiety and insomnia.

Each week I worked with Mary in several three-hour sessions for a total of nine to twelve hours in a variety of team capacities. A staff nutritionist and I met with Mary every Monday from three to six p.m. for a personal check-in which included a recorded weight, a discussion of mindful eating practices, a shared meal and nutritional psychosocial education. We framed our discussions using an integrated blend of cognitive behavioral therapy, a Narrative approach to the humanistic orientation, and elements of Imaginal Approaches to transformative learning. Using art, music, myth/story, and somatic practices, our goal was to help Mary cultivate capacities for living a healthier lifestyle and to mitigate the compulsory effects of her eating disorder.

On Wednesdays I co-facilitated Mary’s therapy with a family systems therapist using a humanistic person centered family systems approach. Thursday’s three-hour sessions were co-facilitated with my supervisor. We worked with Mary using drawing,
journaling, rituals, and dialoguing with her eating disorder, which she called “Ed” as well as with other internal parts. Finally, there were Friday meetings twice a month for family education and psychosocial support for Mary’s family.

Mary had a skilled, supportive therapeutic team which helped her sort through the many issues and complexities of her treatment. There was a weekly case conference which provided for discussion of mutual clients. In addition, the therapy staff was supported with a daily telephone briefing which became a recorded phone log of what happened in each session with Mary. This was important because, aside from my consistent involvement in every session, different therapists worked with her each day. My presence provided continuity for Mary and a valuable collaborative learning experience for me.

As a psychological assistant, I received two hours of individual supervision. My supervisor was a licensed psychologist who specialized in Imaginal Psychology. With her, I shared concerns, questions, treatment planning, and debriefed counter-transference issues. I also attended the weekly case conference with other agency staff which provided me with modeling for clinical discussion. I felt supported and enlightened by both my supervisor and the Quest team.

**Confidentiality and Ethical Concerns**

To insure confidentiality, all names of individuals in this Clinical Case Study have been replaced with pseudonyms. Specific information that could potentially identify Mary has been altered to protect her privacy.
Feeling an interest in Mary’s psychological issues and a personal affinity for her, I first discussed my desire for Mary to be my subject client with the program coordinator, my primary supervisor, and then with the the Quest therapy team. My request approved, I spoke with Mary about three and a half months into our work together. We discussed what being the subject of my Clinical Case Study would entail and I asked Mary if she had concerns. She replied with conviction, “I would be honored to be the client for your Clinical Case Study.” I invited her to speak freely any time concerns or questions arose.

My supervisor was a licensed psychologist who specialized in Imaginal Psychology. I received two hours each week of individual supervision and a one hour case meeting with the Quest team. With my supervisor, I shared concerns, questions, treatment planning, and debriefed counter-transference issues. I felt supported and enlightened by both my supervisor and the Quest team.

While I was disheartened by the announcement of the closing of the Quest program, I also had ethical concerns. Before closing, the Quest program had provided aftercare and support services for all clients upon graduation. With its closing, I was concerned for Mary’s safety and stability after the deeply engaging course of therapy that was different and shorter than the time-tested standard Quest treatment program. While there are no guarantees for safety and stability following a course of therapy and though Mary had some time for testing out newly acquired skills and capacities in the real world, I wondered about the ethical responsibility of Psych Strategies to provide more extensive aftercare and support for Mary since she did not receive the full course of therapy. The Quest team did meet on several occasions to plan support and aftercare for Mary which consisted of referral to hospice for individual and group grief support as well as
continuing with her psychiatrist at Herrick who was monitoring her medications for anxiety and insomnia. She also continued weekly individual and family counselling at Psych Strategies. However, I feared these services seemed not enough. Though the Quest team could not control the closing of a program, I felt that we might have provided better relapse prevention options and more aftercare resources.

Another ethical concern was around the weekly weighing of eating disordered clients. While useful for medical purposes, this was also triggering for Mary and many others. Mary disclosed that the image of the scale evoked familiar fears of being fat. Such body image fears are typical triggers for anorexic and bulimic compulsions. In the future it might be helpful to have a ritual for processing participants’ responses and reactions, in order to include more exploration of that terrain in therapy.

Client History and Life Circumstances during Therapy

Mary was a single 23-year-old Caucasian woman on leave from college when she entered the Quest program. Mary described her daily life as what she called robot living which involved pushing herself beyond her physical capabilities while suppressing and denying an ever-growing need and hunger for fuel in the form of food and love. Through the restrictive eating and compulsive lifestyle of robot living, Mary had pushed herself physically, denied herself food and care, while sometimes eating compulsively, then purging. She was adversely affected by her achievement and food-related compulsions but in therapy, she slowly found her way to her body and soul’s need for care. As her story unfolded, the Quest therapy team worked with Mary’s internal
dynamics by utilizing narrative and cognitive behavioral techniques and Imaginal Approaches such as expressive art therapies.

Mary described her early childhood as uneventful. Her mother and father had a happy marriage and Mary felt close to both of her parents. Her mother, according to Mary, held the family structural boundaries and was the family disciplinarian in a “really good way” but expected a lot from her family and herself. Mary described her father as easy-going and loving, though somewhat distant and uninvolved in the day-to-day functioning of the household. Mary denied any physical or emotional abuse in her childhood. Her only sibling was a brother, three years her senior, whom Mary described as very close and supportive. Later in therapy, however, Mary compared herself unfavorably to him in terms of innate goodness and artistic performance.

According to Mary it was not until her teen years that she began to suffer feelings of insecurity. She recalled envious feelings towards her brother and was competitive with his seeming perfection. Later in the therapy, the story of her family shifted to reveal a passive father, a dominant mother who demanded accountability, and a brother she felt others believed was perfect.

When Mary was 14 years old and at a sleepover with friends, she became intoxicated and a boy who was an acquaintance took advantage of her sexually. Mary never viewed herself as a victim of rape and had always blamed herself until we explored the experience in our therapy together. Until then, Mary had not discussed this event with her mother or anyone else. Mary reported that whenever the rape surfaced in her mind she would brush it off, telling herself, “I will never let something like that happen again.” She avoided her deeper feelings and blamed herself for being intoxicated. When her
mother died several years later, she regretted that she would never be able to tell her what had happened. Already a self-conscious adolescent at age 14, in ensuing years Mary withdrew from friends, isolating and creating a highly restricted social environment. An on and off relationship with her boyfriend reflected Mary’s low self-esteem. At 19, Mary broke up with her boyfriend and departed for Europe as an exchange student.

In Europe Mary soon gained twenty pounds. Disgusted with herself, she began to binge and purge her food. This was the beginning of what became a chronic compulsion to overeat and purge. After such episodes she always felt “disgusted” with herself. Already feeling alone and isolated, it was while she was still in Europe that Mary learned her mother was diagnosed with terminal cancer. Soon after returning home, Mary felt as though her mother’s illness threatened to engulf her. As she watched her mother’s health steadily deteriorate, Mary increasingly restricted her food intake. Traumatized by the specter of her mother’s death, the effects of her mother’s illness settled into Mary’s body. The anorexic and bulimic activities became a primary means of exercising control of herself and her life. Her body’s demands quickly and effectively distanced her from the intolerable experience of helplessness and grief.

Mary watched her mother deteriorate for two years. She was 21 years old when her mother died. By that time, food restrictions and habits of binging and purging controlled Mary’s life. Wanting to get away and “move on” after her mother’s death, Mary moved to San Francisco and registered at San Francisco State University as an undergraduate psychology major. Mary found an apartment close to the school and determined to make it on her own, started a new job with the ferry service. With goals for success, Mary began to apply intense performance pressures on herself. Mary soon
added a second job and continued attending school full-time while also trying to keep up with peer pressures to socialize and exercising for long periods after bingeing.

Throughout this punishing schedule, Mary continued to restrict her food intake, bingeing and purging frequently. With little nutrition fueling this pressured lifestyle, Mary began to have panic attacks even though she tried not to “feel.” As her health deteriorated she began to have insomnia, depression set in, and the panic attacks continued. Within two years, Mary was hospitalized for depression and suicidal thoughts resulting in treatment in a medical psychiatric facility. Just before she was hospitalized, her life had come “to a screaming halt” and she could no longer function. After she was medically stable, Mary was diagnosed and treated for eating disorders. From the hospital she was referred to Psych Strategies in Santa Rosa, where she enrolled in the Quest outpatient program for eating disorders and our work together began. She took a leave from school and work and moved in with her father while she participated in outpatient treatment. However, living with her father presented challenges as he seemed to be drinking excessively to cope with his grief about the death of his wife and he was also in a romantic relationship with another woman.

Mary had been dealing with more than the typical pressures of young adulthood. Affected by the unprocessed trauma of the adolescent rape and traumatized and grief-stricken by the loss of her mother, robot living was no longer working. It had trapped her in a pressure cooker with no time or means for rest, nourishment, or rejuvenation. Mary brought herself to Psych Strategies to decompress and safely begin to heal some of her wounds. We began by exploring her biographical history and the environmental influences on her life and psyche.
When she entered the Quest program, Mary was on leave from school and work and lived with her father in her childhood home. Only a few days after her release from the hospital, she reported that she was no longer restricting her food intake nor bingeing and purging, but the urges were strong and persistent. Though Mary’s physical health was stable, she was still underweight. Fortunately, medical reports indicated no major physical effects upon her vital organs from the restrictive food intake or the bingeing and purging. Mary was lucky in that many anorexics and bulimics suffer long-term and sometimes permanent physical damage such as heart problems, osteoporosis, severe dental issues, and even kidney failure. However, Mary was afflicted by chronic depression and insomnia, first initiated by the acquaintance rape at age 14 and which had arisen again following her traumatization when her mother died two years earlier. Still grieving her mother, Mary also suffered a chronically high level of anxiety. She took an antidepressant, an anti-anxiety medication, and sleep medication during her therapy and still expressed fears of gaining weight, only reluctantly weighing in weekly as required.

The symptoms of Anorexia Nervosa with bulimic episodes that Mary displayed included below-normal body weight and specific food fears. Mary’s bulimic episodes had included regular binge-eating followed by purging after food intake. Mary scored fifty-five in the Axis V GAF score according to the diagnosing psychiatrist which is a typical score for people with eating disorders who are so frequently fueled by anxiety and perfectionism. Mary’s high level of functioning extended to educational and job-related commitments and responsibilities, and positively contributed to her therapeutic process.
Progression of the Treatment

Mary struggled with a perfectionistic and food-related compulsive lifestyle that she called robot living. This image proved to be vital to unlocking, understanding, and treating the underlying dynamics of her eating disorder. Mary’s restrictive eating and pressured lifestyle patterns began to emerge following the rape as she struggled on her own to deal with this trauma by repressing her experience. The eating disorder symptoms were amplified at the time of her mother’s death. Under the cumulative strain of repeated trauma, Mary began to display what Bessel van der Kolk has noted are typical post-traumatic stress symptoms including emotional constriction and a hyper-vigilant stance regarding her internal and external environment. These symptoms eventually led to acute depression and a physical breakdown.30

In therapy, Mary applied her well-honed skills at focusing and getting the job done, in order to explore painful hidden and repressed aspects of her life. We discovered together that her eating disorder represented a protective identity which separated her from painful experiences of loss and feelings of shame, guilt and grief. As we used art, ritual, imaginal dialogue/practice, and somatic practices including Jin Shin Jyutsu, Mary integrated some of these tools and practices into her daily routine, thus creating new ways of doing things at home in order to help her remain safe, stable, and healthy. During the course of treatment Mary and I worked together with each therapeutic specialist sequentially on three days each week. We set up required daily monitoring in the form of weigh-ins and check-ins on the status of Mary’s binge eating and purging urges. These check-ins initiated an ongoing dialogue with Mary about her food-related activities in order for us to track her physical status and her emotional process.
In the beginning of treatment, because of her fear of foods and of being triggered into an eating binge, Mary was encouraged to prepare and eat meals based on daily menus we developed together with a specific caloric and nutritional value. Once Mary established new eating patterns at home, I introduced the team to the mindful somatic practice of holding Jin Shin Jyutsu pressure points on the body to identify and release the emotional content, in order to balance out the body’s energy. The nutritionist outlined mindful eating techniques. Given Mary’s initial positive response to imaginal work, we decided to incorporate inspirational music, story, and poetry into our Monday therapy sessions. Most sessions included affirmations for Mary concerning self-acceptance and self-love. Visualization, mindful eating practices, and music therapy were to be followed by journaling and/or art making to express and integrate her experiences.

Treatment planning for Wednesdays was organized around the exploration of family relationships. Mary’s three-hour sessions would sometimes include discussions about her father or her brother. Using dialogue about current events and situations involving her father and/or her brother, we planned to guide Mary, sometimes with a family member, to explore biographical and environmental influences.

I co-facilitated the Thursday sessions with my program supervisor. Our planned goal was to provide Mary with opportunities and tools to process her emotional responses to her experiences during the course of the therapy by using imaginal dialogue and addressing cognitive issues. We planned exploratory activities including art therapy and narrative therapy that might help Mary get to know her true needs and desires.

Soon after Mary’s treatment began, we learned that due to economic reasons, the Quest program would close prior to her completion of the program. Mary’s therapy
sessions were increased to compensate the shortened program. Mindful eating sessions with the nutritionist one day a week gave me the opportunity to process with Mary about her food fears and resistances that arose. In other sessions, we focused on Mary’s family dynamics and engaged in imaginal dialogue, journaling, and artwork to explore Mary’s inner landscape related to the eating compulsions. The themes and clinical issues that emerged in our work together involved unresolved grief and traumatization at the loss of the mother, the undisclosed rape trauma, and repressed unmet fundamental needs. In the therapy process, Mary became receptive to her own needs and longings for change. This allowed her to establish a framework of praxes at home in which she could apply her many talents and skills to create a new healthy meaningful way of living.

Learnings

A primary principle that informed my work with Mary was Omer’s theory that the soul expresses itself in images. Early in her therapy, Mary’s drawing of a face with a crossed out mouth and a single line running from the mouth to the heart illustrated her inability to express herself. (See Illustration 1 – Hunger for Expression.) The crossed out mouth was one of many images that Mary brought forth during the course of therapy. These images represented the suffering of her soul, which hungered for expression. This longing expressed itself in powerful images. I learned about the vital role of image making in bringing to light significant internal struggles and conflicts which are otherwise repressed or suppressed. One of Mary’s later drawings was of a heart with the words, “I am human and I have the right to all of my feelings.” (See Illustration 2 – I Have a Right)
Another key learning was in discovering the relationship of shame to Mary’s eating disorder and other self-injurious behavior. Donald Nathanson asserts that because the shame affect is unbearable, we avoid and withdraw from potentially shaming experiences. Mary coped with her shame with two specific affect-controlling responses. Mary blamed herself for the rape because she had been drunk. Nathanson would have characterized this as an “attack self” response to avoid shame. Mary also responded with a slow social withdrawal from her peers which effectively pre-empted potential feelings of shame and associated intolerable helplessness and fear.

Through my work with Mary, I learned what it means to avoid ones innate feminine sensitivities and feeling states. Mary was unable to nurture herself. Her sensitivities and tender feelings were absent or dulled. Applying Woodman’s theory, Mary was working against her natural flow of energy. To compensate for her loss of connection to her feminine nature, Mary depended on aggressive masculine internal imaginal structures, which proved to be harshly restrictive of her life experience.

I soon discovered the necessary value of collaboration for the difficult and sensitive work of exploring internal imaginal structures. Collaboration proved necessary with Mary when exploring structures that were impeding Mary’s daily functioning. Mary named her primary imaginal structures robot living and her primary gatekeeper Ed. (For Mary, robot living involved pushing herself beyond her physical capabilities while suppressing and denying an ever-growing need and hunger for fuel in the form of food and love.) Later in the therapy, we worked with an underlying tyrant archetype which subverted the healthy father capacities which impose order and meaning in our life and for us to embody the internal capacities of responsibility, discipline, accountability,
sacrifice and necessity. According to Omer, healthy fathering protects the initiatory process and holds us back when we are not ready as well as pushes us forward when we are ready for experience.\textsuperscript{36} Ed, a misguided inner tyrant, had re-routed Mary down an ultimately self-destructive path.

I also learned from Mary how lack of self-nurturing and self-care creates an insatiable hunger. Mary was looking for a source of mothering. I aligned with her empathetically and then gently nudged her to explore the areas which were triggering her eating related compulsions. In collaboration with the therapy team I learned new ways to contain and evoke essential Mothering and Fathering capacities. In that process emerged Mary’s repressed hungers. Within the framework of a safe therapeutic container, Mary practiced voicing her needs and identifying the imaginal structures that were preventing her from having the life she wanted.

Both Mary’s and my imaginal structures influenced our interactions and I learned how to feel into the undercurrents in the therapy room.\textsuperscript{37} There were visible interactions between Mary’s Pleaser and my Pleaser, both of whom were influenced by our performance-based perfectionists. I became aware of my Pleaser’s efforts to protect me from disappointing Mary by restricting my probing into areas with uncomfortable emotional content. My Pleaser successfully prevented me from encouraging a deeper exploration of Mary’s relationship with her mother. A positive effect of this was that my reticence allowed for the unfolding of Mary’s own natural process of disclosure. I also learned that experience as a therapist and attending to my own structures is what it will take for me to work with and within the many paradoxes that comprise our Human Being.
During my own personal psychotherapy I began to indentify healthy imaginal structures that were useful to me as Mary’s therapists. I discovered inside myself an Owlish One, who sees the bigger picture. I met this part through visualization and meditation when at those times a recurring image of an owl came to me. The Owlish One helped calm my nervous system in times of uncertainty. Similarly, for Mary there emerged a Friend voice which helped her to assert the “right to all of her feelings.” According to Omer, “The friend voice refers to those deep potentials of the soul which guide us to act while passionate objectivity and encourage us to align with the creative will of the cosmos.”

Through Mary’s experience, I learned that grief does not follow a timeline nor take a straightforward path to a particular outcome. Grief finds its own way through the body, the heart and the soul. Mary’s story had a mythic dimension that encompassed a larger story. Mary’s perfectionism commanded by an imaginal structure called Ed hijacked her feminine qualities and wrenched apart her connection to her soul. Like the barren earth after Persephone’s abduction by Hades to the underworld, Mary’s physical and emotional bodies were separated from one another, both starving for attunement and connection.

I recognize that Mary’s healing is not complete; it will be a lifelong process. I found that the healing process is supported by the Imaginal Approach, beginning with a safe container in which both suffering and hopes are explored and witnessed in recognition of the preciousness of the soul’s experience. Mary’s therapy pushed me to develop personally and professionally. I gained skills and deeper capacities for collaboration, patience, and empathy. I learned to more easily recognize the transference
and counter-transference between myself and my clients. As a psychotherapist just entering the field, I also came to realize that I am one of many who will hold therapeutic containers for other Mary’s in the future.

**Personal and Professional Challenges**

Being informed of the early termination of the Quest eating disorder program ushered in my greatest personal and professional challenge for this therapy. Although extra support systems and follow-up had been thoughtfully put in place, I was responsible for advising Mary of the early termination of services. I did so in the beginning of her therapy, but after a few months it became clear to me that endings and loss were important underlying issues in Mary’s life. I feared that a premature ending of her therapy could trigger a relapse.

Mary was clear that in the past, isolation had often triggered compulsions to restrict her food intake and to binge and purge. When she shared her fear of isolation and feelings of loneliness, my internal Protective Mother was stirred to comfort and soothe away those feelings. I was able to recognize this aspect of my own counter-transference, but it required vigilance for me to learn to allow Mary to sit with her uncomfortable feelings while I learned to sit with my own. I was mindful that Mary needed to experience and learn to be with her uncomfortable emotions. I had to remind myself that I could support her in her therapy process but not collude with her to avoid discomfort, which would only serve my own comfort. I was occasionally challenged by conflicting somatic urges to freeze or flee. Fortunately, I was generally able to remain present with Mary and to process my reactions at other times.
As Mary’s explorations led to re-experiencing and expressing painful feelings around abrupt loss and endings in her life, I felt pressured to minimize this painful process. Awakened by my anxiety, the owlish image of the One Who Sees stepped forward from my internal imaginal realm to remind me of the bigger picture, in which this transformative process required witnessing, listening, and holding, thereby showing Mary how to do this for herself. These are capacities I am developing.
CHAPTER 2

LITERATURE REVIEW

Introduction and Overview

The following review examines the literature on Eating Disorders through Biological, Cognitive Behavioral, Psychodynamic, Sociocultural, Humanistic Perspectives, and Imaginal Approaches. The literature herein primarily focuses on eating disorders identified in the DSM-IV as Anorexia Nervosa and Bulimia Nervosa. This review illuminates similarities and differences between the various perspectives and explores the ways in which thinking about these disorders has evolved over the years. In addition, there is attention to the limitations of the literature available on these disorders.

Some literature cited in this review draws upon the journeys of women trying to find their own personal identity, the conflicts that sometimes arise about what they think is expected of them in their families or social environments, and the interruptions of healthy emotional development that can manifest into an eating disorder. Other literature explores the claim that there is an association between eating disorders, trauma, cultural expectations, personal, familial struggles, and the process of grief. The combination of these primary experiences during an important time of ego development for Mary was a recipe for the manifestation of her eating disorder.

The Biological Perspective on Eating Disorders presents an overview of biological causes for eating disorders. This section also demonstrates the importance of genetic and biological implications that may lead to eating disorders. The second section,
Cognitive Behavioral Perspective on Eating Disorders, reviews literature from the standpoint of both etiology and the treatment of eating disorders from a cognitive behavioral perspective. Researchers in this school of thought tend to emphasize maladaptive cognitions to correct harmful behavioral rather than causes of disorders.

The third section, which is entitled Psychodynamic Perspective on Eating Disorders, focuses on early childhood experiences and the interactions an individual has had with their family members. This section looks at attachment to the mother and the relationships, childhood dynamics, and experiences within the family. The next section, Sociocultural Perspective on Eating Disorders, looks at social and cultural issues. This perspective emphasizes and highlights the impact that cultural environment has on ego development and demonstrates the relationship between how the development of the self has been influenced by an individual’s interactions with cultural and social norms.

Following these sociocultural considerations is the Humanistic Perspectives on Eating Disorders section which looks through the lens of human validation, self actualization, and the development of the person.

The sixth section, Imaginal Approaches to Eating Disorders, considers a broad range of resources to bring in meaning and significance while looking through the lens of reclaiming the soul. This section highlights Imaginal Psychology which Omer describes as a “distinct orientation to the discipline of psychology which reclaims soul as its primary concern.” ¹
Biological Perspective on Eating Disorders

This section addresses current research on physical, biochemical, genetic, and biological factors and processes which may predispose, contribute to, or influence the development of eating disorders. From the biological perspective, many researchers found that biochemical and emotional reactions to physical changes in the body can activate tendencies toward the development of eating disorders and frequently associated depression.

Julie M. Clark and Ann Kirby-Payne conducted interviews with adolescent girls to find how weight and depression, along with the effects of the biological and physical changes in the body caused by pubescent hormonal changes, are connected to body dissatisfaction and depression and can lead to eating disorders. Clark and Kirby-Payne asked the teenage subjects of the study to describe their perceptions of beauty. The authors points out that the teenage years are a time of excitement, experimentation, and growth as adolescents come into adulthood and leave childhood behind. Their findings were that becoming an adult involves major transitions, both psychologically and physically, as the mind expands and body size, shape, and functions also expand. Hormonal changes bring about visible metamorphosis which affects social status and perceptions of oneself. Perceived changes in appearance begin to affect the adolescent’s feelings and thoughts towards themselves, which in turn affect health and appearance. The resulting internal turmoil, including “a raging sea of new hormones,” can be both exciting and terrifying and can negatively affect ones emotions, causing self-consciousness and even depression.
According to Steven A. Wonderlich et al., for an adolescent who develops an eating disorder, even when there is minimal distress from the biological changes, trauma can interrupt an individual’s healthy development. Wonderlich et al. “test(ed) the hypothesis that childhood sexual abuse increases the risk of eating disturbance in children.” In this study, 20 sexually abused adolescent girls between the ages of 10 and 15 were interviewed and the results were compared with interviews of another group of 20 children who had not been abused. Participants completed psychological testing which assessed eating disorder behaviors, body image concern, and past childhood trauma. Test outcomes indicate the children who had been abused showed higher levels of weight dissatisfaction, bingeing and purging, and disordered eating habits than the children who had not been abused. Further, abused children reported eating less than control children when they felt emotionally upset. The study also shows that abused children were more likely to exhibit perfectionist tendencies, and to desire a thinner body. The results support previous findings with adult subjects which indicate that a history of childhood sexual abuse is associated with weight and body dissatisfaction, along with purging and dietary restrictions.

Another research study by Wonderlich et al. examined the relationship between sexual trauma and eating disorder behavior. Research with adult female victims of childhood sexual abuse and rape showed that victims of sexual abuse tend to display multiple forms of self-destructive behavior including eating disorders. Further, victims of childhood sexual abuse are more likely to develop eating disorders, body image concerns, and self-destructive behaviors than people who were raped in adulthood. The authors also found that the effect of repeated sexually traumatic events at different points
in the lifespan of child abuse victims suggests that they may be re-traumatized by later abuse experiences. Wonderlich et al. mention that in studies of depression there is evidence that childhood abuse survivors who continue to experience traumatic or stressful environments are more likely to display an endocrine hypothalamic-pituitary-adrenal (HPA) axis dysregulation and are at higher risk for Post Traumatic Stress Disorder. The authors state that there is evidence that early trauma increases the risk of PTSD following later trauma.

According to van der Kolk, McFarlane, and Weisaeth, the effects of overwhelming experience on mind and body which defines trauma can precipitate Post Traumatic Stress Disorder (PTSD). Their research involved collecting information about acute cortisol response from blood samples in 20 recent rape victims. Three months later, they gathered a history of prior trauma and the subjects were evaluated for the presence of PTSD. Victims with a prior history of sexual abuse were significantly more likely to have PTSD than the rape victims who did not have prior sexual abuse. Compared to rape victims without a history of sexual abuse, victims with histories of prior assaults had lower cortisol levels of after rapes. These findings can be interpreted to show that prior exposure to traumatic events results in either blunted cortisol response to later traumas or in a quicker return of cortisol to baseline following stress.

In a study of 934 women, Favaro, Ferrera, and Santonastaso examined the prevalence and phenomenology of self-injurious behaviors (SIB) in young women. The study concerns itself with the relationship of SIB to several variables including body image disturbances and childhood abuse, and also to eating disorders and suicidality. In the study, participants were asked to complete a general health questionnaire which
measured levels of emotional distress and examined their attitudes and feelings about their bodies. In order to screen for eating disorders, the authors included the eating disorders section of the Structured Clinical Interview for DSM-IV (SCID). Participants reported on their past experiences of victimization and violence. All participants who met the criteria for impulsive SIB also reported childhood abuse thus demonstrating that the self-injurious behaviors of participants with episodes of anorexia nervosa, bulimia nervosa, and/or history of suicide appears to be rooted in childhood abuse and victimization.\(^2\) Favaro, Ferrera, and Santonastaso showed that self-injurious behavior and eating disorders share many characteristics. Both occur primarily in females during adolescence and are motivated by a need to control the body during or after experiencing uncontrollable changes during puberty. Self-injurious behavior and eating disorders are also both associated with body dissatisfaction. The authors’ findings indicate that self-injurious behaviors are attempts to both control and prevent uncomfortable emotions and to obtain relief or gratification.\(^2\)\(^3\)

Other researchers’ studies look at ways that various forms of sexual abuse often precede bulimic eating behavior. Authors Regina Casper and Sonja Lyubomirsky explored the relationship between bulimia and sexual abuse. The authors studied 61 women with bulimia nervosa and a control group of 92 women without an eating disorder.\(^2\)\(^4\) The methodology utilized various questionnaires regarding eating behavior, sexual abuse, and individual and family functioning.\(^2\)\(^5\) The results show a strong relationship between sexual abuse and bulimia. Results indicate a stronger relationship between a woman’s psychological dysfunction and bulimia than between her family’s dysfunction and her bulimia. Casper and Lyubomirsky found that people with bulimia...
were more often depressive, suicidal, and/or impulsive but that they did not turn to substance abuse.\textsuperscript{26} They also found that emotional distress and impulsive behavior were important indicators of disordered eating.\textsuperscript{27}

Holly Clemmens et al. write about the risk factors in what they describe as unhealthy weight control involving continual dieting and unhealthy measuring of weight which greatly increase the risks of developing an eating disorder.\textsuperscript{28} The authors also suggest that as eating disorder behaviors progress over time, a physical and emotional breakdown of the mind and body can occur with possible side effects including cardiac abnormalities, stroke, osteoporosis, thyroid issues, vitamin and mineral deficiencies, dental degeneration such as bone loss and gingivitis, and psychological anxiety and depression.\textsuperscript{29}

According to a study by Stewart W. Agras and Betty G. Kirkley, there is a genetic link between bulimia and affective disorders; the appetite of a person who exhibits bulimic eating patterns may be the result of a genetically inherited biochemical abnormality.\textsuperscript{30} The authors found that bulimics exhibit extreme mood swings often with underlying sadness and irritability. They also found that prior to and during a binge eating episode bulimics tend to experience severe and intrusive negative feeling states, particularly anger while after purging, bulimics reported a lessening of angry emotions and increased feelings of control, adequacy, and alertness.\textsuperscript{31} Agras and Kirkley theorize that negative feeling states may predispose an individual to severe depression and increase the risk of developing bulimia.\textsuperscript{32} In this scenario, Ineffective self-regulation results in an intense longing for body thinness which can lead to restrictive eating and when restrictive eating begins, then feelings of deprivation may result in binge eating.\textsuperscript{33}
Divya Kakaiya discusses athletes’ risks for developing eating disorders and examines ways to identify athletes who may be predisposed to develop an eating disorder. She speaks to both genetic and environmental influences which may put an athlete at risk of developing an eating disorder. Kakaiya found that both perfectionism and over compliance were indicators of such a risk. She also discusses the physical impact of eating disorders including heart conditions, endocrine system, reproductive system and kidney functional complications, and effects on gray matter in the brain related to memory and concentration. These physiological effects are complications and results of long term eating disordered behavior and can be life threatening.

Another contribution to the biological perspective in this literature review is from Dan Harmon, who says anorexia nervosa represents a starvation for attention. He also states that the likelihood of a family member developing an eating disorder is greatly increased if a first-degree biological relative, like the mother has also struggled with some form of this the disorder. Some evidence presented by the authors suggests that there is a higher risk of depression if a biological family member has an eating disorder.

A personal example of this family connection is presented by therapist Linda Rio and her daughter, Tara M. Rio, who co-authored the Anorexia Diaries, the story of their struggles with eating disorders. The book tracks their mutual search for healthy relationship with the self as they both share their personal struggle in dealing with an eating disorder and the possible biological connection to eating disturbances. Teenager Tara’s diary held the secret of her eating disorder and when her mom found out, Tara soon learned that her mother also had a secret. The authors present their journey toward recovery as they faced their problem together.
Literature from the biological perspective illustrates a linkage between hereditary factors, adolescent hormonal changes, appearance and performance demands, biochemical tendencies, and eating disorders. From this perspective, Clark, Wonderlich, Favaro, and other researchers agree that biological factors can predispose eating disorders. However, the biological research does not take into account broader family, cultural, and sociological factors which may also influence tendencies toward eating disorders.

**Cognitive Behavioral Therapy Perspective on Eating Disorders**

The cognitive behavioral perspective on eating disorders demonstrates the relationships between thoughts, behaviors, and actions. The cognitive approach is to help illuminate behaviors and belief systems that are contributing to the eating disorder and destructive behavior. Cognitive therapy helps to identify negative core beliefs and cognitive distortions in order to help influence new and healthier behaviors. Cognitive behavioral therapy is the prevailing treatment for eating disorders.

Christopher Fairburn and G.E. Wilson Key, who have been key theorists in cognitive treatment with bulimics, explain the phases and goals of cognitive behavioral therapy (CBT) as applied to bulimia. The treatment has three stages. The first involves education about bulimia and orientation to its treatment with CBT. The second stage brings an increasingly cognitive focus as patients are taught to identify and begin to change their dysfunctional thoughts and attitudes about their shape, weight, and eating. During the third stage the focus moves to relapse prevention strategies that will support the maintenance of change following treatment. The authors assert that CBT produces
reliable and broad-based improvement in clients with Bulimia Nervosa, citing good maintenance over time. They also found that CBT is superior to antidepressant drugs although they do admit the possibility that there may be some value in combining the two and suggest further research in this area. Finally, the authors findings suggest that changing attitudes, perceptions, and behaviors is more effective than medicating and suppressing these thoughts and perceptions. This conclusion leads the authors to argue that CBT is the treatment of choice for bulimia and shows promise as an approach for binge eating.

In another work, Fairburn also discusses cognitive therapy methods for anorexia and bulimia as the treatment of choice. He posits that beliefs and values are very important mediating factors in bulimia and states that change in thoughts, values, and behaviors are a necessity for maintained recovery from an eating disorder. He strongly suggests that CBT produces the needed change for a successful treatment from treating disorders.

According to G. E. Wilson, Lara Hensley Chaote, and Alan Switzer, cognitive behavioral therapy is considered the gold standard for treatment of eating disorders because there is the most evidence for its efficacy. They compared mental health counseling responses on a prevention/treatment continuum for eating-related concerns in young adult women. They claim that in clinical trials comparing CBT with other forms of treatment, CBT is superior to other approaches including medication and note that the National Institute for Clinical Excellence recommends CBT as the first line of treatment for eating disorders and Bulimia Nervosa. Citing Fairburn, the authors note that when a girl or woman with low self-esteem becomes aware of social cultural messages about the
beauty ideal of thinness, she may interpret these messages as avenues to achieving the happiness and self-worth she seeks. She then internalizes these messages and believes that body shape and weight are the most important determinant of her worth.

Marlene Boskind-White and William C. White describe thinking patterns which they call *food for therapy* which primarily focus on behavior. They assert that once negative core beliefs and maladaptive behaviors are identified, then changing one’s thinking can help influence future actions toward more positive response in their lives. Boskind-White and White also write about the binge/purge cycle and coined the term *bulimarexia* to describe the binge purge cycle. They claim that this cycle is a learned behavior and maladaptive response that comes from female socialization. Along with learned behavior, Boskind-White and White found that the patient’s relationship with their parents was also important; low self-esteem and a lack of feeling adequate is fueled by a distant relationship with their father and unstable relationship with the mother. Finally, Boskind-White and White talk about cultural messages via widespread media about beauty and the idealization of a thin body as well as the fact of overwhelming availability of junk food, media, peer pressure to be thin and the influence to eat excessively as prominent factors in disordered eating. Boskind-White and White found that while many factors can influence the development of an eating disorder, cognitive therapy is focused on the treatment of eating disorders regardless the cause and is a treatment of choice for extinguishing maladapted behaviors of the eating disordered.

Cognitive researchers and authors Pamela M. Williams, Jeffrey Goodie, and Charles D. Motsinger, discuss cognitive therapy treatment methods for eating disorders. Williams, Goodie, and Motsinger note that cognitive behavioral therapy
is the most effective form of treatment for eating disorders. They also believe cognitive behavioral therapy provides tactical ways to identify and change unproductive behaviors and achieve more desired outcomes for those struggling with eating disorders.

Richard Stein et al. discuss what drives the “binge” in binge eating disorders and examine root causes as well as consequences of eating disorders. Their subjects were 33 females with binge eating disorder (BED). Using a handheld computer for seven days, participants were periodically prompted to indicate their current emotions, hunger, and binge status. The results were that negative mood and hunger were significantly higher at pre-binge than at non-binge times, but negative mood was even higher at post-binge. Participants attributed binge episodes to mood more frequently than to hunger or abstinence violation. Given that bingeing actually heightened negative mood, the question was what reinforces a binge, including possible escape from self-awareness. Applying restraint theory, the authors stated that an excessive desire for thinness can lead to unrealistic dietary restraint and the need to compensate for excessive deprivation. This abstinence violation effect is a cognitively based variation of restraint theory, suggests that in the inevitable violation of extreme dietary restraint activities of all or nothing thinking of perfect restraint, versus complete failure. These extreme restrictive thoughts and heightened negative mood not only inhibited mood and controlled what one eats it also lead to binge eating. Once binge eating occurs, a tense and rigid restraint is theorized to begin again, and the cycle continues.

Alan Schwitzer et al. researched eating disorders among college women. The research found that though college women did not fit all symptoms for eating disorders, many of their symptoms and obsessive behaviors did fit in the Diagnostic and Statistical
Manual of Mental Disorders (DSM) regarding eating disorders. Symptoms including compulsive exercising and restricting food or binge eating had been actively played out among subjects of the study and that the participants constantly ruminated about food and exercise.  

Though there are limited resources from the perspective of cognitive behavioral theory concerning eating disorders, Fairburn, Key, and others from this perspective claim CBT to be the prevailing and preferred treatment modality for eating disorders. However, CBT alone does not take into account other considerations that are discussed in the following sections of the Literature Review. For example, missing is any mention of trauma, cultural influences and roots and causes of eating disorders.

Psychodynamic Perspective on Eating Disorders

The psychodynamic perspective draws from many theorists and is based upon Sigmund Freud’s work on the relationship between childhood experiences and human behavior.  

According to Raymond Corsini and Danny Wedding, Freud established several general principles of human behavior. One principle that seems relevant to eating disorders is the pleasure principle which states that there is an innate human tendency to seek pleasure and avoid pain.  

Also relevant is Freud’s concept of transference, the process by which a client transfers their feelings about someone from their past onto the therapist.  

This concept is applied widely today to help the client and therapist learn about how they are responding to people in their daily life. Freud’s later instinct theory of personality references innate instincts or drives. The blocking of the instincts creates an anticipation of harm, causing intolerable anxiety and bottled up energy presents as
symptoms. Freud’s later research identified repetition compulsion as that tendency for humans to repeat self-defeating or painful acts as part of an instinct to destroy. In the field of eating disorders, many modern authors and researchers have built upon these theoretical foundations.

Geneen Roth stresses that hunger is not just about physical hunger. She asserts hunger represents the natural hunger for relatedness and intimacy and that binge eating is a solution to the need for relatedness and intimacy. To the one struggling with eating disorder, compulsive or binge eating feels like the only option for intimacy which the binge eater both craves and fears in a cyclical manner. Roth also notes that the individuation process for a young woman can become a feeding ground for eating disorders to manifest in. She speaks to the importance of compulsive feelings about people, things, or substances and ways that food can relieve emotional despair. Children respond to their pain by shutting themselves down emotionally because this is less threatening to them than the overwhelming pain. Roth goes on to speak about using food to substitute for the lack of love and care in our lives.

James Hollis sees the choice of an eating disorder as a personal complex that defends against anxiety in an archetypal strategy for dealing with undefined threat. Citing Carl C.G Jung’s idea that the loss of a nurturing mother activates the negative mother complex, Hollis states that to be abandoned in a motherless universe is unbearable so better to worry about food intake. The abandoned child fears for her survival if her mother is not feeding her emotionally with nurture and care and so turns to food for the feeding. A neurotic worry and preoccupation becomes a way to avoid what one fears would obliterate them in a primitive primal defence against angst.
Helpful when considering the treatment of eating disorder are thoughts from Heinz Kohut. According to Mario Jacoby, Kohut held that individuation necessitates a certain amount of narcissism. Kohut’s view was that without healthy narcissism one may not have enough libido or confidence to individuate from their caregiver.

Nathanson discusses shame and describes four manifestations of this affect which comprise what he calls the compass of shame; these various manifestations provide affect regulation. Nathanson provides an example of shame helping to regulate other affects as follows: A child growing up may take on the belief of being not good enough and being unloved rather than the far more dangerous belief that their parents are incapable of loving them. However, the cost of this belief is feeling unworthy, flawed, and ultimately ashamed for such inferiority. Nathanson theorizes that the resulting overwhelming shame must then be managed through shame affect regulation which includes four poles of possible reactions to any shame experience which are to withdraw, avoid, attack self, or attack others.

Lori Goldfarb discusses another example of affect regulation. Her research consisted of case reports on three women who were survivors of sexual abuse and had eating disorders. This research points to the correlation between childhood trauma and how it can impact the development of the child or adolescent. In her discussion about the association between sexual abuse and eating disorders, Goldfarb speaks to how eating disorders may develop close to the time when a person may be experiencing sexual abuse, and that eating disorders are often triggered during developmental stress. Goldfarb goes on to suggest that eating disorders may serve to manage the pain and provide some sense of control in one’s life.
Mary Bolen and Michael Kerr’s work emphasizes the necessity to differentiate which is an important process of separating from one’s family and building an individuated self. Bolen and Kerr utilize the Bowen Family Therapy Model to discuss how important this process is for the individuality of the person and they note that the consequences for those who do not differentiate from their family are dire. Bolen and Kerr believe the individuality and differentiation are often used to describe the same process, but they see them as two separate operations. They describe individuality as a life force and differentiation as a process. According to Murray Bowen, differentiation, “describes the process by which individuality and togetherness are managed by a person and within a relationship system.” Using Bowen’s model, Bolen and Kerr note that a person with a low level of differentiation generally has relationships that are enmeshed. Additionally, they lack individuality and have difficulty acting with autonomy. Their emotional and intellectual functioning is merged in such a way that their hasty and pronounced emotional reactions put other’s needs before their own. Bolen and Kerr also found that when there is a low level of differentiation and a high level of unresolved emotional attachment to parents, there is a subsequent need to go to extreme means to attempt differentiation. The authors contend that parent/adolescent relationships are influential in the manifestation and the treatment of eating disorders. Without a healthy context, unresolved feelings and internal conflicts create repressed feelings that cannot resolve and adolescent manifests this struggle in many ways such as denial, a severed relationship with self, and or the parent. Further, an eating disordered client tends to eat their feelings.
Cheryl Dellasaga brings a systemic perspective to what families go through when supporting loved ones who are suffering from anorexia. Family dynamics are an important factor in the manifestation of eating disorders and can impede or assist in the healing process. Dellasaga suggests that an individual’s eating disorder is symptomatic of what is happening in the family and that the whole family system needs healing. The author holds that the family’s awareness of how the eating disorder affects not only the individual with the condition but the whole family and the family’s commitment to create and make change together are prerequisite for a successful treatment. Dellasaga uses the image of the *starving family* to illustrate and tells stories of families which have suffered the stressful experience of a family member with eating disorders. Included in her writings are strategies shared by dozens of families who had loved ones that struggled with this disorder.

Steven Giles, Donald Helme, and Marina Kramer also contribute to thinking about family dynamics and as well as social norms. Participants for the study were incoming college freshman were interviewed and researchers studied their disordered eating in relation to social norms, family patterns, and body esteem. Giles, Helme, and Kramer’s findings were that college-age women specifically struggle to fit in and perform in college while bringing with them their past negatively impactful childhood experiences.

Sarah Meehan applies object relations theory to illustrate a link between the psychological experience of emptiness and the development of disordered eating. Meehan argues that when there is a lack of good enough internal presence due to failures in caregiving during early childhood, the result is an experience of emptiness.
there is an intense feeling of emptiness there is likely a corresponding intense longing for a caregiver to fulfill unmet needs. The individual is then likely to seek a caregiver substitute to manage the empty feelings which seem to be a threat to survival of the self.\textsuperscript{101} The author states that food can serve as a substitute caregiver for the bulimic child.\textsuperscript{102}

Meehan also looks at patterns of disordered eating as a physical enactment of object hunger. According to Meehan, a person with bulimia struggles with a conflict between insatiable longings and avoidance of those longings.\textsuperscript{103} The author suggests that effective treatment involves helping a person develop an increased understanding of their experience of psychological emptiness and the ways in which one uses disordered eating as an attempt to express and to manage the unbearable experience of emptiness.\textsuperscript{104}

The psychodynamic perspective provides a foundational view of the underlying dynamics from early childhood development which may predispose an individual to eating disorders. Building upon Freud’s theory that past experiences affect present and future behavior, the psychodynamic literature reveals ways in which adverse childhood experiences contribute to the etiology of eating disorders. However, the emphasis on childhood experiences ignores social and cultural factors that may also influence eating disorders. The psychodynamic literature also overlooks the influence of a child’s individual temperament, personality and biological characteristics relative to eating disorders.
Sociocultural Perspective on Eating Disorders

This section will demonstrate the, family, cultural, and environmental influences related to eating disorders. This section has a wide range of literature with many examples of how social norms and the culture can contribute and influence an individual’s propensity to develop an eating disorder. This appears to be one of the most extensively investigated areas of research on eating disorders.

The sociocultural perspective on eating disorders includes consideration of culture, social interactions, and historical context, in relation to individual psychology. Mary Pipher relates eating disorders to the cultural dynamics that affect a child’s development. One cultural message communicated to young people is to be thin in order to be accepted. Pipher believes today girls are more oppressed than ever before as they come of age in a more dangerous, sexualized, and media-saturated culture. They face incredible pressures to be beautiful and sophisticated which often means using chemicals and being sexual. As they navigate a more dangerous world, girls are less protected because they are objectified which can poison a young girl’s creative spirit and negatively influence her body image. Pipher also discusses the critical difference between how young women and young men are treated in our culture; academic and social expectations during adolescence reduce a young woman’s voice when she is told to smile even when she is sad. Disconnecting from ones true feelings eventually leads to a loss of self.

Yancey discusses how a women’s distorted body image contributes to young women developing an eating disorder. The eating disorder takes hold as young women
use starvation methods, food restricting, yo-yo dieting, bingeing and purging and as family, friends, coaches, and others apply pressure for them attain a certain body type.  

According to Yancey, eating disorders have affected significant numbers of teenagers in the United States but have only been studied seriously since the 1970s. Eating disorders began to gain wider public awareness in 1983 when famous singer Karen Carpenter died from complications of Anorexia Nervosa. Yancey notes that although binge-eating is not considered a true eating disorder, it is identified as a symptom typically present in both bulimia and anorexia. Yancey observes that experts agree that people often overeat for psychological reasons and the symptoms exhibited by binge eaters are similar to those exhibited by anorexic and bulimic individuals. Today more and more eating disorder therapists are treating clients for binge-eating.

In her early works on eating disorders, pioneer Hilda Burch (from 1943 to 1984) found eating disorders to involve an interaction between physiochemical, physiological, psychological, and sociological factors. Though there is much more to be learned before the illness is fully understood and treatment more successful, Burch contributed enormously to today’s understanding and knowledge about anorexia. She was one of the few early on who looked at eating disorders as rooted in a combination of psychological makeup and temperament as well as the socio-cultural influences on one’s psyche manifesting in a eating disorder.

Joan Jacobs Brumberg focused her research on Anorexia Nervosa. She notes that women were starving themselves over a century ago. Interested in the changing historical experience of female adolescents in the United States, she was drawn to the range of issues having to do with adolescent physical, social, and cognitive development
within family relations, education, and sexuality. Inevitably, she had to confront the issue of Anorexia Nervosa and eating disorders because they were gaining attention and momentum. Her curiosity was evoked about which historical forces account for its emergence as a modern disease.

Brumberg says that today’s anorectic is one in a long line of women and girls throughout history who have used control of appetite, food, and the body as a focus of their symbolic language. Although Anorexia Nervosa is considered by many as a relatively modern disease, female fasting is assuredly not a new behavior. In fact, there is a long history of food refusing behavior and appetite control of women dating back to the medieval world. Brumberg notes that Anorexia Nervosa implies important continuities and differences in female experience across time and place but notes that causes may vary and the behavior may or may not be biologically based. She believes that while women with behaviors of fasting and/or food refusing may have a variety of reasons for their behaviors, ultimately they are attempting to control appetite. Brumberg says that even as basic human instinct and appetite is transformed by cultural and social systems this disease has been defined and redefined over time. For example, in the Victorian era there was no diagnosis or understanding of eating disorders. The emergence of Anorexia Nervosa during the throes of the development of industrial capitalism was nurtured by aspects of bourgeois life of intimacy, material comfort, parental love and expectation, and the sexual division of labor. Brumberg notes that being heavy was a sign of affluence at the turn of the 20th century, making eating disorders a middle class phenomenon. Brumberg contends that the middle class population has an expectation for achieving status and control of their destiny which increases emotional stressors. The
abundance of food that middle class style allows becomes a comfort to them. While others before have used food as a sign of status and for emotional gratification, the anorexic’s refusal of food is a parallel sign of control of their destiny. Internally, for the anorexic a battle ensues involving these two manifestations of status and control.

Carol Emery Normandi and Laurelee Roark also speak to the important factor that the cultural attitude to be female is to be on a diet and worried about weight to the point of being on the verge of an eating disorder. Normandi and Roark also declare that to be female is to hate one’s body and to strive for an ideal body that is unnatural for most females. Normandi and Roark speak to the billions of dollars spent on advertising that shows very thin models, and billions more spent on diet programs so that one can attempt to look like these super-thin models. Noting that the pressures are everywhere and there is a cultural attitude beyond physical hunger, the authors state that women are actually taught to diet through images presented in and through magazines, television, movies, friends, and one’s own families.

Caroline Knapp states that a woman’s appetite for food, love, work, and pleasure is shaped and constrained by culture. She gives an account of her personal story and offers a cultural look at female identity and body image. Noting that appetites are for much than about food, Knapp speaks to the importance of “why women want.” She describes the dilemma of denying food because on some level, starving makes sense to young women who are controlling their food. By starving they express their inner conflict and also deny that their emotional needs are overwhelming. Knapp warns that, cultural experiences in society today are creating negative influences upon sense of self and self-acceptance for physically developing youth.
Courtney Martin studied women in different ethnic groups to see how the effects of culture impact body image and behavior. Through interviews Martin observed the struggle of young women attempting to be perfect in order to fit into their perceived cultural values of thinness and external appearance, often starving themselves as a result. Noting the terrible effects of anorexia and the grim statistics of treatment, Martin’s findings were that as many as fifty percent of anorexics treated for the disorder do not respond to treatment and many have later died. Martin shares many stories of young girls tormented by societal expectations to be thin and includes discussion of the different effects for each particular ethnic group’s culture; she concludes that anorexia is a symptom of that we are starving for acceptance in our culture.

Janelle Lynn Mensinger, Deanne Zotter Bonifazi, and Judith LaRosa discuss the cultural and archetypal implications of gender-related body appearance and expectations. The authors discuss the expectations for women to embody an idealized superwoman. They also note that although significantly less evident, in recent years there is a rise among young men aspiring to meet current cultural body image expectations to be thin.

Betsy Lerner explores ways that women’s issues develop in relation to food and self-loathing. Lerner speaks to the relationship of mood swings that accompany the struggles of a young woman living with the extremes of dieting, overeating, obsessive-compulsive behaviors, and depression. Lerner speaks to how many young women struggle with self hatred about their bodies and go to great lengths of physical destructiveness to attain thinness.
Francis Berg talks about how society is creating pressure for young people to be obsessed with their weight. Berg gives clear guidelines of how to make nutritional and supportive emotional changes at home, school, or in the wider community. Berg provides guidelines for self-care through eating for internal health as opposed to external thinness or bingeing and purging to achieve thinness. She speaks to the importance of creating an environment for our young people at home, school, and the wider community that supports self-acceptance and healthy daily living.

Observing that cultural norms can create an atmosphere that permits acts of horrible trauma, Robin Warshaw writes about how culturally rape is not acknowledged as rape when enacted by an acquaintance. Warshaw gives statistics of how only 27 percent of women whose sexual assault met the legal definition of rape thought of themselves as rape victims. Because of their personal relationship with their attacker, it took them longer to perceive an action as rape. Warsaw states this is because for a woman to recognize her experience as rape, it requires one’s acknowledgment of the extent to which her trust was violated which in turn, means the ability to control her own life is impossible and feeling safety in the world is destroyed.

According to J. Mitchell, Bulimia Nervosa can be a symptom of a personality disorder. (In the DSM-IV, a personality disorder is defined as behaviors that are consistently inflexible and rigid and result in dysfunction, distress, and impairment in an individual.) Mitchell asserts that the culture influences bulimia and anorexia because it values thin physical bodies and yet an abundance of food in our culture. Further complicating and influencing the development of eating disorders is shifting roles of
women in society which tends to create confusion for women about who they are and how they should look.\textsuperscript{142}

The sociocultural perspective contains the greatest amount of theoretical literature related to eating disorders. Pipher, Yancey, and Burch provide a foundational view of the sociocultural impact on young girls today. These authors and others provide substantial evidence about how detrimental the pressures and expectations of the culture are upon young women. However, there is a gap between the theory from this perspective and other perspectives, particularly regarding psychodynamic or biological considerations. For example, personality and temperament as well as genetic make-up are also significant factors in considering a young person’s vulnerability to eating disorders.

**Humanistic Perspective on Eating Disorders**

Humanistic psychology is founded on the concepts of self-actualization and validation presented in the works of Carl Rogers and Virginia Satir. The humanistic perspective on eating disorders examines internal states of emptiness and positive and negative regard of the self. The humanistic perspective on eating disorders exemplifies Carl Rogers’ principle regarding the importance of personal development in a growing relationship with the self and Satir’s emphasis on the need for self-esteem and a sense of self-worth.\textsuperscript{143}

Rogers’ approach is to help clients feel unconditionally supported by attentive listening and reflecting to the client what was heard and understood which he called \textit{client-centered therapy} with \textit{unconditional positive regard} for the client.\textsuperscript{144} Rogers speaks about the human growth potentiality and how it is the key to becoming a
He asserts the importance of discovering and becoming who one is with an emphasis on the authenticity of the client’s experience. This authenticity is the prerequisite for the attainment of happiness and well being in life. This approach, combined with art therapy in work with eating disorders and trauma, is, according to Sara Meehan, the preferred treatment to understanding the unmet needs a person’s symptoms that are presenting in an eating disorder. The unconditional positive regard gives the client enough safety to express through art therapy their fears, their hopes, and their internal conflicts.

Natalie Rogers utilizes expressive arts therapy that is grounded in her father’s client-centered approach. Natalie Rogers describes this approach in working with trauma-induced grief and related eating disorders as a caring in depth way a client can work through the stages of grief, anger, sadness, and more in an individual’s grief process; caring in depth is a philosophy which incorporates the belief that each individual has the capacity for self-direction through their grief process. Art therapy can act as a guide for the expression of surfacing feelings associated with bereavement and the grieving process at times associated with eating disorders.

Satir addresses the need for helping clients develop a solid sense of self-acceptance, self-esteem, and self-worth. Her therapeutic model for building a healthy sense of self involves working with the image of a pot of self-worth. She strongly suggests that children with a strong sense of self-worth can better navigate the problems and disappointments of daily life than can those that do not. Satir was dedicated to helping her clients address underlying feelings inadequacy and unworthiness that was negatively impacting their lives. Satir points out the relationship between feelings of
self-worth and resiliency. She notes that when there is a lack of sense of self-worth in daily life, one cannot adequately navigate life’s disappointments; one is not able to rebound and recover which creates further erosion of self-confidence.150 This principle relates to eating disorders which involve attempts to avoid feeling bad about one’s self as defensive and compensatory for feelings of inadequacy. Reaching for perfectionism is an attempt to protect against the vulnerability of being less than perfect. However, given the impossibility of being perfect, one is always flawed. Acceptance of the imperfectness of human existence lives somewhere repressed and unaccepted in the body.

Lisa D. Peck and Owen Richard Lightsey, Jr. note that Maslow’s hierarchy of needs model has a sequential foundation in the basic physiological need for food, then sleep, and next on the hierarchy are safety and shelter in that order.151 According to Peck and Lightsey, this hierarchy can be related to eating disorders because only when the needs are met sequentially can an individual begin to address the next level of social needs such as belonging, love, affiliation, and acceptance. Interruption can prevent the possibility of self-actualization which is connected to self-fulfillment.

Peck and Lightsey studied the eating disorders continuum in relation to self-esteem and perfectionism.152 The authors speak about the spectrum of body image and eating disorders and their link to self-esteem or lack thereof. According to them, perfectionism is a common symptom in those suffering from an eating disorder. Peck and Lightsey talk about the spectrum of body image issues and eating disorders and important connections to the symptoms of perfectionism manifesting in women with eating disorders, noting that lack of self-esteem and prevalence of perfectionist behaviors combine to interrupt the attainment of individual potential.153
According to Suzanne Midori Hanna, narrative therapy provides a technique for externalizing an existing problem for the individual who is struggling with internal structures that impede daily living. The narrative approach is about gaining freedom from internal oppression and gaining liberation through rewriting their story in a safe therapeutic environment. Reframing the story helps the client find possibilities for living life with more freedom and potential. Applying this to the topic of this study, since people with eating disorders tend to become rigid in their beliefs about their body image, narrative therapy can allow them to examine the story in which they are embedded, and to rewrite a healthier more fulfilling edition.

Hanna cites Michael White who suggests that “leading the (client) into hopeful and life-changing conversations about their lives” in order to construct a more hopeful view of events in their lives. Focusing in on the client’s strengths is one of the goals. There is an assumption that the client feels oppressed by their problems. It is important to first learn how the client feels and then guide them to see their own strengths internal power and successes. Part of the therapist’s work involves helping the client create stories of liberation so they are able to separate themselves from the oppression of their problems. This approach, often used with treating eating disorders, uses the language of the client and challenges the client to reframe their perspective on life. In this way, the client obtains freedom and choice with regard the story they have been retelling themselves over the years. This approach emphasizes and affirms steps taken that have helped with the problems and times when the problems did not interfere with the client’s life. Re-writing and re-framing a problem as an old story that the therapist and the client are re-writing together. Narrative therapy tracks both how the client acted and
communicated in the context of the problem, and sequences of actions with presenting destructive cycles and behavior. The goal is to help the client develop a hopeful perspective, enrolling the client’s natural support system in the process.\textsuperscript{159}

A natural internal support system is a perquisite for healthy self esteem and feelings of self worth and somatic psychology offers techniques for getting to know one’s self. Somatic psychology connects one to their bodily sensations and feelings which inform the person of their likes and dislikes. In eating disorders, bodily responses act as a barometer which reflects the polarities between one’s desires and repulsions, and the emotional and physical affect in between. Eleanor Criswell posits that the body is a vehicle for working with mind body integration.\textsuperscript{160} She cites Thomas Hanna who asserted that somatic psychology encompasses the mind/body disciplines. Criswell and Hanna agree that the body is experienced from within, and if this is the case, they reasoned that the impact of psychological experience on our physiology merits exploration. Criswell and Hanna did not work directly with eating disorders, but their concept of the mind/body relationship contributes to the effective treatment of eating disorders.

Rose Murray uses the somatic approach to healing for the well-being of the emotional and physical body through the ancient art of Jin Shin Jyutsu. She states that this art helps balance out the energy in the body where the disharmony may prevent life force.\textsuperscript{161} Jin Shin is a somatic art that helps one connect to the 26 energy locks in the body.\textsuperscript{162} Each energy lock is connected to six depths in the body and is said to be the blood essence that is connected to the secrets of the soul.\textsuperscript{163} These energy locks can be utilized for balancing physical and emotional energies in the body called meridians.\textsuperscript{164}
The body responds biologically and emotionally to this holistic art of balancing one’s body. Murray states this art is a tool for self care of emotional and psychical health as well as a practice of mindfulness for a somatic connection to the physical and emotional imbalances including eating disorders. (See Appendix 4 for Overview of the Jin Shin Jyutsu 26 Safety Energy Locks.)

In this section on Humanistic perspective, theory from Satir and Rogers offers insight into an individual’s emotional development leading toward healthy or maladaptive behavior in the attempt to become self-actualized. Hanna, Criswell, and Murray bring consideration of somatic factors that influence attitudes and behaviors that can lead to healthier self-esteem and self-actualization. However, there is not adequate consideration of cultural and sociological influences involved in a person’s emotional development. The Humanistic perspective does not take into consideration genetics, cultural trauma, and the effects of unhealthy family dynamics.

**Imaginal Approaches to Eating Disorders**

Imaginal approaches to eating disorders integrates many perspectives, by including archetypal forces, myths, stories, and imagery as important resources for understanding and working with eating disorders. Although the majority of imaginal literature does not focus on eating disorders, some theoreticians incorporate the elements noted above in their research.

Omer states that “Imaginal Psychology is a distinct orientation to the discipline of psychology and it distinguishes itself from other perspectives by reclaiming the archetype of the soul.” Omer claims that “soul in psychology is the primary concern.” This
means that soul seems to carry an important message about being true to oneself.

Applying Omer’s thinking to eating disorder, it could be said that the hungry soul is a symptom that relates the message of one’s wounding.

According to Omer, imaginal approaches are “fundamental to the transformation of identity” which is an important element in the transformational learning process. Transformational learning includes a process is called disidentification wherein a person identifies “frozen subjectivities that are restricting experience.” Omer asserts the importance of transforming these “frozen and rigid responses to life experience by working with belief structures to consciously create a spaciousness from otherwise frozen images of the self.” A person can begin to recognize inflexible multiple subjectivities through a process of conversation with the internal subjectivities and gatekeepers and the emergence of the internal Friend can then empower one with reflexivity including about one’s imaginal structures. According to Omer, “gatekeeping refers to the individual and collective dynamics that resist and restrict experience. The term gatekeepers refers to the personification of these dynamics.” Omer defines the Friend as referring to “those deep potentials of the soul which guide us to act with passionate objectivity and encourage us to align with the creative will of the cosmos.” He says that reflexivity “is the capacity to engage and be aware of those imaginal structures that shape and constitute experience.” Omer describes imaginal structures as “assemblies of sensory, affective, and cognitive aspects of experience constellated in images; they both mediate and constitute experience.” The process of using Imaginal Approaches with eating disorders involves recognizing the gatekeepers which are fueling a dysfunction being expressed as an eating disorder and supporting the emergence of the Friend voice to
challenge the gatekeeper’s frozen beliefs and disempower the gatekeeping process; the Friend helps one to examine these beliefs and at the same time support the client who is suffering from these encapsulated centers of subjectivity.\textsuperscript{175}

Omer also speaks about the relationship to the archetypal, personal, and cultural mother and father. He stresses the importance for an individual to have balanced energies of the father, mother, and peer relationships and references the image of a three-legged stool to illustrate the relationship about the Father, Mother, and Peer Principles.\textsuperscript{176} One leg of the stool represented the Mother Principle, which one needs in order to “revive ones innate qualities of nurturing and emotional accessibility.” The second leg of the stool, the Father Principle, “provides the impetus to individuate, to function autonomously in the world, and interact in appropriate relationship to Other in terms of discipline, accountability, and responsibility.”\textsuperscript{177} The third leg of the stool represents the Peer principle which, “through healthy relationships with ones’ peers, provides the vitality and creativity of community and collaboration with others.” When there is an integrated presence of the Mother, Father, and Peer Principles, there is a solid foundation of self-esteem and internal being while if there is not integration, then one is on internal shaky ground of self-judgment and self-imprisonment.\textsuperscript{178} Drawing upon Omer’s theory, the voice of the eating disorder can represent a gatekeeping voice and internal distortion of the Father Principle, pushing one with excessive force to strive for unrealistic expectations and goals.\textsuperscript{179}

Omer also discusses shame, stating that if one can transmute shame then one can have more autonomy in daily life with more freedom to express the true self.\textsuperscript{180} Shame shuts down the self and creates avoidance and withdrawal from life.\textsuperscript{181} According to
Omer principles, shame and guilt are significant factors in the manifestation of eating disorder.

Johnston claims one can transform their relationship with food through myths, metaphors, and story-telling. She sees hunger as a metaphor for love and notes that humans use food to provide comfort, warmth, and even security. This connection between food and love is easily understood considering that the earliest experiences of life typically involved being held in mothers’ arms while being fed. Johnston speaks to the important associations between these early experiences and how a person experiences closeness later in life. In order to re-capture earlier experiences of feeling emotionally nurtured, one might feed one’s self even when not biologically hungry. Johnston notes that eating can be used as a means of comfort at times when dealing with fear or pain; given that modern culture teaches that any pain is bad and should be removed as quickly as possible, food is a convenient tool for repressing pain. Johnston’s philosophy is that a person eats their uncomfortable feelings and she states that alternatively by starving, it is also possible to disconnect from bodily sensations in order to not feel what is inside. One may discover that they plunge into bingeing large quantities of food or eating small amounts of food nonstop whenever those feelings start to surface.

According to Johnston, eating disorders respond well and may be treated effectively with techniques of art therapy, somatic work, imagery, myths and story, archetypal exploration, and metaphor therapy. She observes, “Women can transform their relationship with food through myth, metaphors and storytelling.” Johnston speaks of how loss of story contributes to loss of one’s self. She points out that stories hold symbolic importance in such initiations as a young woman starting her menstrual cycle
when her family and the tribe honor and ritualize her change into the power of womanhood by taking her to a hut for stories of the importance of her new feminine powers and what to expect of her new womanhood.

Marion Woodman, a major contributor to the literature on eating disorders and women’s body image issues from a feminist perspective, states that the current popularity of the thin, narrow, muscular, android body image of the anorexic reflects a male-oriented culture and keeps many unconscious of the feminine principle. Woodman states that in order to find their place in today’s masculine world, many women have accepted male values and accomplished this by compulsive motivation and competition.

Woodman’s states, “Ophelia, the feminine part of oneself, is symbolized by a little walking owl, bewitched by her unconscious feminine, her father, and what ‘they say.’ She never finds her own voice, her own body or her feelings.” Here Woodman uses the myth of Ophelia to demonstrate the way women have disconnected body from soul in order to function in the world today. Woodman also asserts the importance of women recognizing and celebrating their own feminine energy and qualities, for when they do so, they not only accept themselves, but they also thrive in today’s world. The author notes that women today are not utilizing their innate qualities and natural feminine capacities but are instead disowning these capacities and working against themselves in an attempt to become more masculine in their approach to coping and functioning in society. Woodman sees that individuals with body image disorders can be treated with archetypal approaches which help women find harmony in their natural connection to their soul.
According to Woodman, the repression of natural feminine energy is connected to eating disorders in young girls.\textsuperscript{192} She states that the search for perfection can be an archetypal pattern of behavior for girls and women and when one is enmeshed with the need for perfection at the expense of more earthy interpersonal values, the feminine suffers; the increased reliance upon masculine qualities of discipline and action pushes away empathy for oneself and makes more and more demand of one’s self.\textsuperscript{193} Woodman recognizes the need for the feminine and acknowledgement of the beauty of feminine energy, despite their repression.\textsuperscript{194} Woodman relates the psychology of eating disorders and weight disturbances to the Feminine principle and gives insight into the relationship between the individuation process of a woman and the state of her body.\textsuperscript{195} She asserts that feminine energy flows clockwise and when it does so is liberating to a woman’s soul, whereas a counterclockwise flow is unnatural and disrupts the natural rhythm of her soul.\textsuperscript{196} Woodman observes that the efforts of so many women to take a more masculine approach, is “counterclockwise” to the natural movement of energy for women and could be a major cause of depression in women.\textsuperscript{197}

Focusing on women, female identity, and the hungry self, Kim Chernin observes that women’s inner struggles involve the search for true identity which can satisfy their deepest hunger.\textsuperscript{198} Speaking about the child becoming an adult, Chernin sees obstacles in the mother daughter relationship which include the daughter’s conflict with her life transcending the life that her mother led.\textsuperscript{199} Regardless of the attachment and/or relationship between the mother and daughter, the daughter must separate from her mother in order to create her own identity. Expectations for an appropriate female destiny and becoming more of herself is in tension with pulling away from and perhaps
surpassing her mother. The daughter’s guilt about her own more fulfilled life can bring about feelings that she has somehow betrayed and abandoned her own mother which can fuel an eating disorder. For the daughter in adolescent development vomiting can be an archetypal symbol of purging the previous generation. According to Chernin, the daughter’s expression of her struggle to form to a coherent identity given the internal conflict is displayed through her binging and purging.

Chernin observes that given that the daughter must separate and deny her mother’s choices internally and externally, if her mother dies the transformative process is frozen in time and cannot be addressed. The frozen emotion in the young woman’s life prevents her from authentic relationships because she sees all relationships as a reflection of her relationship with her mother. However, the symbolic act of giving birth to one’s mother can move the transformative process.

Chernin’s findings indicate that young women with eating disorders have been unable to individuate, to separate from the mother, because they are carrying the mother’s shadow anger, resentment, envy, and frustration. Reflecting middle-socio-economic class and modern cultural values, it is unacceptable and bad for mother to not be self-sacrificing but also such feelings are never to be spoken of. Additionally, feelings between the mother and daughter were likely not expressed outwardly in the family.

While looking at the daughter’s relationship with the biological mother is important, so too is the daughter’s relationship with the biological father. Linda Schierse Leonard provides this view. She states that a daughter who takes on a masculine identity in reaction to an irresponsible father is cut off from her own authentic life by virtue of her need for power. She may be trapped in a powerful personality that Leonard calls
“Amazon armor,” which may not correspond with her basic personality, since it has been formed out of reaction and not her natural feminine being.\textsuperscript{208} In such reaction, quite often a young woman is cut off from the strength of her feelings, receptivity, and feminine instincts. A woman who has taken on characteristics generally associated with the masculine disposition, would be better served by healthy integration of masculine aspects into her being as a strong woman with the capacity to relate lovingly to the qualities that are associated with the feminine.

Leonard also speaks about addictions and the archetypal obstacles that can prevent creativity.\textsuperscript{209} The judge preys upon the shadow inferior and undeveloped side of the individual and in our unconscious creates a compulsive urge for perfection.\textsuperscript{210} The judge archetype can then play out by judging the self to be not good enough so blocking the natural flow of creativity.\textsuperscript{211} This self-judgment creates a desire for escape often sought through drugs, alcohol, romance and power.\textsuperscript{212} This judge archetype occurs as a common symptom for eating disorders and the addictive cycle of restricting food, a need for perfection and control, as a compensation for internal helpless feelings.

Among the myths and stories of the wild woman archetype that Clarissa Pinkola Estes explores is one called the joyous body and the wild flesh.\textsuperscript{213} She speaks to how wolves accept their floppy ears and deformed limbs and live according to who they are rather than try to be what they are not.\textsuperscript{214} In contrast, women are encouraged to be a certain temperament and have a certain restrained appetite that is considered acceptable.\textsuperscript{215} Too often, women internalize an attribution of moral goodness or badness based upon a singular ideal size, height, weight, and shape which they try to conform to. When women try to maintain moods, mannerisms, and contours according to a single
ideal of beauty and behavior, body and soul become captive and they are no longer free.  

Estes considers the body to be both a sensor and communicator pertaining to motive and intuitive information. She sees the body as a powerful vehicle of spirit and a prayer of life in its own right with memory of images and feelings lodged in the cells themselves; like a sponge filled with water, anywhere the flesh and body is pressed memory may flow out in a stream. Estes sees that to confine the beauty and value of the body to anything less than this magnificence is to force the body to live without its rightful spirit and its rightful form. She notes that women have good reason to refute psychological and physical standards that are injurious to the spirit, which sever relationship with the wild soul. 

According to Kalsched a resurgence of attention to childhood physical and sexual abuse has revived psychiatric interest in trauma. In his clinical writings, Kalsched explores the interior world of dreams and fantasy images encountered in therapy with people who have suffered unbearable life experiences. Focusing primarily on certain dream images which occur in response to critical moments in therapy, the author shows how in an ironical twist of fate, the very images which are generated to protect the self from retraumatization can manifest as malevolent and destructive forces and internal constructs which are themselves the agents of further traumatization, resulting in further trauma. Kalshed further connects Jungian theory and practice with both contemporary object relations and dissociation theories and shows how Jungian understanding of the universal images of myth and folklore can illuminate treatment of the traumatized patient. Drawing on numerous clinical studies, Kalshed gives special attention to the
problems of addiction and psychosomatic disorders as well as related dissociative anxiety and redefines classical interpretations of Jungian theory on trauma by focusing on the archaic defenses of the self and the mythopoetic language of dreams and fairytales.\(^{224}\)

According to Kalsched, trauma is about the rupture of those developmental transitions that make life worth living.\(^{225}\) Kalsched sees this as a spiritual problem as well as a psychological one, and in his observation of trauma he provides a compelling insight into the inner self-care system attempts to save the personal spirit.\(^{226}\) The protector/persecutor self care system is a dual defensive inner complex which disassociates parts of the self as a means of protection from what it views as dangerous.\(^{227}\) Vulnerable parts of the self are attacked and defended. If the complex originates in a severe or early trauma, the result is intense anxiety which has a dissociative effect upon the ego because it disturbs the homeostatic balance of those bodily sensations upon which the ego depends for its cohesion.\(^{228}\)

Carl Kerenyi recalls the myth of Persephone and Demeter, goddess of harvest, as an archetypal image of mother and daughter.\(^{229}\) Demeter’s sheltered daughter was abducted by Hades, god of the underworld, and so was separated from her mother and forced to live in the dark underworld. In her grief the mother stopped tending the harvest which left barren lands and starvation in her absence. In the meantime, Persephone, who must learn to survive in the underworld on her own, found her internal capacities to mother herself. According to Kerenyi, the story of Persephone’s abduction is symbolic of how culture prematurely pushes women into traumatic experiences for which they are unprepared and how they deal with pain, loss, survival, and abrupt transitions in life.\(^{230}\)
According to Robert Bly, a breakdown of the family unit and the dissolution of spiritual and moral values in our culture results in competitive and self-damaging behaviors which are symptomatic of a deeper loss of connectedness to one’s soul. Bly suggests that children today are the products of a generation of missing mothers who have joined the missing fathers forced away from home and family concerns by economic pressures. According to Bly, young people lack support and guidance in the face of life’s traumas and they are deprived of vital experiences and capacities usually transmitted by the parents.

Sylvia Brinton Pereira talks about mythology of the shadow and how this can impact us in our relations with others and ourselves. The shadow can manifest scapegoating in one’s own body. When one believes they are defective compared to the standard of the community, one views themselves as an outsider exiled from the community and so scapegoated. Although she is not directly speaking to eating disorders, there is a correlation in women who are suffering from eating disorders. They begin to isolate from others this greatly impacts their relationships.

Ann Ulanov and Barry Ulanov write about envy in society, illuminating the hurt and pain for both the envied and the envier. According to the authors, the envier needs to dehumanize the envied person and wants to kill what is so right and good about the envied in an attempt to make themselves more acceptable. They note that envy is a part of eating disorders, showing as a young women’s self-loathing and loathing others, all the while they are comparing themselves to some unrealistic ideal. Ulanov and Ulanov show that freeing oneself from the effects of envy, shame and guilt is an
important step in accepting oneself and healing from the self-defeating thoughts of an eating disorder.

In treatment of eating disorders and issues about connection to one’s body, expressive arts therapy helps provide a safe container. Shaun McNiff states that the art space becomes a safe place that is a vessel of transformation. He states that art can heal inside such a container as it allows one to let go and express freely, allowing the most authentic expressions to merge and grow. This type of therapy is also used in imaginal psychology as a modality that frees up the archetypal images inside.

Through the works of theorists including Omer, Woodman, Johnston, and Chernin, Imaginal Approaches to Eating Disorders helps to identify what is restricting the authentic expression of a person’s soul. Theorists help to identify and address the underlying unmet longings of the soul and the fear and shame that can result in eating disturbances. While imaginal approaches allow in-depth examination of the larger patterns of the psyche, because of the risk factors in eating disorders, imaginal approaches require augmentation to support physical health and feelings of safety in the therapeutic process.

**Conclusion**

The commonalities of the psychological perspectives show a similar goal of helping improve the quality of one’s life and differences in treatment approach and what are considered to be causes of eating disorders. Theorists with a biological perspective demonstrate a connection between two or more biological family members who had or
have an eating disorder. The statistics suggests that most eating disorders are intergenerational, due to the interaction of biological and behavioral influences.

From the cognitive behavioral perspective, there is emphasis of the impact of distorted belief systems. The belief of one who has an eating disorder can go hand in hand with the distortions of black-and-white thinking and irrational beliefs. From this perspective, the identification and treatment of these dysfunctional beliefs, attitudes, and behaviors is understood to be primarily a process of instruction and re-learning.

A wide range of the psychodynamic literature demonstrated the relationship between childhood experiences that can interrupt development and predispose one to the manifestation of an eating disorder. The ego development, once interrupted, creates maladapted coping skills that take the place of normal ego development which in turn disrupts the child’s healthy individuation process. The literature in the Sociocultural Perspective explores the environmental and cultural influences which affect the way one feels about their body image. The literature suggests the importance of understanding how individuals are impacted by social norms and cultural expectations.

The Humanistic Perspective on Eating Disorders demonstrates the important relationship between becoming self actualized and the imperative need for individuals to be validated for their experience in order to build of self worth. Imaginal Approaches demonstrates the value of working with images, music, archetypal stories and imaginal structures in order to uncover the underlying causes of dysfunctional affect and beliefs which can be expressed as an eating disorder.

The major theme running through the literature on eating disorders is of how complex and difficult to treat these conditions are. The causes vary and the approach and
orientation of treatment is not clear-cut. Effective treatment may entail an eclectic treatment plan of choices put together by the agency and or therapist in charge of the overall treatment plan. All effective approaches closely monitor the medical risk, health, and well being of client. Many describe eating disorders as a sociocultural and psychodynamically based disorder due to the cultural influence and childhood experiences during an important time of development in adolescence. However, it is unclear whether biological influences alone without other complicating factors can precipitate an eating disorder which, under different circumstances, might not be expressed. Sociocultural influences may be important etiological factors in eating disorders, either precipitating or exacerbating the condition.

Also unclear is whether eating disorders are actually disorders or alternatively extreme forms of cognitive and/or affective responses to other traumatic experiences. It does appear that traumatic experiences manifest in the form of eating disorders, which are incompatible with good health or a balanced way of daily living. In much of the literature, the terminology and diagnoses can handicap understanding. Terms are simultaneously used interchangeably to describe conditions, which in many cases may look the same but are very different. Symptoms may appear similar but express themselves differently and therefore an individual’s treatment needs to be customized because everyone responds uniquely to alternative treatment approaches.

Imaginal Approaches in clinical settings represent an integrated approach that can provide a client with a blend of diagnosis, treatment, and aftercare that best meets one’s biological, cognitive/behavioral, psychodynamic, humanistic, and imaginal needs. All perspectives, combined with Imaginal Approaches help to identify the root cause of an
eating disorder. For example, the therapist’s task of preparing the client for relapse prevention by using the cognitive behavioral skills is significantly enhanced through supporting the client’s dialogue with the imaginal structures. This comprehensive approach to treating eating disorders can create a more complete treatment plan of care that addresses the symptoms and the causes of the manifestations of symptoms.
CHAPTER 3

PROGRESSION OF THE TREATMENT

The Beginning

I met Mary Jones in the context of my work as an intern at Psych Strategies in Santa Rosa, California. In June of 2008, I received training from an eating disorder specialist who helped to orient me to my new internship in the Quest eating disorder program and the Sequoia addictions program. Once I was registered, I was matched with one supervisor for both the eating disorder and the addiction programs. Shortly after I began the internship, it was quite a shock when staff was notified that the program would be closing in a few months. After some internal adjustment I settled into my work and enjoyed learning about the various therapeutic modalities employed in group work with eating disorders as well as addictions. For the first month, I worked primarily with groups in both programs. I was then briefed on the history of a new client named Mary Jones who was enrolling in the eating disorder program.

The following Monday, I met with Mary and the Quest nutritionist. The three of us had planned to meet together to prepare and eat a meal and get acquainted. When I walked into the spacious group therapy room to meet Mary for the first time, there on a big fluffy sofa sat, cross-legged, a thin, pale young woman with her eyes cast down. I wondered at the time what was in store for her future. I knew she had just been released from Herrick Hospital days before, and here she seemed to be waiting at the threshold of a new experience.
As that first meeting unfolded, with initial introductions and friendly dialogue, Mary soon exclaimed that she had reached a dead end in her life and she was physically exhausted. Mary talked about her stay at Herrick Hospital where she had been diagnosed with Anorexia Nervosa and bulimic episodes as well as depression, and had been prescribed medications for her symptoms. From Herrick Hospital, Mary had been referred to the Quest intensive outpatient eating disorder program at Psych Strategies. She had taken a leave of absence from both work and school and now lived in her childhood home with her father and two family dogs.

Mary began treatment in the Psych Strategies Quest intensive eating disorder program three times weekly between nine and fifteen hours per week, including a twice monthly family education evening also attended by her family members. Her treatment involved an intensive therapy program with a complicated schedule. She was assigned a nutritionist, a family therapist, a group process therapist, an individual therapist, a physician and a psychiatrist. As a psychologist intern I was the co-therapist for each of her activities. In this context, I began working with Mary three days a week in three hour sessions.

The first issues to be addressed by Mary’s treatment team (which included her) were the troublesome side effects of her medications, her lack of appetite, depression, and insomnia. Mary was visibly scared and often expressed anxiety and overwhelming apprehension about the future. She was nonetheless cooperative and participated actively and enthusiastically in discussions and exercises and engaged readily in dialogue about herself and her experiences. However, at the same time, Mary’s affect revealed uncertainty and ambivalence about what was important to her. A withdrawn body
language and soft, often hesitant speech contrasted noticeably with her surface enthusiasm and articulate dialogue.

Mary was naturally fair skinned, but even so, she appeared pale. Her straight, shoulder-length white blond hair was clean but unstyled. Her speech was accompanied by delicate hand gestures. She was notably articulate and her demeanor sweet and friendly, while her eyes reflected a deep sadness. Her affect was calm and composed, and yet there was something incongruously delicate, almost fragile in her hand gestures and the way she held her body as if she were sinking or caving into herself. Mary’s shoulders sloped forward and her eyes were half-closed and downcast most of the time. As a posture specialist trained in Yoga, and a personal trainer, I noticed that her ribcage was collapsed and her upper back was hunched forward. This gave her a depressed, sunken-in appearance as if she bore a heavy weight.

In the early days of therapy, Mary ruminated about letting herself and others down, but she did not express her deeper feelings about herself or her situation. She struggled with a compulsive drive to return to school and work, although she was aware that she did not have the strength yet to do either. As Mary struggled, my own performance anxieties arose. After each of those early sessions with Mary, I met with my supervisor. Together, we did breath work and I created a transformative ritual about letting go of worrying about making a difference in Mary’s life. I visualized a garden where seeds are planted by many who witness and help facilitate Mary’s healing journey. I told myself I am one of the many on Mary’s path of exploration and I began to feel calmer through this self-care practice of releasing myself from my own inner voices that were holding me to unrealistic expectations.
Shored up by my supervisor’s support, I began focusing with Mary on the issues that she brought forth concerning her present situation. She was having a hard time adjusting to her medications; Prozac for depression, Lorazepam for anxiety, and Ambien for insomnia. There was a long process of trial and error before her psychiatrist finally found the right combination of medications. In the beginning of therapy, several medication adjustments affected her appetite as well as her mood and her sleep patterns, and seemed to exacerbate fears of gaining weight even though Mary was forcing herself to eat on a regular basis. The treatment team addressed these immediate concerns with collaborative menu planning, which provided a practical focus for getting acquainted and a means to explore new terrain in her relationship with food.

Mary also described difficulties at home in her relationship with her father, who was drinking heavily at times which Mary believed was his means of coping with grief over the loss of his wife. His lack of presence at these times, in addition to his attentiveness to a new woman he was dating left Mary feeling more isolated. Mary’s eyes reflected pain and distress as she described a feeling of helplessness as the urges to restrict her eating and to binge and purge continued. Every day, at every meal, she was afraid she was going to lose control and resume these habits. She continued to be haunted by fears of being fat.

Mary said she felt “frustrated, exhausted and miserable” much of the time. Some of this may have been caused or aggravated by chronic insomnia as well as her weakened physical condition. She felt confused and overwhelmed as she was forced by her health concerns to make major decisions about permanently leaving school and her job and giving up her apartment in San Francisco. Mary was letting go of past parts of her life
and ways of being while she felt weak and vulnerable and uncertain about her future. She would need guidance and support to establish new, healthy life choices.

In therapy we laid a foundation of trust and transparency for Mary to explore the origins and internal dynamics of her eating disorder, and we turned to Mary’s artistic imagination to bring to light her deeper values, hopes and capacities. While Mary was still struggling with the urges to binge and to restrict her food intake, she was also unhappy about her daily lifestyle, which she named “robot living” in one of our first sessions. With this term she referred to the cycle of restrictive eating and then bingeing and purging cycle combined with a compulsive school and work lifestyle. Through these means she pushed herself physically and denied herself food as well as time and space for emotional expression. She was deeply worried about her compulsions and their effects upon her physical and emotional health and well-being.

**Treatment Planning**

The Quest program director assembled a team to provide customized treatment services based on Mary’s initial intake assessment and the information provided by Herrick Hospital. The treatment planning process was overseen by a program coordinator. Our collaborative team consisted of a family therapist, an MFCC specializing in family systems, a licensed nutritionist, and a licensed psychologist. I was part of the team as a therapist intern. Prior to the therapy, we met to discuss how to schedule and integrate the various components of Mary’s treatment plan.

Mary’s treatment plan was complex. Mary and I worked together with each therapeutic specialist sequentially on three days each week plus two Fridays a month.
Each day the focus was on a specific aspect of Mary’s life and experience with the goal of exploring and healing the underlying therapeutic issues and concerns. Below is an overview of the treatment planning in each area of Mary’s therapy.

The nutritionist and I worked together with Mary on Monday afternoons for three hours. We set up required daily monitoring in the form of weigh-ins and check-ins on the status of Mary’s bingeing and purging urges. These check-ins initiated an ongoing dialogue with Mary about her food-related activities in order for us to track her physical status and safety. Mary’s eating habits had altered her biological functions and her hormonal balance, which consequently affected her moods and caused her menstrual cycle to be irregular or completely absent for months at a time. Dietary and nutritional management was an instrumental element of bringing her body and psyche into functional balance.

In the beginning of treatment, because of her fear of foods and of being triggered into an eating binge, Mary was encouraged to prepare and eat meals based on daily menus we developed together. With what proved to be a lively metaphorical mind, Mary soon began to refer to the menus as her “life preservers.” The team decided that once Mary established new eating patterns at home, I would guide Mary to explore images and practices to support her in evolving an overall more healthy and satisfying lifestyle. I introduced to the team the mindful somatic practice of holding Jin Shin Jyutsu pressure points on the body to indentify and release the emotional content, in order to balance out the body’s energy.¹ The nutritionist outlined mindful eating techniques. From Mary’s initial engaged response to imaginal work, we decided to incorporate inspirational music, story, and poetry into our Monday therapy sessions. Most sessions included affirmations
for women concerning self-acceptance and self-love. Based on Mary’s positive responses these methods soon became an overarching theme for Mary’s total therapy which the various therapists collaborated to provide. Visualization, mindful eating, and music therapy were to be followed by journaling and/or art making to express and integrate her experiences and learnings.

Treatment planning for Wednesdays was organized around the exploration of family relationships. Mary’s three-hour sessions would sometimes include discussions about her father or her brother. Using dialogue about current events and situations involving her father and/or her brother, we planned to guide Mary, sometimes with a family member, to explore biographical and environmental influences. A primary intention was to educate the family on eating disorders, with the hope that family members could join with Mary in developing a safe, supportive container for continued healing at home.

I co-facilitated the Thursday sessions with my program supervisor. Our planning goal was to provide Mary with opportunities and tools to process her emotional and psychic responses to her experiences during the course of the therapy by using imaginal dialogue and addressing cognitive issues. We planned exploratory activities including art therapy and narrative therapy that might help Mary get to know her true needs and desires. In seeking access to Mary’s authentic voice we initiated imaginal dialogues with “Ed,” her name for the internal gatekeeping voice that reinforced her eating disorder. Our intention was to help Mary create and live into a new story of her life in which she was in charge rather than Ed. In this process it was useful to help Mary identify cognitive distortions affecting her life.
The Quest team applied these imaginal and cognitive approaches simultaneously and interchangeably throughout the therapy. Cognitive distortions were viewed through the lens of cognitive behavioral therapy and imaginal structures were viewed from various imaginal approaches. Both were then explored with the goal of allowing more integrated and authentic choices and perspectives.

Using a variety of practices, we approached these weekly sessions as opportunities for Mary to explore her repressed internal psyche relative to her emotional and physical distress. Our plan was to help Mary identify the active subjective aspects and source(s), of her identified eating disorder and to understand specifically where and how they were influencing or tripping her up in her daily life. We hoped that Mary would have time to explore her deeper aspirations, hopes, and wishes, and in that process that she might recognize and reclaim some of her suppressed abilities to lead a more healthy and capacitated life.

The focus of the treatment plan for every other Friday evening was “family education and outreach.” These sessions included her father and sometimes her brother with the intention of building support that Mary would need. Sessions were co-facilitated by other therapists in a rotation. We planned to educate the family about the nature of Mary’s eating disorder and to give Mary a chance to share her real needs, fears, and concerns. These sessions were also designed to provide a safe container for her family to ask questions and express their feelings, thoughts, and concerns with the hope to build a more supportive family dynamic.

Although integrating this complex program into a shortened time frame seemed overwhelming to me at first, my fears were short-lived because it was a truly
collaborative enterprise. The planning process focused unwaveringly on Mary, bringing our various skills, ideas, and contributions into play in a harmonious way. Discussions arising from our differences gave depth and breadth and specificity to what we wanted to achieve. While I might have felt peripheral with such experienced therapists, instead I found that my contributions were included and valued.

I experienced the planning for Mary’s treatment as time-efficient but careful, reflexive, deliberate, and supportive. These qualities of the planning process happily influenced the course of the treatment, which involved collaboration on a daily basis with the other staff members who worked with Mary. When Mary’s treatment was completed, she left the Quest program with a more solid foundation of self-awareness and new healthy habits of self-care. For me, though there is a great deal more to understand about eating disorders, the integration of these psychological approaches offered a multi-perspective and integrative treatment approach to the recovery process for people with eating disorders.

The Therapy Journey

Within a few weeks after Mary’s therapy journey began her medications were stabilizing. Mary began to open up about her deeply held grief about the loss of her mother to cancer two years earlier. She also articulated the difficulties she faced in moving back into her childhood home with its many memories. Her dogs were still there and helped her to feel welcome and at home. She slept in her childhood bedroom, which Mary pointed out was down the hall from the room where her mother had died.
In one of her first sessions Mary described a painful and demanding relationship with her eating disorder and the resulting driven lifestyle that she called robot living which had brought her to her current state. The nutritionist and I listened intently and recommended a few books about eating disorders, including *Life Without Ed* and *Eating in the Light of the Moon*.

At the next session Mary reported that she had obtained copies of a few of the books we had suggested, among them *Life Without Ed* which became her favorite. To Mary, Ed reflected in a meaningful way what she was going through. She talked about what it was like living with Ed whose commands not to eat, to binge, and then get rid of the food overpowered her. Her compulsive obedience to these commands exhausted her and was driving her body into the ground. She described how she longed to be free of these compulsive urges.

In another session around that time, Mary expressed how exhausting it was to be her. She reported that nothing she did was ever enough, either at work or at school. Mary longed to feel “normal.” She wanted to wake up in the morning and not feel tired or depressed and instead to awaken with energy and feeling good “like everyone else.”

Following up on these revelations, in the subsequent therapy sessions, we explored what Mary expected of herself. She stated that she expected to be able to work full-time at a highly efficient level, and to attend school full-time and achieve top grades. She also expected to be independent and to balance these tasks without much emotional difficulty, while overcoming her eating disorder. Clearly these expectations were excessive and unrealistic. I wondered how much this self-applied pressure to excel beyond reason had contributed to her physical and emotional exhaustion as well as her eating habits. As I
listened to Mary, I experienced uncomfortable pressure in my own diaphragm as my body somatically responded to heavy demands she placed on herself.

As we offered ways for Mary to express her experiences and feelings and coached her in the process, Mary began to tease apart the various aspects of her being. Through drawing and journaling, Mary began to examine her thoughts, feelings, attitudes, and behavior in the context of her life. We utilized reflexive dialogue as a way to ritualize Mary’s checking in with her feelings on a daily basis. In this way, she accomplished the delicate task of uncovering hidden or repressed feelings and internal structures underlying the eating disorder and body image issues.

Soon, in another session, Mary talked at length about her feelings of helplessness which began when she was a teenager and now weighed even more heavily as she felt so out of control and knew not what each day would be like. She wondered aloud if she would feel sad and depressed forever or if she would ever be able to sleep peacefully through the night. She asked herself if she would ever be able to sit and enjoy a normal meal with her family or ever feel comfortable in her body or not have the compulsion to restrict or binge and purge her food. With the Quest team coaching her and given her own background as a psychology student, Mary soon noticed how controlling her environment helped to mitigate her anxiety. She explored how the chronic anxiety drove her to what eventually became robot living.

Early in the therapy, Mary only engaged in the artwork/image making and journaling during her therapy sessions at the center. As the therapy continued, she began to process in her journal or sketch an image that came to her while she was at home. Often when I entered the therapy room, I would find Mary curled up in a corner of the
big overstuffed couch lost in a drawing or journaling with an intense focus. Sometimes this scene made my heart swell and brought tears to my eyes. Mary felt deeply connected to the images she created and once stated about her drawing pad, “this is a place for my feelings. Sometimes I don’t even know these feelings are inside me until I see them on paper.”

Mary’s artmaking and journaling brought out powerful internal messages about her struggles to cope with daily living. She named these many pieces of artwork that represented her struggles with Ed. One of Mary’s favorite drawings was an image of a “bubble of protection.” (See Illustration 3 – The Hardened Structure) Mary related that in her past she had imagined a protective structure with a hardened exterior shield because she felt vulnerable to the dangerous outside world. As she was progressing in therapy she wanted to create a more permeable layer of protection. This image came to her in the form of the bubble that protected her and yet allowed certain people in for more intimate relationships. (See Illustration 4 – The Permeable Bubble of Protection) The creation of this permeable protection was an important part of her healing and she frequently referenced “my bubble” with affection and gratitude throughout the remainder of her treatment. When she took the drawing home and shared this image with her brother, who is an artist, he made and framed a painting of a bubble of protection which he gifted Mary. Mary had mixed responses to this gift. First she expressed dismay that his painting looked “better” than her drawing. A week later, she relayed with pleasure and pride that she had hung the painting in her healing area.

Another important recurring image was repeated in a number of drawings which Mary entitled “The Crossroad.” (See Illustration 5 – The Crossroad) The image of a
crossroad represented where Mary saw herself standing at the time the therapy began. In one of the drawings, a wooded area on one side of the road was rich with plant life and vibrant with color which represented her longing for the fullness of life. On the other side, another wooded area was barren and dying. Mary felt that if her eating disorder continued her life would be so barren.

The Crossroad was followed in her next session by a drawing of a kitchen cupboard. On one part was a cupboard filled with abundant food, and on the other side of the drawing was a barren cupboard. (See Illustration 6 – The Conflicted Cupboard) Mary used this drawing to describe her internal conflict about food. When she shared this image, she said that she wanted to trust the process of getting her needs met and believed that this was connected to letting herself enjoy food. I noticed the internal polarities or splits which these drawings might illustrate.

As the therapy continued, Mary pondered and we explored together what would happen if she just let herself feel need. This brought up feelings of vulnerability and fears of rejection if she expressed her needs. I wondered if testing these waters was too much of a risk for Mary at this early stage in her recovery; I was worried about relapse. I chose to trust her process and I sensed that this could be a transformative experience in her healing journey. I hoped that this process might expand Mary’s tolerance for these uncomfortable feelings.

In one very important session in the second half of the therapy program, Mary disclosed for the first time that she had been “taken advantage of sexually” while drunk at a party when she was fourteen years old. The perpetrator was a boy that friends had introduced to Mary a couple of times. It was my experience that this session took the
therapy to a deeper level as Mary slowly unfolded a painful and limited memory of this traumatic event. The team of therapists attended carefully, bearing witness to Mary’s exploration of the details of this pivotal event in her young life. It seemed clear to us that this session held a key to understanding Mary’s eating disorder.

After several tentative exploratory foray, Mary opened the floodgates to repressed memories and painful feelings about the rape which had been hidden for almost ten years. She displayed visible relief in admitting that she had actually been raped. A little later, Mary reflected on her previous use of modified language in describing the experience. For example, she usually reported the incident with the statement, “I was taken advantage of at a friend’s house because I was drunk.” Mary would then add, “I will never let that happen again.” Another therapist and I used these statements as a starting point and wove into the ensuing discussion links between rape, accountability, and boundaries. We helped Mary to understand that the fact that she had been drinking did not mean that she had given passive permission to have sex without her consent. Mary reflected that she knew this on some level but did not want to admit she had been raped. After this disclosure she sat quietly for a very long time.

As Mary continued to sit, her expression was very sad but she was not crying. In front of us on a pillow on the floor in the center of the therapy room I spied a ceramic heart, which had become symbolic to Mary of her most tender feelings. Intuitively, I stood and draped a nearby woven throw around my shoulders. Feeling into the archetypal Mother, I slowly bent over and picked up the heart and cradled it in my hands and gently rocked it back and forth. Slowly tears began to slide down Mary’s face. I do not know how long this went on but at some point I cautiously asked, “Do you want to hold your
feelings?” and she responded, “Yes.” I handed her the heart and as I seated myself on the floor Mary added, “Thank you for holding my feelings.” She tenderly cradled the heart in her hands for the rest of the session. My own heart was full. As the session progressed, Mary and I sat together on the floor and continued to dialogue about her experience of that trauma and the subsequent isolation which further eroded her trust in herself and others. Mary acknowledged that she had lost faith in her own judgment and believed that being raped was a major contributing factor in her eating disorder. She expressed tearfully how she wanted to believe and to trust her own judgment.

This experience deepened our connection and Mary’s level of trust. After Mary left the session my tears came and still do as I write this. It was in this poignant precious moment that I discovered why I want to do this work and how deeply I am moved by the plight of young women in our culture today. After that session, I began to understand why Mary had separated herself from her peers. At this point in the therapy, I saw how important it would be for Mary to build capacities she could trust to handle the inevitable shocks and disappointments of peer relationships. Friendships with peers would be essential to the quality of relationships in her life, both internally and externally. I decided to factor this into our further explorations and healing work together. I hoped that with patience and encouragement, the Quest team could support Mary in developing some capacities for healthy peer relationships, and that she would someday be strong and resilient enough to enjoy true friendship in a world that had robbed her of her innocence and pushed her so violently over a threshold towards adulthood without adult resources.

In this context there began to emerge for me an image of the three legged stool often referenced by Omer in lectures about the Father, Mother, and Peer principles.² One
leg of the stool represents the Mother Principle which I interpreted as symbolizing Mary’s innate qualities of nurturing and emotional accessibility that were needing to be revived. The second leg of the stool represents the Father principle which “provides the impetus to individuate, to function autonomously in the world, and interact in appropriate relationship with the Other in terms of discipline, accountability, and responsibility.”

Ed seemed to represent a distortion of the father principle that pushed Mary with excessive force to strive hopelessly for unrealistic expectations and goals. The third leg of the stool represents the Peer Principle which “provides the vitality and creativity of community, mutual support, shared experience, and collaboration with others.”

Holding that Omer taught of the importance of a “capacitated integration of the presence of the Mother, Father, and Peer Principles,” I introduced the image of the three-legged stool to Mary. We discussed her need for a functional balance between the energies of these three principles in order to be able to go forward in the world as an adult and to have healthy and satisfying peer relationships. I asked her to consider how these archetypal forces had impacted her life thus far and to consider how she would like to call these energies to herself in a more balanced way in the future. I reasoned that this would help Mary shift from the innocent victim position to a more capacitated, self-actualizing position. I hoped that some movement in this direction would weaken the hold that the internal structure of Ed exercised on her psyche and give her creative spirit what Omer, referring to Linda Sussman, calls “loose reins” to carry her into a better future.

As Mary continued therapy she began to value her feelings and wanted to improve her relationships with herself and others. Mary realized that her current family dynamics were affecting her, specifically her father’s romantic relationship with a new
woman whom she had not met yet. Although it had been two years since her mother’s passing, Mary expressed resentment and said that she felt forced to accept the presence of “that woman” in the home where she and her father lived. She was also able to express her fear, anger, and disappointment about her father’s drinking and his inability to effectively cope with his grief or to be present to her own.

Mary made many changes and much progress in self-care during the course of her therapy. In the process, she began to notice people she loved doing things which were harmful or destructive to them, including her friend’s relapse into binge-eating and purging and her father’s drinking. She reported watching a friend who had been hospitalized with her at Herrick Hospital suffer relapses in his eating disorder. Rather than avoiding how these things affected her, Mary expressed feelings of frustration, guilt, and fear about loved ones so harming themselves, and eventually realized that she could not fix or help. Mary also began to realize that she could not control the behavior of others, and more importantly, she began to recognize in them the self-destructive aspects of some of her own actions and habitual behavior.

Mary and I explored the destructive effects of her restricting eating to the point of severe malnutrition. Mary also identified the destructive potential of filling her stomach excessively with food and then throwing it up. She looked at the physical effects of pushing her energy to extremes, and similarly examined the emotional effects of isolation which led to depression and distrust of herself and others. She concluded that she had been obeying Ed, the voice of the eating disorder that was telling her what to do.

These important revelations were facilitated mainly through ritual dialogues between Mary and the gatekeeper, Ed. One of the Quest therapists would ask, “Who is
saying that?” Together we teased apart the voices of Mary and Ed, and encouraged Mary to explore what she, herself, really wanted in the context of the dialogue. For example, when she was hungry Mary often heard an inner voice commanding, “You’re not really hungry. You don’t need to eat dinner.” While Mary explored these experiences, we would call her attention back to her new menu plan in order to help her re-set her biological eating pattern, feel her hunger again, and strengthen her metabolism. These interventions supported Mary to act authentically in her best interest despite the presence of Ed.

By this time in therapy, Mary was able to disclose and emotionally connect to the feelings she had avoided since the rape trauma. These repressed or dissociated aspects of her experience appeared to have significantly contributed to her eating disorder. Her self-blaming statement, “It was my fault for being drunk,” came from a imaginal structure that was awash in the shame affect and what Nathanson has characterized as an “attack self” response. Mary also saw that she had developed a habit of withdrawing from social or intimate situations in order avoid shame and helplessness and fear.

It would appear that withdrawing and attacking herself had effectively overridden the intolerable shame response. The long term effects were feeding into her perfectionism and not allowing Mary to make mistakes or to be in intimate relationships with peers or with herself. As we worked with Mary about the dynamics of shame, her increasing awareness of these inner and outer dynamics softened their effects and loosened Ed’s hold on Mary.

After further exploration in a session later that week Mary was able to identify her connection to robot living. Mary was able to talk about the uncontrollable internal turmoil
that caused her to want to control her environment on the outside and realized that she longed for a foundation of support. We pondered together how such a foundation is created and what is needed to accomplish that creation. Mary began to think about more ways to nurture herself. She began to envision a healing space at home. Mary and I sat together on the floor and continued to dialogue about her experience of that trauma and the subsequent isolation which caused her to lose trust in friendships. She had also lost faith in her own judgment. She wanted to believe in herself again and to be able to trust her judgment.

As Mary continued therapy she increasingly appreciated the importance of her feelings and wanted to improve her relationships with herself and others. She realized more fully how stressful her family dynamics were for her. Although it had been two years since her mother’s death, Mary became able to verbalize that she was not ready to bring the person she called “that woman” into her life. Mary realized that another source of stress at home was her father’s drinking which prevented a healing sharing of mutual grief about Mary’s mother’s death and instead left Mary feeling alone with her grief.

Mary continued to journal and draw at home, often bringing into the therapy session the poetry, notes, and drawings she had made. These often became the focal point for the therapeutic dialogue that day. One drawing was of herself with her mouth crossed out with an X and an arrow drawn from her mouth down to her chest. The heart also contained an X. (See Illustration 1 – Hunger for Expression) Mary said that this represented her difficulty in speaking from her heart. In a process session later that week she made a drawing of a big heart on which was written, “I am human and I have a right to my feelings.” (See Illustration 2 – I Have a Right) With these words Mary began to
recognize and verbally assert her right to be and to express herself. She grew to respect her feeling.

After these drawings were processed, in subsequent sessions Mary was able to more freely explore the painful feelings she had been avoiding since the rape trauma. Mary had uncovered a structure that had once protected her from the pain of the trauma, but had also impeded her healing process. As Mary’s talked about the rape, she realized that she had been blaming herself for ten years. Her protective imaginal structures had advised her that it was her fault because she had gotten drunk. In her judgment of herself she also believed she was judged by her peers as well, thinking “They must have thought it was my fault,” which made her pull away from her peers even further. Mary realized that she had already been struggling with trying to fit in with friends and at age 14 was deeply affected by not only the night of her rape, but every day since that traumatic day. She tried to avoid her internal conflicts of self-blame and victimization which could have brought up fears of the trauma and feeling unsafe in the world.

Over the next few weeks, we continued to test the impact of this protective and confining “it was my fault” structure, with the goal that Mary would gain tolerance for the affective responses and be able to function well even in their presence. Her artwork and conversation indicated that Mary was deconstructing this structure which had restricted her ability to express herself authentically. Eventually, Mary proclaimed with feeling on several occasions, “The rape was not my fault.” She no longer actively blamed herself, and entered tentatively into the process of forgiving herself for being drunk that night. This was a big step away from her typical perfectionist compulsions to protect the wound and towards allowing herself to make mistakes.
During the therapy, Mary shared that her habits of food restriction, bingeing, purging, and over-exercising were triggered by a looming sense of guilt and embarrassment which I recognized as signals of underlying shame. Her habitual responses appeared to be a means of punishing herself, possibly to pre-empt the shame. In the associated therapy sessions, she used charcoals, markers, and colored pencils to illustrate her feelings related to embarrassment and guilt.

The hidden potential of underlying shame puzzled and fascinated me. I was aware that in other cultures shame is part of the common vocabulary but is rarely heard in our culture where shame-related discomfort might be described as guilt or embarrassment. I chose to reflect Mary’s choice of words to support our rapport and allow her to process at her own pace. One of Mary’s drawings was of a sad infant which Mary referred to as “this one (who) feels bad about herself.” (See Illustration 7 – The Sad Infant) Mary was demonstrating increasing access to her repressed parts and feelings of sadness, helplessness, and anger. Artmaking and journaling continued to be instrumental in her healing process. Mary drew many images of the grief and depression that lived inside her. She became quickly able to describe how she was affected by these internal images.

In later sessions, Mary expressed her feelings of helplessness during the long two years while her mother’s life was wasting away. I wondered if she had also repressed anger and frustration during this time of her mother’s dying. More than once, Mary asked, “How could I put food into my body when my mother was dying?” However, Mary more easily made connections between her repressed feelings and her habits of restricting food intake, bingeing, and purging than to her grief.
Approximately six weeks into the therapy, I introduced Jin Shin Jyutsu and yoga as somatic practices to help Mary self-soothe, get grounded in her physical body, and develop the habit of recognizing what she was experiencing somatically. The Quest team and I encouraged Mary to bring symbolic images that represented her therapy journey. After her first therapy session when she was gifted a sketch pad and journal by the program, Mary always brought them with her. In the second week of therapy, Mary began to include the ceramic heart which she always placed in the center of the room in the beginning of our session. In another session Mary exclaimed, “I want a healing area like this at home,” and enthusiastically envisioned the art work and other items she would put in her healing area.

In subsequent sessions Mary shared how her healing area was coming together and how pleased she was to have a space to be with her feelings. I felt happiness and relief as I watched her glow with satisfaction about this project. As a team, we frequently affirmed to Mary that she was worth the efforts being made by all of us. This seemed to support the momentum of her process of revamping her lifestyle at home.

In a session weeks later, Mary said that she wanted to plant a tree in honor of her mom. She talked with her family and they decided to plant the tree together in the backyard of her childhood home which they did over that next weekend. Mary expressed how important this was to her and her face registered satisfaction and happiness while her body seemed to sigh in relief.

In a session about three weeks later, after talking about her past and present feelings, Mary began to consider what she wanted for her future. I was pleased by this healthy sign of hope and aspiration. On this day Mary shared her love of horses. The joy
and pleasure she experienced with horses lit up her face as she talked about the smell of
horses and the hay in the barn. Mary and I shared a love of horses, and our discussions on
this topic were lively and enthusiastic. She described an emerging longing for contact
with these animals and I asked if this was a need she could meet. She recalled an old
friend she could contact. I encouraged this because it would also help her to reconnect
with friends in a healthy environment. A few weeks later Mary reported excitedly that
she had reconnected with a friend who had horses. According to Mary, their mutual love
of horses rekindled a friendship she had abandoned after her mother died and she had
been absorbed by internal turmoil. Soon after this reconnection with her friend, Mary
realized that she had abandoned many friendships and activities she loved because she
became fearful that no one could relate to what she was feeling and doing. She described
a growing uncertainty about her words and actions during that earlier time. Mary realized
that her confidence had plunged during the last couple of years and she had decided that
she just did not “fit in” with her peers. During those years, as her isolation had increased,
Mary had wanted to stay away from friends whose body images she viewed as better than
her own. She felt ashamed of her compulsive lifestyle centered on eating, and her
pervasive depression. Her primary outlets for the repressed energies had been work and
school where she spent excessive amounts of time with little interaction with others
outside of these two structured arenas where she excelled in performance. Mary reported
that until this time in therapy she had not realized how disconnected she had become. Her
longing for reconnection with peers became an even stronger motivation as she unpacked
the underlying thoughts and feelings which prevented her from experiencing intimacy.
The other therapist and I asked Mary to explore what else moved or inspired joy in the way that the horses did, Mary replied that her art work and journaling did so. It was providing her with an emotional outlet as she practiced expressing and communicating her feelings to herself and others. She described the relief she felt as she shared the fear and vulnerability which she had been repressing. She also said that saying her feelings aloud was scary because she feared this would lead to rejection.

About two and a half months into the therapy, Mary was encouraged regularly to explore and identify thoughts, attitudes, and behaviors that were connected to her internal subjectivities. Mary was compiling an inventory of these underlying structures, some of which protected Mary from experiencing intolerable feelings of helplessness and vulnerability. When Ed entered as a gatekeeper and began to control her environment, for example, Mary had felt safe and protected. In therapy these structures were being challenged and reality tested as Mary was able to see the harm that had resulted. As Mary’s old embedded structures were being examined, new ones were emerging, which spoke out with such statements as, ”I have a right to all of my feelings,” “I am enough,” “I am lovable,” and “I want balance.” These structures are discussed further in the Learnings chapter.

As we approached the three-month-mark into the therapy, Mary identified her mother’s dying as a major trigger for the withholding food, binging, and purging compulsions. “I think I was punishing myself because of my mother’s illness,” she said. “I could not eat when she was wasting away.”

About three months into therapy, Mary disclosed a recent particularly strong urge to buy “bingeing food.” She recognized in her body the tension between her intense
hunger versus the anxiety and repulsion that she felt about having such a compulsion. When she went into the store to buy the food she started to hyperventilate and panic rose in her body. Mary reported with a flushed face, a sad, quiet voice, and fearful affect that she ran out of the store and stood in a nearby pet shop until the panic subsided and she felt safe. Mary was disappointed in herself and scared by the feelings of fragility she had experienced as she reflected on that moment. Mary admitted that she still felt unstable in her recovery process and had thought she was much stronger.

Clearly, shame was evoked by this vulnerability. To support Mary in her process, we discussed and decided on a desensitization treatment plan involving grocery shopping and buying one preplanned item at a time. Mary and her family all liked this idea and sometimes her brother or father would request an item for her to buy, or would go with her when she felt she needed more support. Mary later reported that each time she went to the grocery store she felt relief that she could shop without panicking. She also expressed a growing sense of confidence and accomplishment, which her family confirmed. The backslide moment which led to this milestone seemed to be an important step in Mary’s therapeutic process. I learned firsthand how backsliding can provide opportunities for looking deeper and developing, strengthening and refining capacities.

In a later session that week, I introduced another yoga and Jin Shin meditation/visualization practice intended to help Mary calm herself in stressful situations, and to help her feel grounded and accepting of herself in the present moment. I intuited that this simple Jin Shin/yoga combination would be both comfortable and effective for Mary’s experience of these somatically based modalities.
We started with a simple Jin Shin treatment similar to acupressure to help regulate her nervous system. As she began to breathe deeply, I guided Mary to sequentially hold a series of energy locks, also known as pressure points, that are located in each finger. These energy meridians represent fear, anger, worry, sadness, and trying too hard. Together we began to practice listening and feeling the pulse in each finger.

Following the Jin Shin work, I helped Mary to assume a yoga “butterfly” cross-legged seated posture. Then, guided by my voice, she imagined she was in a slow-moving river. The water represented her emotions as they flowed naturally through her body. Mary was soon breathing calmly and soon she began to describe feelings of sadness and grief for her mother. As she breathed more deeply, she was able to imagine letting her feelings of sadness flow through her body naturally, like the flow of a river. After Mary experienced these somatic practices Mary’s affect changed. She expressed a feeling of physical relaxation as she felt her feelings run more naturally through her body. She felt relaxed and satisfied with being more in touch with her body and her sadness. She said with surprise that she had thought she was supposed to work towards getting over the death of her mother to feel better, rather than letting herself grieve and accept and acknowledge her feelings.

This allowed us an opportunity to talk about the natural stages of grief and how there is no order or sequential pattern to the grieving process, rather more like the flow of the river with twists and turns, detours, and periods of turbulence and calm. If the river is allowed to flow naturally it will find its own way through these twists and turns and move easily with the force of the changing currents. Mary seemed to respond very positively to the image of the river, and I could see and feel a new sense of peacefulness and presence.
in her body. I made a note to myself to bring something symbolic to represent Mary’s river to our next session.

At that time I became concerned about the possibility that when Mary was alone, her new capacity for grieving might diminish or disappear. I further considered that she could have a delayed internal reaction to the experience of feeling peacefulness in her body around her grief, which could re-trigger her feelings of isolation and depression. As a precaution, as she prepared to leave the center that day, I reminded Mary that her loved ones were there for her through her healing process and that the Quest team was available if she were in need of additional support.

On this day I strongly felt my own countertransference. I had to put aside my own feelings of pain, sorrow, and fear associated with the sudden traumatic death of my friend in my presence when I was eight years old. I felt my own longing for a river to put my feelings in. I did not learn how truly to understand my own grief until, as an adult, I worked as a bereavement coordinator for a children’s program. During this and later sessions with Mary, I harvested the gift of empathy from this countertransference. This enabled me to provide a sensitive container within which her feelings could flow naturally. I sighed in relief when my clear urging to creative action arose in the therapy session.

During the next session Mary had a stronger stance and fuller voice; her eye contact was clear and she appeared grounded in her movements and posture. Mary initiated an exploration of ways that she might further ritualize her mother’s passing. She decided to honor her relationship with her mother by creating a healing area for her grief and to represent her process and the healing she was inviting into her life.
In light of her request, for the following weeks of therapy, I brought a blue Thai silk scarf to represent the river and placed Mary’s heart in the center of the river to represent the natural flow of her feelings. Mary was demonstrating a balance of vulnerability and resilience in therapy and it showed in her art making, journaling, and somatic practices. Whenever she felt the need, she would say, “I want to journal about something,” or “I brought something that came to me last night.” Often when I entered the therapy room to begin a session I would find Mary in a yoga posture, holding energy points, or writing and drawing images.

Throughout therapy Mary responded enthusiastically to suggestions for self-care activities. Rarely, did I see the one who wanted to please, or perform perfectly, or the one who was not good enough. I still wondered with a healthy skepticism, whether this was partly driven by her compulsion to do everything perfectly. I decided to stay open to this possibility. Meanwhile the Quest team and I were happy to see before us an emerging one who could say, “This is what I like, want, and need!”

In Mary’s fourth and last month, she brought up her conflict with her dad regarding his relationship with a new woman. The Quest team felt that Mary was now ready to work on this important area with her father, and recommended that they begin this process in a family therapy session. I noticed as the session began that Mary’s father’s usually passive, affable affect was tense and slightly aggressive as he stated his desire that Mary meet his new companion. He wanted desperately to move on with his life and believed that once she met the new woman, Mary would like her.

Mary was feeling guilty about not wanting to meet the woman that her father wanted to introduce to his family. She understood that her father should move on with his
life, and she wanted her dad to be happy. However, she had felt forced to allow this new woman into her life before she was ready. In this joint therapy session, father and daughter explored together the father’s need to go on with his life, and Mary’s need for time to adjust to changes at home. The Quest team observed strength and resilience in Mary’s willingness to engage with her father in this sensitive frontier and to express her needs in the face of possibly disappointing her father.

Mary continued to add art work to her healing space at home and was enjoying this outlet for her intentions and hopes for her future. By the last month of the therapy, Mary was regularly adding self care tools to her tool belt which already contained her ongoing practices of art-making, Jin Shin pressure point energy balancing, and dialogue with Ed. As our work together progressed, Mary displayed a vivid practical imagination which seemed to bring a sparkle to her eyes, energy, enthusiasm, and courage for the difficult process of re-structuring her life, and increasing self-awareness.

To help with recurring feelings of isolation and loneliness, Mary planned calls and visits to friends, play time with her dogs, and art-making activities. When feeling sad, she would talk with her dad or her brother, both of whom had agreed to be available and supportive when Mary was grieving her mother’s death or struggling with emotions that were difficult for her.

**Closing the Container of Therapy**

The Quest team met on several occasions with the director of Psych Strategies to plan support and aftercare for Mary. The plan included a referral to hospice for individual and group grief support and continuing care from her psychiatrist at Herrick who
monitored her medications for anxiety and insomnia. Mary would also continue weekly individual and family counselling at Psych Strategies. However, I feared these services might not be enough. Though the Quest team did hold the seriousness of this necessity to provide aftercare, we could not control the unfortunate closing of a program. This decision was out of our hands and actions had been in process by the board and the director for some time. We all made the best effort to provide a safety net for Mary but I still felt twinges of concern mixed with lots of hope and trust for my clients healing process.

In one of the last therapy sessions, Mary said that she was uncertain whether she could maintain her self-care regime on her own. I reminded her that she could trust herself and to remember to breathe. To help reinforce these messages, Mary and I reminisced about some helpful experiences of self-care. She recalled with pleasure, times she had called her dogs to lie with her on the bed, and other times when they went for walks together. She recalled times spent in her healing space, and commented “these things really helped; my feelings are not so hard to be with anymore.” We sat there in silence for a while. As I met her eyes, I recognized a new vitality that did not exist in the beginning, and tears of gratitude welled in my eyes. I sensed that Mary was coming home to herself, and I felt privileged to be a part of her journey. My countertransference here had the positive effect of calling my attention to Mary’s new capacity to provide healthy mothering for herself in the context of her own accomplishments. We both smiled in mutual recognition of Mary’s wonderful accomplishments in this short period of time and shared hopefulness for her future.
As therapy was ending, Mary’s desensitization program for purchasing food in reasonable portions was still in progress. She had fewer urges to buy binge foods and her general level of anxiety had diminished. Mary prepared for graduation from the Quest program and planned for her future. With coaching, she put together her own relapse prevention plan to present to the therapists at the graduation ceremony.

The graduation ceremony took place during our last session. Members of the Quest team brought symbolic gifts to honor Mary’s journey. In a ritual I brought from the Sequoia addictions program, we wrote out our hopes and fears for Mary’s future. We read these to her, and then gifted these thoughts in writing, with blessings and good wishes. The Quest team gave her valuable feedback relapse prevention and offered encouragement and congratulations her on her very hard work. As she left, Mary said to me, “I felt connected to you from the moment we met,” and I nodded in full agreement.

After Mary left that day, we closed the Quest doors for good. All that was left was the furniture that held the memories of so many young women who struggled to find and accept themselves. This was a sad day for me, for my colleagues, and most especially for our community. Because of the nationwide financial crisis, Sonoma County lost a needed resource that could have made important differences in the lives of so many people.

Legal and Ethical Issues

During the course of Mary’s therapy my supervisor, a clinical psychologist well versed in the Imaginal Approach, was able to support a broad spectrum of methodologies. I consistently received helpful and supportive supervision.
No legal issues arose in the course of Mary’s therapy. I faced an ethical dilemma at the beginning of my internship when I learned that the Quest program was scheduled to close in four months, one month short of the usual time frame for participants enrolled in the eating disorder program. Mary was the last client to enroll. To compensate for the shortened duration Quest increased her individual therapy from one to three hour sessions. While I was disheartened by the announcement of the closing of the Quest program, I also had ethical concerns. The Quest program had provided aftercare and support services for all clients upon graduation. With its closing, the program, including that component, would no longer be available. I was concerned for Mary’s safety and stability after her deep engagement with the course of therapy. While she had received much longer individual sessions, her program was one month shorter than the time-tested standard Quest treatment program. While there are no guarantees for safety and stability following a course of therapy and though Mary had some time for testing out newly acquired skills and capacities in the real world, I wondered about the ethical responsibility of Psych Strategies to provide more extensive aftercare and support for Mary since most graduates stay for individual and aftercare group support.

In my experience with Mary at Psych Strategies, therapy for eating disorders was gender-skewed toward young women clients and female therapists. The therapy also tended to be biased toward mothering and away from fathering which would address unpleasant feelings and resistant places in the client’s psyche. Ethically, while comfort and empathy were necessary for building trust, there was more required in order to transform dangerous, unhealthy internal defenses into safe, healthy, capacitated beingness in the world. This bias also contributed to the countertransference which inhibited my
willingness to take Mary to an important edge in her therapy process. Encouraging deeper exploration of her relationships with her parents could have helped Mary transform the shame underlying her symptomology and thus better ameliorate her grief, resentment, and any repressed anger.

Although Mary’s was a success story in many ways and I felt good about our work together and how far she had come, I still feared for Mary’s future. The statistical prognosis for people with eating disorders is grim and I still have my fingers crossed. Eating disorders have serious physical and emotional consequences for many young women today. Experts in the field note that many women are dying from medical complications of Myocardia (heart failure.) There is also a significant incidence of severe osteoporosis (brittle bones) which although not fatal is a chronic condition that makes it extremely easy for them to break bones so that routine physical activity becomes quite risky. Clemmens et al. observe that in addition to permanent heart problems and osteoporosis there may also be severe dental issues and even kidney failure. Such physical conditions coupled with the psychological torment of body image dissatisfaction and chronic low self-esteem pave the way for possible relapse. According to Martin, the grim statistics of treatment are that as many as fifty percent of anorexics treated for the disorder do not respond to treatment and many have later died.

Outcomes

During our therapy, Mary began to discover the value of creating reminders both to help her be aware of herself and to access useful tools in difficult moments at home and in the world. Some of Mary’s new self-care tools were tested in her daily life when
she experienced feelings of isolation, depression, and sadness during the therapy period. Her tools included plans to call on friends and family as needed for support and keeping a file of helpful responses regarding experiences and events that might be triggering. Mary learned to explore her complex internal gatekeepers and imaginal structures, such as Ed, robot living, and the archetype of the tyrannical father which uses repression and suppression to control experience.

I learned from Mary how lack of self-nurturing and self-care can result in an insatiable hunger in the soul. With practice I learned to align with her empathetically and then gently nudge her to explore the areas that were painful and triggering of her eating disorder. Mary learned that she had a right to all of her feelings.

Mary’s treatment had many outcomes. At the end of the program she was able to identify negative beliefs and cognitive distortions carried by the voice of her eating disorder. She had developed a habit of dialoguing with Ed when she was affected by pressures to resume food restricting, binging or purging. She made a practice of expressing difficult feelings through drawing. She resumed contact with a close friend around riding horses, and had plans to contact other friends. She and I planned carefully for relapse prevention. Mary was using her healing space at home for self-care and the healing space included her art work as well as care for the tree that her family had planted for her mother.

At the end of the program, Mary’s shopping desensitization program continued and Mary remained binge and purge free. She was actively getting to know her boundaries in relationships with others. She was able to successfully follow her menu plan and to substitute healthy foods for triggering ones without evoking anxiety. Mary’s
still has grief and trauma work to do and I can only hope that she found and is finding ways to continue to do so.

Mary decided not return to school or full-time work in order to continue the level of self-care she still needed. She planned to work part-time and give herself time for more therapy and healing. Mary felt she had begun to establish healthier relationships with family and friends. Neither robot living nor Ed seemed to be running her life any longer.

After graduation Mary’s plan was to continue working with her grief through Hospice. Hoping to plant a seed for her future, I suggested that Mary consider further work about her adolescent rape trauma experience. Mary did a tremendous amount of intelligent, reflexive work in sensitive areas of the psyche where trauma and grief dwell. I admire her courage and was inspired by her tenacity and determination. I hope that Mary’s experience in the Quest program has helped her establish a more intimate, loving and healthy relationship with herself, and that her emerging self-awareness and self-expression have continued to bring her a life that unfolds with fulfilling hopes and dreams.

The Quest team did the best we could to provide a good enough container for Mary’s intensive therapy. I know that there were missing links and unexamined territories of her life and her psyche which will present challenges to a healthy functional lifestyle. Mary’s fears will be triggered again and there will be periods of robot living in her process of finding her way to a life she loves. I have both hope and concern for Mary’s health and safety but I pray that she has built enough resilience and self-care to support her through the rough times. To my knowledge Mary is still working part-time and continues individual and family therapy at Psych Strategies.
CHAPTER 4

LEARNINGS

In this chapter I will discuss and give meaning to my work with Mary as I present the key concepts and major principals that I used to frame my interpretations. I will also describe what happened during the course of Mary’s therapy, identify and discuss her imaginal structures, track how I was affected and explore my own activated imaginal structures. Integral to my learnings is the primary myth which was thematic in the meaning-making. Next I will explore my personal and professional development as a direct result of working with Mary. Finally I will discuss what I learned in the process of applying Imaginal Approaches to the psychotherapy of eating disorders.

Key Concepts and Major Principles

The key concepts and major principles that informed my work with my client in this Clinical Case Study are brought together in themes that were also outlined in the Literature Review. The first concept is robot living, which came from Mary herself as a descriptor for the compulsive and pressured lifestyle that she had been leading. Mary’s term proved to be quite important to her therapeutic process. In order to explore what Mary meant by that term, it will be helpful to draw upon theory from Woodman and Kalsched. Woodman’s discussion about perfection seems related. She discusses a direct connection between the cultural repression of the feminine and eating disorders and views the search for perfection as an archetypal pattern. According to Woodman,
enmeshment with the energies of productivity and goal orientation can create an addiction to perfection at the expense of interpersonal values and feminine soulful awareness, feelings, and creative capacities can become buried, twisted, or lost.  

In Kalshed’s work with dreams, fantasies, and images, he found that trauma and overwhelming experience can damage the ability to process and integrate experience. Kalshed conceptualizes a self-care system consisting of polarized defensive internal structures which are both protective and persecutory. Kalshed found that the cognitive, affective and sensory aspects of trauma can lead to a fragmented concept of self which impairs the ability to process new experiences and an attack on self.

Several concepts and principles from Omer also help in thinking about Mary’s journey. A true initiation, according to Omer, is a transition that requires a transformation of identity in order to complete and integrate. Omer says that when there is a premature crossing of an initiatory threshold in a sort of a forced initiatory experience the result may be an incomplete process of initiation. Omer brings a key dimension to understanding the transformation of identity with the concepts of the gatekeeper and the potentiated inner Friend. According to Omer, gatekeepers are the “personification of … the individual and collective dynamics that resist and restrict experience” while “the Friend refers to those deep potentials of the soul which guide us to act with passionate objectivity and encourage us to align with the creative will of the cosmos.” Omer uses these concepts in a particular Imaginal Approach which allows interaction and dialogue between gatekeepers, Friend, and subjectivities within a person. This Imaginal Approach allowed gatekeeping to be expressed in the voice of Mary’s eating disorder and for the inner Friend voice to emerge over the course of Mary’s therapy as well as helping to indentify
and address the inner subjectivities which were fueling Mary’s eating disorder. In therapy she was learning to recognize her multiple and often conflicting internal voices. Some of these internal voices are referred to as imaginal structures which Omer defines as “assemblies of sensory, affective, and cognitive aspects of experience constellated into images; they both mediate and constitute experience.” Mary also found the voice of her inner Friend who both challenged the gatekeepers’ beliefs and supported and defended her against the gatekeeping.

Three primary thematic principles drawn from the work of Omer that were evident in Mary’s therapy process were the Mother Principle, the Father Principle, and the Peer Principle. Omer uses the image of the three-legged stool to illustrate these principles and their interconnection. Omer uses the image of a Three Legged Stool in discussing the Father, Mother and Peer principles. One leg of the stool represents the Mother Principle which Mary needed in order to revive her innate qualities of nurturing and emotional accessibility. The second leg of the stool, the Father Principle, provides the impetus to function autonomously in the world and interact in appropriate relationship with others with the capacities for meeting necessity with discipline, structure, accountability, and responsibility. Healthy peer relationships are made possible by the Peer Principle, the third leg of the stool which requires the support of the Mother and Father principles. Omer describes Peers as mirrors which provide important reflections of ourselves in the world. This sensitive and often difficult peer relationship depends on the internal integration of the internal Mother’s capacity to engage in mutuality and the Father’s capacities to initiate and maintain healthy relationships in the world. In
Mary’s therapy it became clear that lacking these capacities, when she was afflicted by traumatic events Mary withdrew from the potential support of peers and isolated herself.

Another important concept for thinking about Mary’s journey is the concept of shame. Omer offers a definition of shame as “being’s call to belonging.” Associated with shame is the concept of guilt. Omer defines guilt as “a compound emotion constituted by the effects of fear, grief, and shame.” According to Nathanson, shame is the affect modulator which means that shame sends the message to stop. Nathanson goes on to describe four defensive patterns related to shame, withdrawal, avoidance, attack others, and attack self; these defences allow an individual not be overwhelmed by their intolerable experience of the shame affect. Borrowing from Nathanson, one way of thinking about eating disorders is that they involve an attack self reaction which is an attempt to cope with ones shame. Nathanson asserts that attempts to wipe away intense affect are compensatory behaviors. Nathanson also refers to chronic stress and chronic shame as circular and that they mutually increase in intensity which is a useful idea when considering the compulsive cycle and addictive cycle of the eating disorder.

Theory from Chernin also helps understand Mary’s work in therapy. Chernin asserts that a daughter’s guilt when her mother dies can interrupt the daughter’s development and may emerge as eating disturbances. When a daughter decides that her mother’s habits, and choices are wrong for her, the daughter wants to disown this part of her inner mother. If the daughter’s feelings are not addressed, or even more certainly if her mother is dead, the unprocessed feelings can become frozen internally and all other relationships become the mother who did not meet her needs.
Another important concept from Chernin is self-mothering which she defines as “a maternal presence, where one can seek refuge, to which one retires to sort things out and take comfort from the act of self-reflection.” Self-mothering is a concept connected to Mary’s eating disorder as well as to the Eleusian myth of Persephone and Demeter. As in Kerenyi’s interpretation of the goddess Persephone’s abduction to the underworld by Hades, Mary was abducted by the act of rape and plunged into an internal underworld of lost innocence. Also like Persephone, Mary was separated from mothering. Mary coped with the pain and fearful vulnerability by harshly restricting her feeling life and her physical life in order to feel safe. As Mary learned to care for herself during therapy, Satir’s “Pot of Self Worth” image arose, illustrating the necessity to provide oneself with experiences that build self-worth and self-esteem. Mary’s self-care and self-mothering work during therapy appeared to do just that. Her growing sense of self-worth supported the development of inner strength and resilience.

Bly says that both competitive and self-damaging behaviors are symptomatic of a deeper loss and connectedness to one’s soul. Eating disorders could certainly be considered to be among those symptoms of loss of soul. According to Bly, the breakdown of the family along with spiritual and moral values in the culture means that young people lack adequate resources that would enable them to face life’s traumas. Instead Mary diverts her power to her eating disorder Ed who promises to keep her at safe distance from powerlessness and offers control of her environment.

Pipher relates eating disorders to the cultural dynamics that affect a child’s development. One cultural message communicated to young people is to be thin in order to be accepted. Pipher believes that girls today are more oppressed than ever before
as they come of age in a more dangerous, sexualized, and media-saturated culture. These cultural negative pressures and dangers impacted Mary’s ability to feel safe in the world.

**What Happened**

Mary was hospitalized because of low weight and suicidal thoughts. Very shortly after this event she left her job and her apartment in San Francisco and moved back into her childhood home with her father as well as its memories of her mother. As her eating disorder escalated she had given up a successful job, her senior academic status and pending university graduation, and her independence. Mary’s father and brother were worried about her and tried their best to support her even though they did not understand. Like Mary, they were still grieving the loss of her mother who had died from cancer two years earlier.

When Mary arrived at the Quest clinic after being released from the hospital she suffered from insomnia, constipation, and digestive problems, as well as a lack of appetite. Her habitual coping skills were no longer working for her. Alone, uncomfortable, lost, and unable to function, Mary was acutely depressed. She longed to feel whole.

Soon after meeting her during our first therapy session, I felt an empathetic connection with Mary. On our last day of therapy, Mary told me as she departed that she had felt a connection with me since that day. The therapy facilitated Mary’s exploration of the origins and dynamics of her eating disorder. She was depressed after her mother’s death, which she felt had re-triggered the bulimic episodes and the restrictive eating behavior initiated years earlier by the trauma of her adolescent rape. She was concerned
and unhappy about her daily lifestyle which she named robot living and also about her habit of pushing herself physically and emotionally beyond her physical and emotional capabilities.

Mary’s father’s easygoing distant affect did not transmit healthy fathering capacities to his daughter. Leonard asserts that a daughter who has taken on a masculine mode of operation in reaction to irresponsible fathering is cut off from her inner feminine soul life by virtue of her need to protect herself from a world that she cannot fully meet.\(^{30}\) Reflecting Leonard’s theory, Mary armored herself with perfectionism and driven ambition which did not correspond with her natural sensitive, thoughtful nature. While trauma robbed Mary of her feminine qualities and wrenched apart her connection to soul, her perfectionism filled the emptiness with activities and drove her with fear. From my own experience I could relate to pushing beyond one’s healthy normal limits. Although our circumstances were entirely different I saw how we both tended to cope with emotional discomfort through extreme performance and accomplishment.

Mary found just being alive to be exhausting. Admonished constantly by her internal perfectionist, she felt as if nothing she did was ever enough, either at work or at school. She longed to feel “normal,” to wake up in the morning and not feel tired or depressed. She imagined waking up with energy and enthusiasm, “like everyone else.” At this point in the therapy we uncovered the perfectionist aspect of Ed, the tyrannical oppressive internalized voice which was trying to protect her from further re-traumatization by driving her away from potential further grief and loss by means of ceaseless externally-directed activity.
As we unearthed the heavy demands Mary placed on herself from moment to moment, I experienced uncomfortable pressure in my diaphragm. A later check in with myself revealed my own familiar perfectionist structure which similarly, although to a lesser degree, separates me from uncomfortable feelings. Able to perceive this via the counter-transference, I revisited the destructive potential of this internal structure in my own life. I could see how effectively I offset its effects in my present life through the intimacy of play and relaxation with my family. This insight was particularly helpful in my work with Mary, because it brought to light the importance of Mary’s process of re-connecting with her family, friends, self-care practices, and her own internal joy.

Mary had expected herself to be independent and to function without emotional difficulty while struggling with her eating disorder. These excessive expectations were discussed in therapy to allow a healthy, more gentle nurturing structure to emerge. In the past, the control Mary had exercised over herself and her life had functioned to push intolerable emotions away enough to feel safe. Now, however, Mary felt that her need to control had overpowered and turned against her. She needed help and that is why she ended up in the hospital.

In the beginning of the therapy, Mary felt little hunger and had trouble sleeping. In the hospital she had been prescribed medications for depression and insomnia. Her body had not adjusted to these medications and she was physically uncomfortable. She worked with the Quest nutritionist to create a meal plan to regulate her body and to establish mindful eating habits. A visualization ritual around food before each meal was difficult for Mary at first because she no longer felt hunger and she had to force herself to eat. The structured eating plan was a cognitive behavioral therapy technique which was
applied at Quest for eating disorders. While working to balance sleep, medication, and eating patterns at home, in therapy Mary began the work of reconnecting with the parts of herself.

Although Mary had always liked to journal, she had stopped writing after the death of her mother. In therapy, Mary resumed journaling with encouragement to attune and attend to her body and to express the fears, frustrations, anger, and other emotions that arose. She had been working long and hard to be productive and efficient in her jobs and to earn exceptional grades at school. Feelings were something she had pushed aside. She had also learned to repress or sublimate physical and emotional hunger. Using an imaginary emotional barometer to track her emotional status, she began to initiate journal writing and art projects both in therapy and at home. Her engagement with these practices was amazing to witness. Pipher often references the repressed feminine, and it seemed as if Mary had begun to access her instinctual nurturing capacities. Woodman might agree that Mary had been working against the natural flow of her feminine energy and had now begun to discover feminine parts of herself that had been repressed.

As vital parts of Mary’s psyche were revealing unmet needs and unfulfilled desires, Mary also began to be aware of parts of her that were constricting and subverting her quality of life. Mary identified an imaginal structure she called robot living which she described as “living without feeling.” Early in the therapy I learned that robot living was a complex coping mechanism which restricted Mary’s life experiences. Robot living was led by Ed masquerading as a friendly presence while commanding distorted and dysfunctional perceptions and behaviors which seized and took over Mary’s life. Her emotional life was repressed, she was isolated, and her health deteriorated with nearly
fatal consequences. An important learning for me was that robot living is a recognizable pattern and a useful concept to be aware of in working with people with eating disorders. In the future, when I see a similar pattern of suppressed emotions, driven perfectionism, and isolating and self-destructive behavior, I will be alerted to the possibility of a concurrent eating or body image disorder. As I look back I realize that this was what Woodman termed a counterclockwise energy flow, in which Mary’s robot lifestyle was working against the self. The tumultuous conflict between the parts of Mary that longed for love and fulfillment and the protective parts that restricted her from the longed-for experiences was key to the disconnect between her physical and emotional body. To escape the confusion, pain, and uncertainty, Mary turned to self-denial in relationship to food. The food restricting, binging, and purging cycle gained its own momentum and continued to manifest while the voice of Ed made meaning, however distorted, of this destructive, robotic way of living.

Ed’s distorted and partial truths became part of Mary’s belief system. When therapy began, we learned through Mary’s art-work, journaling, and dialogue with Ed, that Mary’s identity was tied to these distortions. Through an imaginal approach Mary was able to engage in dialogue with Ed, the gatekeeper who protected Mary from re-traumatization. The scope, magnitude, and dynamics of Ed’s cognitive distortions were revealed in Mary’s journaling and drawings. Through Mary’s intricate, delicate soul-unfolding process, the archetypal Friend’s maternal voice continued to comfort and guide Mary’s focus back to herself.

Self-mothering was an important part of Mary’s healing process which required Mary to find a connection to her physical and emotional needs. This was initiated by the
therapy team through modeling loving, attentive, and nurturing qualities and thus awakening in the therapy container Mary’s own archetypal internal Mother. The Mother Principle as taught by Omer was a primary theme throughout Mary’s therapy. The rape trauma followed by the death of her mother impacted Mary’s coping structures and resulted in a physical and emotional loss of self. In Mary’s process of exploring the territory of repressed emotions, a capacity to nurture herself was born.

The Mother Principle gifts us with the capacities for self-awareness, compassion, and a deep understanding of our underlying needs. These emergent capacities allowed Mary to lovingly witness her feelings and soulful desires in the context of unconditional acceptance and regard. I observed the impact on Mary when compassion and empathy of the internal Mother began to comfort her in her grief. Mary’s hunger for mothering revealed the fundamental necessity of learning to mother oneself and letting mothers mother us, described by Omer. Learning to mother oneself is one aspect of self-care.

While establishing the boundaries of a safe therapeutic container, the father principle fosters the development of accountability, responsibility, and necessity in the process of self-exploration. Applying the Father Principle, the therapy team sent Mary into her world again and again to try out the self-care practices she was learning. By formally introducing the father principle, we helped Mary recognize and define her own healthy personal boundaries and to develop a true accountability to herself rather than a false accountability to others and to the world. As self-awareness grew, Mary began to view the rape for what it was and to let go of self-blame and punishment for being drunk that night.
I learned during my experience in therapy with Mary not only how, but why I want to work with young women with eating disorders. The “why” is the precious opportunity to lovingly witness the transformative journey of young women as they come to terms with pain, losses, and new possibilities in life. The “how” is using an imaginal approach in the context of the therapeutic milieu. I knew that I could not take away Mary’s pain, but I could be by her side for the journey and bear loving witness to her experience.

As Mary began this difficult inner work, she would need to develop those capacities for nurturing herself, and further to be able to sustain self-care practices after the therapy ended. Throughout the therapy Mary filled her self-care “toolbox” with practices which she tested at home. The Mother Principle as modeled by the Quest team supported Mary’s explorations of her inner and outer worlds which fed her hunger with loving attention and nourished her soul. It nourished my heart to be part of a team that provided mothering where mothering was needed. This modeling also helped me learn with gratitude and humility how to recognize and witness with love the blossoming of a young woman opening to her soul. I witnessed how important and powerful it is to consciously nourish the inner and outer parts of ourselves, the biological and emotional aspects of our being.

From the beginning I was aware of the high risks involved in doing deep inner work with someone who had been traumatized and could be easily triggered into self-destructive behaviors. I learned with fear and trepidation of the mindful, delicate tuning and aware presence in the moment that is required for doing this sensitive work.
The Mother Principle arose and receded like ocean waves on the shore time and again throughout Mary’s therapy experience. Subsequent to the rape, Mary was neither able to care for herself nor to accept mothering from others. The later death of her mother played a key role in the manifestation of the persistent voice of Ed distancing Mary further from her feeling self. The unfolding of Mary’s capacities for mothering herself allowed her to experience and express her feelings, to be more present in her life, and to participate authentically in close relationships. Over time there was a new visible quiet confidence emanating from Mary in the therapy sessions. As Mary underwent this transformation, the habits of robot living slowly fell away and mothering support expanded from the therapy room to her family, friends and community.

Trusting oneself in relationship with others represents an honoring of oneself and what one feels is important. According to Woodman, when self-trust disappears, one is going against one’s own natural energy and working counter-clockwise against the self.34 The ebb and flow of the Mother Principle is a predominate undercurrent of Mary’s journey and is addressed throughout this study.

Imaginal psychology was also a theoretical basis of my interpretation of Mary’s relationship with Ed. She relied heavily on her male or masculine energies to fulfill the demands of Ed for physical self-deprivation and perfection in performance. Ed represented an internal gatekeeper, enforcing an imaginal structure which enacted Mary’s compulsive robot living. This gatekeeper was a distorted form of the Father Principle which modulates impulses from within and without, representing inner and outer authority. As Omer notes, trustworthy outer authority provides protection that lets us find our inner authority.35
Ed’s inner tyranny had the effect of repressing Mary’s female or feminine qualities. Mary denied herself and others the receptivity, compassion, flexibility, and collaborative experience that represents the interactive feminine. In her writings on the subject of eating disorders, Lerner identified this type of masculine/feminine imbalance and proposes that such a denial of oneself “results in self-loathing.” I saw Mary’s self-loathing and destructiveness as signaling the presence of the tyrannical gatekeeping energy which can both punish and drive one beyond one’s physical and psychic capabilities.

Ed, the inner tyrant, entered Mary’s life as a protective structure following a traumatic event, but later severely constricted Mary’s feeling experience of herself and her life. Not only did Ed protect Mary from unpleasant feelings of grief, despair, fear, and helplessness, but he also repressed and restricted the vulnerable parts of Mary that desperately needed loving attention and self-acceptance. In these ways, Ed is an example of Kalshed’s self-care system; he demonstrates the polarized defensive internal structures, both protective and persecutory. Consistent with Kalshed conceptualization, Mary developed a fragmented sense of herself which made it difficult for her to process her experiences and led to her create an internal protector and then a self-attack in the form of robot living and an internal persecutor whom judged her every move.

Mary’s work in therapy began to loosen the reins of the unrealistic inner tyrant. Nurturing feminine energy of the Mother and her emerging Friend voice began to expand Mary’s inner and outer life. The flow of natural feminine energy discussed by Woodman came through with increasing frequency in Mary’s artwork, dialogue and journaling. With encouragement in therapy, Mary’s feminine nature welcomed her grief with loving
permission. Once the healthy Mother Principle was activated, Mary’s new nurturing friend voice gravitated toward exploring healthy forms of the masculine energies as exemplified by the Father Principles of accountability to herself, self-discipline, self-protection and self-containment with its attendant capacities for meeting necessity and going into the world toward others. Early on in therapy I could see how Mary’s loneliness and isolation had left her at the mercy of Ed’s internal demands and exacerbated her compulsive and destructive habits of robot living. However, I did not become aware of the absence of feminine energies, or the distortion of the masculine until Mary began her self-care routine and the results began to positively affect her relationships with her family.

When her mother died, Mary’s self-care skills were not adequate. She was re-traumatized and a primitive survival mechanism kicked in which evolved into robot living. Mary’s art work revealed how she insulated herself from others and from her own feelings so she could feel safe in the world. Mary depended on robot living to distance herself from the pain. By the time she entered therapy those coping skills were no longer helping her feel safe from the world or from her own feelings. Some part of her realized that she needed more from herself and from life than her survival coping patterns allowed. Mary brought to therapy a part of her that wanted to live her life more fully.

I realized that Mary’s childhood innocence ended the night she was raped when she was fourteen years old. A combination of factors contributed to the walling off of her emotional life. It might have been adolescent social pressures, or resistance to the painful realities of approaching adulthood, and of course the abrupt violation of her emerging womanhood. Mary gathered her determination and all of her internal resources to take
the therapy journey that would teach her about all the subjectivities that resided within her.

Mary still needed protection for the young parts of her that were afraid to be in relationships with others. In terms of the Father Principle’s self-protective function, Mary created a more permeable structure in her drawings, Illustration 3 – The Hardened Structure and Illustration 4 – The Permeable Bubble of Protection, which represented her self-protection in relationships. This bubble of self would allow Mary to be in close relationship with others while she maintained personal boundaries that were permeable to healthy mutual affection and friendship. Mary’s therapeutic work allowed her to develop intimate relationships, while maintaining her Mary-ness to care for her vulnerabilities. So armed, with her newly developed capacities, she stepped onto the long and winding path that would take her through the joys and sorrows, bright surprises and disappointments that come in close relationships. She drew this as Illustration 8 – The Long and Winding Path.

Mary slowly began to come out of isolation and to be among her peers. She had been raped by one of her peers at a party with others her age. She never spoke of this trauma in fear of judgment from others. Instead she blamed herself and in her mind it was overwhelming and dangerous to try to fit in amongst her peers.

Today, prevailing social norms hold young adults to unrealistic standards of fitness and thinness when it comes to body image. Our culture does not celebrate differences in body shape or size, and the emphasis on cover girl perfection undermines a developing adolescent’s confidence during the awkward physical transformation into adulthood. Mary had slowly withdrawn from her friends and family since the time of the
rape, and even more after the death of her mother. Satir’s writings bring to mind the possibility that perhaps the combination of external social norms and internalized expectations undermined her sense of self-worth.\textsuperscript{41}

Mary was like a pressure cooker after these traumatic experiences. Her instincts told her that she was in mortal danger, sending her nervous system into survival mode. Mary no longer felt safe among her peers physically or emotionally. It is possible that being among peers during this time period was too much for Mary’s fragile psyche, and triggered Mary’s eating disorder.

Integrating the Sociocultural lens with Omer’s idea that peers mirror our experience back to us in positive or negative ways, I have concluded that in this culture the negative face of the peer principle idolizes young women’s beauty.\textsuperscript{42} This idolatry is primarily based on outward appearance. Thus a young woman views how she compares to the cultural standard of beauty as a primary barometer of her value. Bly notes that western culture today pits peers against peers always competing with one another for, self-worth, value, popularity and sadly for love.\textsuperscript{43} Influenced by her culture, and triggered by her traumas, Mary sacrificed her connection to her own body and its infinite wisdom. This disconnection was a betrayal that severed the natural loving connection between body and soul and was reflected in Mary’s disconnection from her friends. Mary hid behind her work and away from feelings that made her feel unsafe. Reconnecting with her friends was an important step toward recovery.

I learned through observation how the absence of peer relationships can leave us frighteningly removed from ourselves. As Omer has pointed out, without feedback, we have no way of knowing the effects of our presence, our behavior or our actions. In order
to get to know herself Mary needed to be among her peers. As I began to understand the extent to which Mary was unaware of her feelings and beliefs, I glimpsed the direct relationship between her distance from others and her distorted view of herself and her body. I could then understand something of the dynamics in seeking external perfection as a frantic means of establishing some kind of acceptable sense of self in the world.

According to Omer, healthy peer relationships can bring profound energies of collaboration and vitality to our lives. As Mary improved her relationships with herself she was able to reunite with friends. With the emergence of self-care, and diminishing dependence on Ed’s distorted demands Mary’s sense of self began to blossom.

I could see Mary’s body language, the strength and timber of her voice, and the growing assuredness about the decisions she was making that Mary was feeling better about herself. To use the language of Satir, Mary was slowly building an internal foundation of stronger self-worth and self-acceptance grounded in the truth of her body and soul. She was not out of the woods yet however. When the Quest team encouraged her to begin to expand her diet from the basic menu she had been following diligently for a couple of months, Mary admitted that leaving the comfort zone of that now familiar “life preserver” was an emotional risk. Meanwhile, on occasion Ed would rise up and insist that she could not survive without him, causing her to feel emotionally wobbly. Such occurrences made it difficult to be part of a social scene where eating was involved.

Included in the Appendix of this study are a number of Mary’s drawings telling the story of Mary’s therapy journey. I learned from Illustration 5 – The Crossroad, the crossroad drawing of the barren woods and the path how Mary felt about her future among her peers. She envisioned two possibilities for her future; a bleak life dominated
by Ed or a path filled with vitality and aliveness, without Ed. The reality will depend on
Mary’s self-awareness, self-care, and the support and contact of family and friends. Mary
wondered if she could continue to sustain her recovery in an expanding lifestyle. Mary
wanted a life rich in relationships. However, the process of developing relationships
could put her at risk for relapse. Mary’s relationships with herself and others were
reflected in her relationship with food. Mary worried about her future as she reflected on
a drawing of a leaf where she felt her life was like a leaf blowing in the wind. She said
she sometimes felt out of control and turbulent as represented in her drawing shown in
Illustration 9 – The Leaf.

Mary desperately wanted to let go of the need to control her environment through
restricting her relationships with peers and with food. Her early drawing of a cupboard,
one filled with food and one barren, shown in Illustration 6, represented her conflicted
feelings about being nourished both physically and emotionally. Mary was hungry in her
soul. She wondered what would happen if she just let go and allowed herself to feel her
needs. I wondered, would she ever be met and would she ever feel happy and full as
represented by Illustration 10 – The Tree of Life.

The concepts and principles mentioned above reflect what emerged for me in
examining Mary’s therapy. They provided a larger context for understanding her process.
I saw how fear of one’s own emotions can create debilitating and destructive coping
mechanisms and the loss of self-nurturing. I learned from Mary how the absence of self-
nurturing and self-care produces an insatiable hunger.

I was aware that Mary was becoming more vulnerable and was beginning to let go
of her self-protective hyper-vigilance. Her inner conflict between needing and not
wanting to need provoked the emergence of Ed. Mary was now in the process of reshaping her old beliefs systems, no longer pushing away the uncomfortable feelings associated with past trauma. The need to control her affect was falling away as she made contact with her peers. She was forming her own supportive internal Mother and own protective internal Father. Mary began to feel confident enough to begin to socialize with her peers. While her old world had come to reflect the dangers of rape and loss, the emerging face of Mary’s world reflected possibilities for friendship, camaraderie, and acceptance.

My experience with Mary continues to teach me many things. I learned how disorienting and debilitating trauma and loss can be. Mary’s decisions and actions had become motivated by protective impulses to please others and follow safe social norms and expected behaviors. She lost touch with her true desires and aspirations. As Mary learned to consciously attune to herself and listen to her inner needs, I observed how scary and difficult this process was. I also noticed that the focus and intention required to feel into one’s underlying dynamics seems to diminish the effects of compensatory and inauthentic modes of being and doing, and also reframes experience and perspective from past triggers to present possibilities.

Mary’s journey taught me about the fragility of the process of adolescent development and how significantly an interruption in that process can affect both the character and the experiences of the emerging adult. The rape was an interruption in Mary’s adolescent development and Ed provided a lopsided foundation for coping with her life lessons. The distorted gatekeeper ran the show, overwhelming the nurturing mother and in the type of dynamic that Perera observed exiled Mary from her soul and
from her peers. Mary’s drawing of herself separating from Ed’s distorted truths, Illustration 11 – Separating from Ed, illustrates Mary’s difficult task of separating from a part of her identity that had protected her in times of great vulnerability and suffering in order to allow for the discovery/emergence of a truer sense of self and more inclusive identity.

Near the end of therapy Mary had established a stronger, more resilient and resourceful emotional foundation. At that time, Omer’s image of Three Legged Stool became increasingly useful. Initially, Mary had lacked the Mothering she needed in order to restore or gain needed capacities for nurturing and emotional accessibility. She also lacked fathering which she needed in order to function autonomously and enter into healthy relationship with others. Ed represented a distortion of the Father Principle, pushing Mary with excessive force to strive hopelessly for unrealistic goals. Mary required these parental principles in order to access the vitality and creativity to engage in healthy shared experience and collaboration with peers. Mary began to develop and apply some of these crucial capacities in the process of her therapy and her home self-care practices.

The Quest program became the protective father containing and guiding Mary’s gradual unfolding more fully into adulthood. The Quest team embodied the nurturing and loving attentiveness of the Mother Principle. We all worked together witnessing and supporting Mary through the dark and the light places of her healing journey. Mary had to enter the dark underbelly of her suffering in order to re-emerge and take her place in society among her peers. This journey is not over. Mary will revisit the positive and negative aspects of these principles many times in her life. Hopefully she will find a way
to digest these experiences and the possibilities that they bring. To maintain a safe, healthy life after therapy, Mary must continue to develop a healthy inner father and mother as she ventures into the world with her peers.

I saw the consequences of Mary not attending to her most basic needs. Restricting the assimilation of what human beings need at the most basic level, love, food, and nurturing creates an insatiable hunger in the body and in the very core of the psyche, in the Soul. In reflecting on this, I asked myself what was hungry. I concluded that her Soul was hungry for experience, her heart was hungry for love and attunement, and her body hungered for connection.

There is no prescription or straightforward path to healing the deep wounding that can lead to body image disorders. Mary has to find her own way through her body, her heart, and her soul to collect the parts she had left behind. A drawing of Mary’s that particularly moved me was Illustration 12 – Child Wrapped in a Blanket. To Mary this illustrated her deep need for safety, comfort and nurturing. In a series of hearts and body awareness drawings Mary illustrated her emerging intention to listen to her feelings and to let her feelings be known. (See Illustration 13 – Heart Connection 1, Illustration 14 – Heart Connection 2, and Illustration 15 – Heart Connection 3)

After the death of her mother, whose actual nurturance and care remains a matter of conjecture, Mary gave up or lost any capacities she may have had for caring for herself as she descended into the underworld of soulless survival. As therapy ended, Mary was learning how to be the mother she needed and longed for, and she was developing important capacities to protect, support, nurture, and express herself authentically.
Imaginal Structures

How I Was Affected

From the very first therapy session Mary’s story captured my interest and sparked my curiosity. I looked forward to our sessions and especially enjoyed witnessing her determination and enthusiasm. I found her courage and transparency in the therapy work remarkable and found it easy to engage in the work with her. My emotions ran the gamut from sadness, protectiveness, anger, confusion, and fear to relief, joy, delight, and wonder. I also experienced feelings of inadequacy prompted by inner subjective structures triggered in the transference. These are discussed in the following section on my Imaginal Structures.

Initially I was fascinated by Mary’s story, but on occasion I wondered if I had the courage and skill to follow through in the therapy with her. I knew it was important to track my experience for later reflection in supervision. Sometimes I felt protective of Mary’s fragility and other times I was awed by her strength. Determined to give it my best, I learned to trust Mary’s process and to let her lead the way. There were many highs and lows for both of us.

To offset the countertransference, I created self-care meditations and visualizations around the parts of me that wanted Mary not to suffer and pushed me to find ways to end her suffering. A wise inner voice cautioned me to let go of when, where, and how Mary’s suffering would be alleviated. By the end of Mary’s therapy I had learned to be quite fully present to Mary, wherever she was and however she felt about it.
My Imaginal Structures

Sometimes I thought that Mary gave me more than she ever received from me. From Mary’s self-discoveries and my internal resonance I learned how, like her, I can get lost in following social norms and expected behaviors in order to gain acceptance or avoid retribution. As Mary tuned into herself, she discovered a very active internal “Pleaser” subjectivity within her and I found my Pleaser waved hello. Whereas Mary’s Pleaser was influenced by a perfectionist who emerged in the context of Mary’s performance, my Pleaser was activated in therapy to protect me from disappointing Mary or not being accepted in my role as therapist.

Learning of the approaching termination of the Quest eating disorder program ushered in my “Protective Mother” which was particularly activated by her “Abandoned Child.” Although support systems were thoughtfully put in place, after a few months I noted that abandonment was an underlying issue in Mary’s life with a significant role in her eating disorder. Mary was clear that isolation usually triggered compulsions to restrict her food intake and to binge and purge. Her fear of isolation and feelings of loneliness touched the heart of my internal Protective Mother and I was naturally inclined to comfort and soothe away those feelings. My own feelings of isolation as a young woman were stirred. It was and remained difficult for me to explore, rather than soothe away, Mary’s painful feelings of abandonment. Sometimes my body went into survival mode with conflicting urges to freeze or to flee. I was challenged to distinguish my own responses from Mary’s feelings, and to put my responses aside for later reflection.

Such countertransference also arose during Mary’s process of re-mothering herself. Mary’s re-mothering work comforted and enlivened the heart of my own internal
“Little One” who lacked the experience of a supportive and nurturing mother. Working with Mary’s self-care refuelled my own energies for re-mothering myself.

I recognized that there was important learning for Mary in re-experiencing and expressing painful experiences and associated feelings in a safe container. The owlish image of the “One Who Sees” stepped forward from my internal imaginal realm to remind me of the bigger picture, in which this transformative process required witnessing, listening, and holding, thereby showing Mary how to do this for herself.

A helpful aspect of the counter-transference arose in the form of my instinctual sense of how to help Mary feel safe in the therapeutic milieu. Although feeling safe in the context of the therapy was important for Mary, I also had to be mindful that this was her process, and that there would be situations in Mary’s immediate life that might not be safe at all. Any mothering needed to be in service to Mary in the long term. With this in mind, I applied my mothering urges to inform me of what was missing in Mary’s life and making itself known in the therapy. This generally turned out to be Mary’s lack of skill and experience nurturing and caring for herself.

As a young child I had witnessed my closest friend’s accidental death which had resulted in a generalized perception of the world as unsafe. This view was reinforced by my father’s verbal abuse and dangerous unpredictable anger. Like Mary, but in my own way, I disconnected from my underlying fear and distrust as I grew older. A tough “Ghetto Girl” imaginal structure protected and compensated for my traumatized child inside, as Mary’s “Perfect Performer” compensated for and protected her traumatized inner child. Similar to Mary’s compulsive over-achieving to control her unsafe environment, I used weight lifting to compensate for my feelings of helplessness and
insecurity in what I perceived as an unsafe world. Also like Mary, this sense of imminent
danger was rooted in trauma. My identifying the similarities between Mary’s Perfect
Performer and my Ghetto Girl helped me to be receptive to Mary’s relationship with the
Perfect Performer, Ed, and robot living.

Mary was so likable and so sad at times. I continually tracked my responses to her
emotional states. I found that by recognizing my counter-transference and honoring my
personal boundaries I was also modeling for Mary the capacity to hold polarized internal
aspects while caring for and protecting myself.

The immediate connection Mary and I shared came in part from my own
experience with a body image obsession. My experience was much briefer and less
severe but I knew Mary’s crossroads for what they were. I identified with the forks in the
road, and the important decisions she must make regarding self sabotage and self-care.

I frequently have urges to solve people’s problems, to provide solutions. I did not
allow my inner Fixer into the therapy because Mary would need to learn to solve her own
problems. I wanted Mary to explore her problem areas wherein she could discover her
own capabilities and desires. It turned out that Mary had her own Fixer.

Both Mary and I were tempted by our Fixers to solve others’ problems. By
modeling respect for Mary’s process of meeting her own problems, I hoped to engage her
sense of boundaries in relationship to the people she loved.

In response to Mary’s struggle to stand up to Ed, memories of my own struggle to
exist in the presence of my dominating father arose. It was at that time in my life that
Ghetto Girl made an appearance. I recognized similarities between Ghetto Girl and Ed. In
recognizing that Ed had once been a protective force in Mary’s life, I began to see how
my once protective Ghetto Girl had become a negative controlling force in my own life. This helped me to empathize with Mary’s difficult position in learning to hold those polarized forces which played out in her eating disorder. As her struggle informed me that Mary’s eating disorder was a symptom of a loss of self, my structure informed me of Mary’s unbearable feelings of helplessness.

For twenty years as a fitness trainer and coach I have stood beside people and urged them, “Do not give up!” As I observed Mary’s impatience with herself in her efforts to get better I recognized my inner Cheerleader who says, “You can do this!” However, I was also aware of the necessity to hold space for Mary’s process, which included accepting her limitations and the parts of her that were not ready. This was an important learning for me as a therapist.

Mary’s Imaginal Structures

As therapy continued Mary unearthed a number of active imaginal structures. Some of these structures had protected Mary for a long time from experiencing intolerable feelings of helplessness and vulnerability. When Ed entered her life and began to manage her relationships with her environment, for a time Mary had felt safe and protected. Eventually however, Ed’s complex protective mechanisms began to control her life with consequences of isolation and self-destructive habits and compulsions.

In the course of the therapy these structures were explored and challenged and Mary began to see their destructiveness. The exploratory process loosened Ed’s grip on Mary’s psyche and made room for brighter perspectives. One of Mary’s favorite, most heartening affirmations was that she had the right to all of her feelings. With
encouragement from the Quest team, she employed other affirmations such as, “I am worth it,” “I am enough,” and “I am lovable.” She began to develop a stronger sense of self-worth and let go of the self-blame and guilt which had held her hostage since the night of the rape and was amplified by the illness and death of her mother.

Mary’s new affirmations activated some internal polarities between her hopes and intentions and the inhibiting self-protective habits and compulsions that had driven her to seek help. At times Mary could not admit that she needed help. “I cannot feel lonely,” she would say, “I do not want to feel. I want to hide. It is all my fault. I need to work harder, to keep moving. I am not enough.” Mary’s underlying belief that she was “never enough” left her hungry for fulfillment. This insatiable hunger led to binging and compulsive perfectionism. Her driven lifestyle kept at bay how much she really needed.

Robot living with all of its limitations and restrictions on her feeling experience continued to battle for control. This caused Mary great discomfort. She had depended on these old embedded structures to protect the internal vulnerable little one who could not ask for help or support. This little one’s fear affected Mary, making her cautious and stimulating her to control the therapy environment by perfection in performance. Fortunately, she was in the right place and in the context of the therapy process Mary’s protective structures lost some of their destructive force. Therapy offered a new venue for success in the form of getting to know and be herself.

Many of Mary’s unhealthy structures appeared to have been activated by trauma. Mary’s only way to cope following the rape and later the death of her mother had been to move forward in her life and not feel, to work hard and stay very busy. Her “keep moving” habit helped her avoid uncomfortable feelings but did not allow her to ask for
sorely needed love and attention. Perfectionism overrode the grieving process Mary would need in order to heal.

Mary’s structures also temporarily distanced her from overwhelming loss and trauma. All endings are painful; the human capacity to grieve our losses and be enriched by the process is a large part of living and evolving as human beings. It represents an aspect of the soul’s unfolding. However, traumatic endings can interrupt even the healthiest life.

Prior to therapy, Mary’s “I don’t feel” structure had prevented her from acknowledging or grieving the losses and traumas in her life. By affirming her essential right to be herself, to be safe and to thrive, the therapy team created a place for her internal supportive voice and access to the capacities she would need. In addition, Mary would need to digest and integrate the guilt that she was alive and her mother was dead in order to live into her life in meaningful ways.

**New Learnings About My Imaginal Structures**

I missed an opportunity to bring fresh eyes to the Quest program treatment planning process. When the daily weighing-in of the clients was discussed, I had an inner adverse reaction to that activity. I recognized from my response that it could be triggering for people with eating disorders, but I did not express my concern nor ask if it had been considered. Instead I told myself that the experts in the agency probably knew what they were doing. I would just wait and see.

In retrospect, I saw that my decision not to speak up was influenced by self doubt and the possibility of a hostile reaction. Considering whether or not to voice my
differences with the Quest team in the treatment planning stage stimulated buried fears of retribution, probably based in my father’s constant prophetic threat during my childhood, “You’ve got a big mouth. Someday somebody’s going to shut you up.” Although there were positive aspects to both speaking up and waiting to see how it played out, I really wish that I had taken the chance to express my reservations. In this case, my self-doubting structure got in the way, as it sometimes does in the presence of external authority.

I also missed opportunities to deepen and enrich Mary’s therapy experience. My inexperience and inhibitions got in the way. As a child in the presence of suffering I was helpless, and I felt fragile. This influenced my perception of Mary as fragile and I responded first and foremost to what I perceived as her need for nurturing and protection. In doing so, I missed early opportunities to help her identify and apply her strengths to the issues at hand.

Although my colleagues and I maintained a safe container for Mary’s inner explorations, I did not guide her as much as I could have to explore more deeply her relationship with her parents. That relationship was pertinent to Mary’s lack of self-care and acquiescence to the demeaning voice of Ed. In this empathic failure I see that the absence of parental accountability in my own life indirectly inhibited my work with Mary. In the addictions program, significant fathering accountability practices were applied in the therapy. However in the Quest program, the work was grounded primarily in mothering principles of nurturing, attending, caring, and loving. I will never know how much more of a push might have been helpful or harmful to her process, and this remains a question in my mind.
My Pleaser structure also inhibited exploration of Mary’s relationship with her mother. Because during therapy Mary was still mourning her mother’s death, the Pleaser part of me did not want to upset Mary by bringing up conversation about that relationship. I believe my recent painful loss of closeness with my own mother may have contributed to the counter-transference. Unconsciously, I avoided exploring the mother-daughter relationship more deeply, projecting from my own experience that Mary was too vulnerable. Even as I write these words my heart is heavy and I feel my own sad vulnerability in this area.

As I inquired into the more subtle ways that my imaginal structures affected my work with Mary, I gained a new respect and appreciation of the influence of unconscious or hidden inner dynamics at play in my life. I discovered that healing from suffering and grief does not follow a timeline nor does it take a straightforward path to a particular outcome. Deeply felt grief, fear, and pain find their own way through our being and reveal more about ourselves in the process of our soul’s unfolding.

**Primary Myth**

The Myth of Persephone and Demeter tells about the cycle of life, death, and rebirth. There are several versions of the myth, but most agree that, as May points out, it tells the story of seasonal changes brought about by Demeter’s grieving for her abducted daughter who was taken to the underworld. In her grief, the mother neglects the earth.

According to Ingri d’Aulaire and Edgar Parin d’Aulaire, in the later Olympian pantheon of classical Greece, Persephone was the daughter of the earth-mother goddess, Demeter and the sky-father god, Zeus. They recount, “And Zeus came to the bed of
bountiful Demeter, who bore white-armed Persephone;” Persephone, a Nature goddess before the days of planting seeds and nurturing plants, lived far away from the other deities. In the Olympian telling, many young gods wooed Persephone, but Demeter hid her daughter away from the company of the male deities. Thus, Persephone lived a peaceful, innocent life before she became the goddess of the Underworld, which, according to Olympian myths, occurred when Hades abducted her. Persephone was innocently picking flowers with some nymphs when Hades burst through a cleft in the earth and carried her back to his home in the Underworld. Later, the nymphs were changed by Demeter into the Sirens for not having intervened. In Persephone’s absence, Demeter neglected all and flourishing life on the earth came to a standstill as the devastated Demeter searched for her lost daughter. Helios, the sun, eventually told Demeter what had happened.

D’Aulaire and d’Aulaire point out that if Persephone was the goddess of Nature, for her soul to fulfill its purpose of experiencing itself, she must obey the natural cycles; she must gestate in the nurturing womb of the earth (Underworld) to nourish the roots of her being, her soul, before she could bloom in the air and light into the fullness of herself. As she evolves, parts of her return to the earth to gestate and re-seed and bring to light the shadow aspects of herself and her life on the earth. The Persephone myth represents Mary’s plunge to root in the earth, the dark places of her soul and to bring these to light, bit by bit, to enrich and deepen her quality of life and to nourish her soul with experience.

Finally, the story goes, Zeus pressed by the cries of the hungry people and by the other deities, forced Hades to return Persephone to restore the earth’s bounty. It was a
rule of the Fates, however, that whoever consumed food or drink in the Underworld was
doomed to spend eternity there. Before Persephone was released to Hermes, who had
been sent to retrieve her, Hades either persuaded or tricked her into eating pomegranate
seeds, which required her to return to the underworld for a season each year. When
Demeter and her daughter were reunited, the Earth flourished with vegetation and color,
but for some months each year, when Persephone returned to the underworld, the earth
once again became a barren realm. This myth in all its versions conveys the significance
of the mother and daughter bond, and the necessity of the separation that brings change
and maturation.

The relationship of the Underworld Nature Goddess Persephone with her Mother
Demeter of the sun and the harvest, as recounted in the Greek mythology of the Elysian
Mysteries, was a theme in Mary’s life which came to light in therapy. As an adolescent,
Mary was suddenly and harshly removed from her safe world of childish innocence by a
traumatic event. Young Persephone also experienced an abrupt loss of the life she knew
when she was abducted by Hades to the Underworld. Both Mary and Persephone were
torn abruptly from the innocence and freedom of childhood and found themselves in dark
and frightening worlds for which they were unprepared and which required adult
capacities to negotiate.

Life is filled with loss and change. From the moment of birth our culture does not
hold us gently; it abruptly pushes us through the cycles of life until death. When Mary
was raped, and later when her mother suffered and died of cancer, new stages in Mary’s
life were painfully initiated. Like Persephone, Mary was removed from her mother’s care
and taken to the Underworld. Persephone was forced to live with her abductor, Hades,
lord of the Underworld. Likewise Mary lived with Ed who had abducted her from the brightness of childhood innocence and carried her into her own inner darkness. Eventually both young women emerged wiser and more capacitated, but not until the Mothers went looking for them. As Mary’s therapist, I took the role of Demeter by reaching out to Mary in her dark, hidden places of trauma and loss.

After she was raped Mary withdrew from her friends. Lonely and afraid, she was seduced by Ed’s pseudo-protection which slowly separated Mary’s psyche from her natural feeling body. This disconnection from her soul created emotional famine and subservience to the dark internal demands of Ed/Hades. In the darkness, robot living and physical deprivation kept at bay her grief and fear.

Over time during therapy Mary’s experience of life, like the world abandoned by Demeter, began to allow for darkness, dryness and famine, as well as sunshine, rain and harvest. During Demeter’s grieving and the resultant scarcity of food, Zeus forced Hades to return Persephone to the world to renew abundance. Mary, too, was compelled by inner urgings to return to the underworld, but now she would enter with her eyes open, actively seeking for insight and wisdom and understanding of herself that are found only in that dark place. Both young women enter no longer as victims but seekers after their own souls.

In the hospital, Mary came close to Death and was retrieved to the upper world by medical intervention. In therapy, with support she re-entered the underworld of her own volition. There she revisited the trauma and death that had pulled her down there, and shining in the darkness, she found something that was needed, something missing; her desire for happiness and life. Moore notes that some Classical Greek myths point out a
child’s susceptibility to dark, dangerous places may be unavoidable for soul-making. For Mary, the darkness was clearly an important part of her life journey.

**Personal and Professional Development**

Collaborating with Mary in her healing journey was a privilege. It was also a personal and professional challenge. I had to expand my normal one-point focus on the client to include my own experience of the therapy process. Tracking my experience while being open on a deep level to Mary’s experience expanded my capacities for processing complex and varied levels of information and for reflexivity. Gauging what Mary reported against my observations and my inner responses improved both my understanding and discernment.

I experienced counter-transference in our mutual rapid processing of information. Mindful of this I would say, “Let’s slow down and explore this further,” which helped us both become more present to and aligned with this delicate process. Jin Shin awareness informed my work with Mary, letting me know when to slow down and acknowledge her difficulty in this process. My Pleaser imaginal structure both hindered my willingness to steer Mary toward her learning edges and helped me to be patient with her process. The Pleaser also alerted me about when Mary became too uncomfortable to proceed.

From tracking my projections onto Mary, I learned about the unconscious communication that exists in a therapeutic relationship. I am clearer today about professional and personal boundaries, although there are places that are still blurred regarding how much to push through for both myself and the client of our uncomfortable places in exploration and communication that is vulnerable and this is felt in the room. In
the future, those blurry signals will alert me to the situation in the moment and possible inner reactions I am having. My curiosity about the human psyche and the soul/body connection feels more purposeful, and I found that I can rely on my internal Owlish One who sees the bigger picture and knows when exploration of vulnerable places is needed and also about balancing that with the necessity for the client to be safe in exploring the terrain. The Owlish One know it is a delicate process requiring constant mindfulness and reflection by the therapist with attention to the assumptions and projections of the therapist that can get in the way of this fragile process.

I will miss working with Mary and I feel warmly privileged to have had this collaborative experience within the Quest team. The therapeutic alliance we shared serves as a foundation for my professional development.

**Applying Imaginal Approaches to Psychology**

Imaginal Approaches provide a broad spectrum of useful tools for deep therapeutic and transformative work. The foundational work of reclaiming the soul connects one to one’s deepest desires and illuminates internal conflicts which stand in the way. Drawings, imaginal dialogue, journaling, and ritual gently and effectively called forth Mary’s hidden, repressed, or avoided feelings and needs. Image-making and imaginal dialogue awakened Mary’s sleeping desires and informed her of her barriers.

Imaginal approaches provided guidance and support when Mary disclosed she had been raped. This was accomplished by embodying the archetypal mother to model self-comforting and soothing and which called forth Mary’s internal Mother when Mary needed those qualities.
Using my training in Imaginal Approaches as well as my intuition I learned to
discern my impulses to rescue Mary from my urges to take appropriate creative action.
Ritual helped Mary to express her grief and transform it with love. Imaginal Approaches
also brings a necessary attention to be being attuned to the therapy field and to the
necessities of the present moment allowed me to take creative action that met Mary
where she was. It was in these moments that I understood the importance of Imaginal
Approaches. I could not fix Mary’s pain but I could hold, witness, and engage with her in
the healing process.

As I reflected on what worked and what was less effective in my work with Mary,
clearly accessing her artistic imagination was key to unlocking Mary’s suppressed
feelings and experiences. Mary’s imaginal work gave Mary her own brand of insight into
her self-destructive internal dynamics and the means to transform them. Imaginal
approaches allowed exploratory dialogues with Ed allowed Mary to begin to discern her
genuine feelings and desires apart from Ed’s distorting influence and to establish a new
relationship in which Mary herself made the choices and decisions. Stories and music
helped Mary to identify and then express her inner struggles and attune to her inner
wisdom. Together these approaches supported Mary to integrate a healthier ways of
living and caring for herself in daily life.
CHAPTER 5

REFLECTIONS

Introduction

My work with Mary and the research and reflection involved in writing about that work have deepened and broadened my understanding of eating disorders. I also discovered more of myself; these reflections chronicle my personal and professional development in the process of the therapy with Mary. I also uncovered new inner mythical dimensions which color and shape my work and my life.

I spent a great deal of time examining existing literature within the orientation of Imaginal Psychology, and reflected on the significance of incorporating Imaginal Approaches into therapy with people who have eating disorders and related presenting issues. I have come to deeply appreciate the necessity for bridging and integrating Imaginal Approaches into the prevalent therapeutic modalities applied to the treatment of eating disorders, particularly those having parallel concepts and techniques. In this chapter, I expand on discussion of the significant gaps in the literature on eating disorders and suggest areas which I feel are important for future research.

Personal Development and Transformation

The process and experience of writing this clinical case study has changed me. As the writing challenged me to look more deeply at the dynamics and structures at play in Mary’s life and being, it frequently triggered and brought to light my own. This
experience has challenged, developed, and enhanced my understanding, skills, and capacities for patience, perseverance, discipline, creativity, collaborativity, and self-care.

This process touched every corner of my life, demanding personal, relational, and financial sacrifice. My family life was severely impacted by my unavailability. I am still plagued by twinges of guilt and surges of shame about my failure to do it all.

However, those early morning hours provided quiet access to my internal creative Writer. I was fresh in the early hours and fully present to the task. Commitment deepened between myself and my writing group as we engaged in a disciplined schedule which required many evening hours for all three of us. Without this lively collaboration, Mary’s story would not have come to light in quite the same way. We laughed and cried and struggled together on our projects and sometimes exhausted ourselves and each other. We fought and yielded, blamed and forgave, caused disappointment and were disappointed, quit and resumed, and somehow held true to ourselves and our shared purposes. In that challenging process we came to understand and cherish the meaning of true collaboration, commitment, and friendship.

During the writing of this Clinical Case Study, there were moments when I felt the task to be impossible. Yet, it seems that my blood, sweat, and tears seemed to wash away my deep despair and cleansed wounds that were re-opened but which also reminded me of my own secret dark places. I found insight which I could not imagine when I was in the midst of the long months of this task. I also acknowledge Hermes the Trickster because it probably took a lot of his energy to capture my imagination and hold me to my task the way he did.
As a normally responsible, disciplined person I imagined that I was well suited for this academic endeavor. I did not foresee that it would rearrange my life from the inside out, a life of which I was quite fond. The challenges came in many forms, such as a twice-crashed computer and formatting nightmares, scheduling conflicts, diminished financial resources, and an increasingly irritable family. Commitments to my personal training and home care clients, internships, my teenage children, managing several community events and fundraisers, and the near-death of a close friend from a stroke resulted in pure exhaustion and at times, a complete loss of faith and trust in myself. I spent untold hours on the phone with my writing partners, doing research at various libraries, poring over textbooks and notes, writing, re-writing and re-re-writing. I persevered because Mary’s story got ahold of me and would not let go until it was told. I tried to allow it to unfold in its own creative process.

I endeavored to minimize my stress and anxiety by playing with my family as often as possible as well as exercising and meditating daily. I processed my anguish and frustration with my writing partners until I felt I could not tolerate one more moment of reflexive dialogue. When I reached the part of the study that focused on my internal subjective dynamics in the therapy field my exercising, meditation, and walking reached an all-time peak. By then my very patient husband had just reached the limit of his tolerance for my frantic level of activity and recurring need of computer technical support. We took time together then but it was not enough. I think that I owe him, and my children, several years of uninterrupted attention, the prospect of which I find intimidating.
My usual self-care practices were not enough to support a necessary level of functioning during this writing. I increased my Jin Shin energy balancing work and established ritual time alone for silence and reflection. Jin Shin, exercise, and mindful practices are old friends. The quiet of the early morning hours created a space for me to be with my written words, thoughts, emotional reactions, and somatic responses to my own process of unfolding in the journey. This ritual set the tone for my day and improved the quality of my experience as a personal trainer and active member of my community.

My well-developed time management skills were challenged daily. I struggled with my Perfectionist’s pressure to meet the constantly receding deadlines. Deadlines had previously been a prime mover for me. I failed on a regular basis to meet the deadlines I set for myself and began to realize that something else was brewing. Apparently one’s creative process has its own timeline. I continued applying timelines because they gave me an imagined sense of order.

At this point, my heavy hitter inner subjective deadline person came out to salvage something from the shambles of my life-as-I-had-known-it. Like Mary’s Perfectionist, my deadline person created intense internal pressure fueled by anxiety to ramp up performance. Neither my family nor my writing partners were very fond of my deadline person. However she soothed my fear of being left behind, re-buried any stray wisps of shame, and bolstered that aspect of my identity related to performance. Upon reflection, I saw that both my Deadline part and my Perfectionist function to compensate for repressed feelings of inadequacy and unlovableness.

In therapy, Mary was able to access the voice of the inner Friend, buried beneath structures similar to mine, to help her integrate and balance her internal dynamics and her
life in the world. She developed practices that increased her confidence to be herself and express herself authentically. Mary’s work with the Perfectionist helped her separate from that identity and allow for her imperfections as lovable, informative aspects of who she is. In that process, Mary made room and safe harbor for the little one who got left behind by that gatekeeping.

I have learned a great deal about myself and about life in general and I admit that I feel proud of how I attended to my client and worked collaboratively within the Quest team. I am also proud of my collaborative relationship with my writing partners. One day as we were discussing our work, I said to my writing partners, “We are creating memories right now, today,” and they agreed. This was a precious moment and I am reminded that this study was not just a required task but a collaborative enterprise of love undertaken with my client, my colleagues, my friends, my partners, and my family.

I cannot say that I will ever choose to begin another study of such magnitude again because it will take a great deal of time to recover from this one. But I would not be too surprised if someday I do, because my soul loves this work, this aliveness, and engagement of all the parts of me. It has been a soulful journey, and I do not suppose my soul is going to just give that up permanently.

**Impact of the Learning on My Understanding of the Topic**

New learnings have changed my initial understanding of psychological disorders in general and eating disorders in particular. I had become aware of my own body image dissatisfaction over time as I worked with women suffering from body image issues ranging from mild body image dysmorphia to full blown eating disorders. According to
the DSM-IV, these disorders are clinically characterized by a distorted body image and the morbid fear of obesity, often manifested in abnormal relationships with food. However, my prior knowledge and experience in no way prepared me for the journey with Mary into the underworld of the wounded soul.

As Mary’s therapist, I became aware of the impact of trauma on the mind, body, and psyche. I understand better why trauma victims seek refuge from the world by any means possible, including eating disorders. Most individuals struggling with eating disorders go to great lengths to decrease their body weight in order to meet cultural standards. In my personal healing process when related impulses arise, it signals the necessity to re-connect with my real wants and desires.

My work with Mary brought a deeper understanding of the complex needs and desires of the ensouled human being. The imaginal practices of image making, somatic therapy, and imaginal dialogue were essential to identifying and addressing the unmet needs and repressed desires underlying distorted relationships with food.

I have witnessed the tenacious and potentially destructive compulsions and addictions driving disordered eating, and the prevalent cognitive distortions regarding body image and self-worth. Healing such complex dysfunction is not a simple matter of gaining weight or saying affirmations in order to alter one’s body image. Rather, healing requires an introspective journey to reclaim lost parts of the self, of the soul. To be able then to maintain a healthy connection between body and soul, therapy for these disorders requires initiation into a way of life that supports reality-grounded experiences of acceptability, loveableness, and self-worth. This sensitive work demands attentiveness
and attunement to the signals in the therapy field. The process flourishes naturally in the context of a safe container and ritualized imaginal exploration.

I felt privileged to witness and assist Mary in initiating this part of her lifelong journey towards wholeness. When she concluded her Quest program, Mary was not free from suffering because suffering is part of being in touch with the self and the soul. However, I know that Mary is learning to tolerate better some of her most uncomfortable feelings and to engage healthy means of soothing and comforting herself.

Mary’s vivid descriptions of shopping for food and hyperventilating as panic arose in her body gave me a closer view of the painful character of daily life with an eating disorder. From Mary’s description of an intense physical tension between feelings of insatiable hunger and shame and repulsion toward herself for having such hunger, I now have a sense of the urges to binge and purge. I understand more clearly why people with eating disorders need to have support for all aspects of their relationship with food.

The forceful gatekeeping voice of Ed had given Mary a false sense of safety and a means to a superficial identity as a strong, unfeeling, and effective student and worker. Mary had experienced herself as a helpless victim of a rape. Her intolerable helplessness and hopelessness brought this survival-based internal protector into a dominant position in Mary’s psyche. Like Kalsheed’s protector-persecutor self-care system, Ed’s gatekeeping turned into a complex that disassociated and distorted parts of her awareness when in the real or imagined presence of danger.²

It appears that eating disorders that involve a history of trauma have an avoidant connection to underlying shame. I had the opportunity to observe Nathanson’s four distinct patterns of defense against potential experiences of shame in the present and
future. In Mary’s responses to uncomfortable thoughts and feelings I recognized Nathanson’s withdraw, avoidance, attack others, and attack self patterns of shame-based behavior. By working with Mary I learned to recognize this in Mary’s behavior.

This study not only helped me to better understand eating disorders, it helped me to be a better person and a better therapist. I want to bring what I have learned from these experiences to the field of psychology and my profession as a therapist. The more that I experience therapeutic work utilizing imaginal approaches, the more excited and aligned I feel with its integrative orientation.

**Mythic Implications of the Learnings**

The Elysian myth of Persephone, Goddess of the Underworld, tells of a girl, childish in her innocence, abducted from a lonely, carefree life by Hades, God of the Underworld. Persephone’s journey through darkness and back to the light domain of her mother, Demeter, Goddess of nature and the harvest was a theme which emerged repeatedly in the course of Mary’s therapy.

Like Persephone, Mary was separated abruptly by rape from the domain of her mother and thrust into the dark underworld where her soul languished, its feeling life dimmed, guarded, and provoked by internal forces of mythic proportions. Persephone’s sunlit idyllic world dried and withered from neglect while her mother searched aimlessly for her daughter. Mary’s world shrank similarly to include only work and study.

The mythic implications of forced separation from the mother can be a key factor in the manifestation of an eating disorder. The daughter either has been prepared and
developed capacities to survive or thrive in relationship with new peers and new environments, as did Persephone, or she must hide in fear, as did Mary.

Being raped forced Mary into adulthood abruptly and at a tender age, just as innocent Persephone was exiled from all she knew and was forced to be a wife and then, a mother. It can be presumed that Persephone was removed from the care and control of her mother and was both confined and cared for by the servants of Hades.

When Mary entered therapy, she was unable to care for herself. Protective internal survival structures had created robot living as a way to safely maneuver through the treacherous unpredictable currents of life, empty and bereft of feeling. As Mary pushed herself relentlessly to perform in the context of the cultural values and norms as she saw them, so must have Persephone forced herself to conform to confinement in the Underworld as she saw it, and from which she knew no escape.

Meanwhile, Mary’s soul helplessly watched her live a meaningless, robotic life dictated by guilt and shame and fear, the same lords of the Underworld who controlled Persephone’s daily life. Like the barren earth after Persephone’s abduction, Mary’s body was starving for food as her soul starved for attunement and connection to an embodied life. Just as Persephone’s soul in servitude to the darkness starved for sunlight and warmth, Mary’s mother’s death activated Mary’s repressed longings for the life-giving feminine soul qualities buried in the debris of trauma.

Like Persephone, Mary had to rely on her masculine capacities for operating in the world. Influenced by her experience with her distant, passive father, Mary’s gatekeeping took a domineering male role which subverted and twisted the meaning of the Father Principle’s sacrifice, accountability, discipline, renunciation, responsibility,
and necessity to establish an impermeable shield around Mary, protecting her from all feelings and experiences which might lead to re-traumatization. Mary and Persephone were both in Hell. Without access to the life sustaining nourishing parts of themselves, both fell into obeisance to harsh masters.

Over time, both young women became identified with their internal subjective tormentors, Hades and Ed. By the time the Mothers came looking for them, Persephone was the Queen of the Underworld and the mother of Hades’ child. She conducted herself as an adult and a royal peer to her mother. Mary excelled in her business and academic pursuits and, in that arena, became likewise a peer to her mother.

Persephone soon learned that her presence would be required in the Underworld for part of every year, in order to insure the health and balance of the natural world. In therapy, Mary realized that her therapeutic forays into her internal underworld would need to continue in order to keep connected with her soul. She found that in retrieving and examining repressed feelings and experiences, she felt more authentically herself and more whole. The process of retrieving hidden feelings and parts of herself brought fulfillment in little ways and capacitated her in her life in the world. I found nothing in the mythical literature indicating that Persephone went kicking and screaming each year back to her husband in the Underworld. Both girls became women in the process, and both women engaged in a quest to embody a full, ensouled life by doing what it takes.

In reflecting on Mary’s personality, the image of an Amazon arose on several occasions. The Amazon archetypal persona is often reflected in a woman who has taken on characteristics that are generally associated with the masculine disposition. Rather than integrating the masculine capacities that could make her a strong, balanced woman,
she identified with the power aspect of the masculine, and renounced the feminine capacity to relate lovingly. According to Leonard, the Amazonian tendency to renounce the feminine can lead to victimization by the unbalanced masculine energies.\(^4\)

While Persephone lived in the underworld, it can be presumed that she directly experienced her soul’s Hell, possibly mitigated by the attentions of her lover, Hades. Mary initially avoided awareness of her inner pain and suffering which nearly cost her life, but her experience of life was also Hell, in which Ed the tormentor was also seen as her savior and only friend. In therapy, Mary was gently guided to take a fresh look into her Underworld and was helped and supported in connecting with her feeling soul. Mary began to live consciously with her pain and loss.

**Significance of the Learnings**

It was through empathy, and of course the countertransference, that I recognized Mary’s need for mothering. As Mary was learning to care for and nurture herself, I noticed that her new efforts to develop relationships with her brother and her old friends were tentative and short-lived. As Mary and I explored the dynamics of Omer’s Mother, Father, and Peer Principles through his image of the three-legged stool, it became clear that Mary’s internal relational base was out of balance and ineffective.\(^5\) She required collaboration and connection between her emerging feminine capacities for attention, nurturance, and self-care and healthy masculine principles for being and doing in order to be functionally stable in the world. The concept of the three legged stool can bring to the treatment of eating disorders a direct, effective, and non-threatening therapeutic tool with a built-in constructive component.
Ed represented a distortion of the Father Principle which embodies healthy discipline and necessity but instead pushed Mary with excessive force to strive hopelessly for unrealistic goals. The third leg of the stool, the Peer Principle, represents the missing vitality and creativity of community, mutual support, shared experience, collaboration, and intimacy needed to create a new healthy and satisfying lifestyle. According to Omer, challenging peer relationships require the integrated presence of the Mother and the Father Principles, which seemed true for Mary.6

There is a need for both the male and female aspects of one’s nature to create a buffer against inner self-destructive forces and trauma-related survival tactics and to bring conscious attention to one’s whole experience. Including polarized inner responses makes room for, and invites into body and soul, the life force needed to heal and evolve.

Being raped had interrupted Mary’s adolescence and separated her from her peers. Wonderlich et al. note that there is an increase in self-destructive behaviors following sexual abuse.7 In Mary’s case, it was clear that sexual abuse had triggered Mary’s initial anorexic behavior, and re-traumatization related to her mother’s death had contributed to its intensified recurrence leading to anorexia and bulimia.

Another significant learning that I became aware during the therapy process was how directly somatic practices which bring conscious attention to one’s body can forge a deeper, broader, and truer inner connection to oneself and one’s experiences. In the literature, the Jin Shin practice of holding pressure points has not been connected to psychology or eating disorders. This tool feels like an important bridging link between soma and mind which is relevant to the field of psychology and specifically to eating disorders. Jin Shin helps people get grounded in their bodies and, by balancing the energy
meridians, brings a needed sense of physical well-being and confidence into the therapeutic process. The body has powerful knowledge to give through pure affect before thoughts and identity structures distort the behavior. The body is the physical, experiential barometer of the internal subjective life and is symptomatic of the internal developmental journey.

I have more questions than answers. I wonder how we as therapists learn to facilitate the return of lost and disconnected parts that have been shattered by repeated trauma. How can we help traumatized individuals to develop trust in themselves in a world that, indeed, is not always safe? How can we help build inner resilience?

Mary’s robot living was a complex internal dynamic which restricted and limited her life experiences. It masqueraded as a helpful coping mechanism, but actually generated distorted perceptions and self-injurious compulsions. This maladapted form of protection seized and took over Mary’s life, isolating her, and adversely affecting her physical health with potentially fatal consequences. She became in her words “a workaholic,” squeezing out of her heart, mind, and body, the overwhelming grief and fear she could not face.

By working with Mary, I discovered that robot living is a recognizable, identifiable pattern of affects and compulsive behavior. In the future, when I see similar symptoms, particularly if there is also evidence of emotional detachment, isolation, and irrationally high expectations, I will be alerted to the possibility of a concurrent eating disorder.
Applying Imaginal Approaches to Psychotherapy

During Mary’s therapy I worked closely with my supervisor who is an imaginal psychologist. I was able to practice imaginal approaches with expert guidance and support. Through art, Mary unearthed archetypal images of active polarized subjectivities living in her psyche and contributing to her eating disorder. Through imaginal dialogue, Mary was able to begin to align her internal dynamics with her desire for health and wholeness and her aspirations for a normal, healthy life. Using Mary’s imagery, segments of the therapy sessions were ritualized, which created a safe environment for her inner explorations. I also brought into the therapy somatic practices from fitness training, Yoga, and Jin Shin Jyutsu, and Mary’s inner explorations and art work were often accompanied and supported by life-affirming music and relevant stories.

Throughout Mary’s therapy, imagination was a key transformative agent in her process of accessing and exploring the underlying dynamics of her illness. I watched as through Mary’s art making the images gave access to her hidden internal dialogue. Through image making, ritual, dialogue, and story Mary began to understand the inner workings of her experiences, past and present. Her dialogue with Ed revealed imaginal structures that were distorting her daily decision-making and impacting her life in a self-destructive manner. Accessing the Friend brought forth untapped wisdom, inner guidance, and emotional support.

Observing Mary, I noticed how directly and effectively ritual created both a feeling of reverence and a sense of safety which gave natural impetus toward inner exploration and authentic expression of repressed feelings and experiences. For example, when Mary began to talk about the rape for the first time in her life, I was deeply stirred.
Moved by my inner stirrings, I thought to ritualize the moment by holding the ceramic heart as a symbol of holding Mary’s hidden pain and feelings as she was beginning to become conscious and aware of her vulnerable self. (Later, in another ritualizing moment I invited Mary to hold the heart as a symbol of she, herself, holding those feelings as an act of self-care.) Afterward, Mary thanked me as tears poured down her cheeks. In ritual silence, Mary’s feeling life was recognized and honored in a way that touched and unified her body and soul. Who knows when this memory may arise in the future to help Mary when she is frightened or sad or tempted by compulsive urges?

From this experience, I identified some of my internal signals for creative action in the context of therapy. This moment was pivotal for me in learning to work with deeply held pain and suffering. I knew that I could not take away Mary’s pain but by honoring the urgings of my imagination, I could actively support her in finding inner resources to cope with her feelings in ways that were more loving and respectful of herself.

Early in the therapy I saw how important it would be for Mary to build capacities so that she could trust herself to handle life’s inevitable disappointments in the future. For example, Mary would need to develop the capacity to be vulnerable enough to enter into authentic friendships and aware enough to protect herself from harm.

When the image of the three-legged stool arose in a therapy session, it led to a fruitful discussion of ways for Mary to provide fathering and mothering to herself. This particular image became a useful and comprehensive reference for the development of balanced, healthy self-care practices. It helped Mary shift from the innocent victim position to a more capacitated, self-actualizing perspective. I hoped that movement in this
direction would weaken the hold that Ed exercised on her psyche and give her spirit looser reins.

I also found somatic therapies helpful in working with eating disorders. According to Criswell, the Greek word *soma* refers to the living body. People with eating disorders lack connection to the messages and needs of their physical bodies and there is a notable absence of the physical sensations of hunger and fullness. In an anorexic state, even the discomforts of starvation are shut off. For Mary, both yoga and the Eastern art of Jin Shin Jyutsu proved helpful. Although I have not seen Jin Shin Jyutsu identified as a somatic therapy modality, it accesses the body image meridians. Mary easily incorporated these practices into her self-care regime and reported that as a result she felt a deeper, more solid sense of herself as a whole.

**Bridging Imaginal Psychology**

Omer states that Imaginal Psychology meets the possibility of transformation with imagination. Omer’s theory and Meridian University’s imaginal approach to transformative learning both effectively bridge between Imaginal Psychology and mainstream psychological orientations. Based in experiential learning methods, Imaginal Psychology practices provide personally relevant and direct means for accessing, exploring, understanding, and transforming the inner landscape of human beings in the context of their individual lives and experiences.

At Psych Strategies, therapy was primarily viewed from a cognitive behavioral perspective. In the more traditional addictions program, art-making was a familiar, acceptable way to bridge between the behaviorally-oriented cognitive therapy and
underlying structures which required attention in order for behavior to change in a meaningful way. Art-making revealed and reflected an individual’s relevant inner dynamics and supported the cognitive behavioral goals of reality testing and identifying cognitive distortions. In the imaginally-oriented eating disorder program, the drawings that Mary made spoke for themselves, illustrating her imaginal structures and her conflicted internal subjective perspectives.

A spectrum of somatic practices similarly bridged naturally to both the eating disorder program and the addictions programs. In the context of the Psych Strategies agency, yoga fulfilled the “Health and Nutrition” component of each program, while also forging healthy therapeutic connections between psyche and soma.

Likewise, ritual can be brought into an existing program in the context of the requirements and goals of the program itself. For example, the Twelve Step Program used in most addictions treatment includes ritualized practices in both group and individual therapy. In my work as a personal trainer, I coach people in nutrition, physical fitness, and in awareness of their physical and feeling bodies. In my work as Director of Education in the performing arts industry, I specialize in building self-esteem and leadership. Body image issues and eating disorders frequently show up in both of these arenas.

In teaching yoga classes, I used meditation and visualization to close each class. Most recently I have been able to apply mindful eating practices both in the gym and in the clinical setting with clients who are struggling with body image dissatisfaction. This made a bridge for participants from traditional behavioral oriented therapy to deeper, more reflexive participation in the program activities and in their own lives.
In traditional talk therapy there are bridging opportunities to introduce imaginal dialogue via the language used by the program or the client. For example, people are generally responsive to the suggestion to name a part of the self that does undesirable or desirable actions. This bridging technique initially provides relief from the pressures of maintaining an acceptable identity, and then allows for more troublesome parts of the self to show up and be accepted.

**Areas for Future Research**

There is a large body of literature supporting a Cognitive Behavioral approach to the treatment of eating disorders. An area of future research that interests me is the use of Imaginal Approaches to access, identify, and bring to awareness intersubjectivities explored through Cognitive Behavioral therapy in the traditional treatment of eating disorders.

Applying the Cognitive Behavioral concept of cognitive distortions helped us to discern the unhealthy influences of the inner subjective aspects of Mary’s eating disorder, which included black-and-white thinking, irrational beliefs, and an all-or-nothing perspective. However, it was art therapy and imaginal dialogue that unearthed the underlying dynamics and processes at play. I am interested in the possibilities for integration of Cognitive Behavioral Therapy with Imaginal Approaches for deeper understanding of eating disorders and to stimulate personal transformation that can capacitate clients to achieve and sustain healthy, satisfying lives.

Another area of interest for future research concerns robot living and its manifestations and multiple facets in the context of trauma. I propose that robot living
may be a typical signifier and protective coping mechanism for trauma. While it is generally agreed that trauma underlies most eating disorders, I propose that robot living is often both concomitant with eating disorders and representative of an identifiable defense against re-traumatization which disengages the soul from the individual’s awareness. I would like to see more research on the presence and effects of robot living and what forms of therapy can best re-connect one to their soul. I further hold that more needs to be understood about how the soul is related to and impacted by self-deprivation, starvation, self-punishment, pushing beyond one’s physical limits, and the cutting off one’s feelings.

There appeared another gap in the literature regarding the relationship between the guilty feelings associated with eating disorders and avoidance of shame. Chernin’s reference to guilt in relation to surpassing the living mother was the only one I found relevant to eating disorders. My observation is that guilt is a coping mechanism in our culture against the intolerable affect of shame. More research is needed to explore the impact of both guilt and shame on eating disorders. I propose that when guilt becomes a driving force in daily life it is founded in avoidance of untenable feeling states.

Mary’s relationship with her mother appeared to be colored by her death, and yet there is much that was not explored about this important relationship. Mary’s relationship with her distant father, a competitive feeling towards her brother, and a lack of safety with her peers clearly impacted Mary functioning. Information about the cumulative effect of trauma and stressors upon such primary relationships appears to be lacking in both the literature on, and therapeutic practices applied to, eating disorders.

There is more work to be done about what factors pre-dispose individuals to eating disorders. For Mary it appeared to be a combination of life experiences and the
history of missing or subverted internal and external relationships. Burch holds that eating disorders are the result of combined cultural, psychological, physiological, chemical, and family influences. I would suggest that additional research along these lines, using an integrative imaginal approach, is essential to fully understanding and addressing the dynamics of these complex and ultimately life-threatening interrelationships.

We cannot ever fully comprehend an individual’s psyche because each person is a unique, complex, and evolving human being. When we view from a single lens, or treat from a singular psychological approach, whether it is Biological, Psychodynamic, Humanistic, Sociocultural, or Cognitive Behavioral, our perceptions are embedded in and influenced by that perspective. We no longer see with fresh eyes. According to Omer, soulful expression of our individual humanity emerges from experience, and the experience is in the individual journey. I want to bring fresh eyes to my work so that I can be fully present to people’s stories. I want to consider the messages and their implications from all perspectives. Even as I write, I am embedded in my own perspective. I need to be able to see things through my clients’ eyes. I need to hear the voices that are speaking to them.

My experience with Mary and our work together has deepened my understanding and provided valuable insights into the workings of the soul. I have put these precious resources in my tool belt for my work as a healer, educator, and most importantly, as a listener to what is spoken and what is not spoken. These are gifts which Mary brought to us both from her courageous journey to the Underworld.
APPENDIX
APPENDIX 1

INFORMED CONSENT FORM

To: Mary

You are invited to be the subject of a Clinical Case Study I am writing on eating disorders. The study’s purpose is to better understand ways women struggle with eating disorders in today’s society.

For the protection of your privacy, all of my notes will be kept confidential and your identity will be protected. In the reporting of information and published material, any and all information that could serve to identify you would be altered to ensure your anonymity.

This study is of a research nature and may offer no direct benefit to you. The published findings, however, may be useful to those who are suffering from eating disorders and may benefit from the understanding of eating disorders.

The Clinical Case Study does not directly require your involvement. However, it is possible that simply knowing that you are the subject of the study could affect you in ways which could potentially distract you from your primary focus in your therapy. If at anytime you develop questions or concerns, I will make every effort to discuss these with you.

If you decide to participate in this Clinical Case Study, you may withdraw your consent and discontinue your participation at any time and for any reason. Please note as well that I may need to terminate your role as the subject of the study at any point and for any reason; I will inform you of this change, should I need to make it.

If you have any questions or concerns, you may discuss these with me, or you may contact the Academic Service Coordinator at the Institute of Imaginal studies, 47 Sixth Street Petaluma, California, 94952, telephone: 707-765-1836.

I, Mary, understand and consent to be the subject of, or to be referred to in, the Clinical Case Study written by Tari Webber, on the topic of eating disorders. I understand private and confidential information may be discussed or disclosed in this Clinical Case Study. I have had this study explained to me by Tari Webber. Any questions of mine about this clinical case study have been answered, and I have received a copy of this Informed Consent form. My participation in this study is entirely voluntary.
I knowingly and voluntarily give my unconditional consent for use of both my clinical case history, as well as for disclosure of all other information about me including, but not limited to, information which may be considered private or confidential. I understand that Tari Webber will not disclose my name or the names of any persons involved with me, in this Clinical Case Study.

I hereby unconditionally forever release Tari Webber and the Institute of Imaginal Studies (and all of its trustees, officers, employees, agents, faculty, successors, and assigns) from any and all claims, demands, and legal causes of action whether known or unknown, arising out the mentioned, use, and disclosure of my clinical case history, and all information concerning me including, but not limited to, information which may be considered private and confidential. The Institute of Imaginal Studies assumes no responsibility ability for any psychological injury that may result from this study.

The terms and provisions of this consent shall be binding upon my heirs, representatives, successors, and assigns. The terms of provisions of this consent shall be construed and interpreted pursuant to the laws of the State of California.

Signed this ______ day of, ______________ 2008, at ______________ Santa Rosa, CA.

By: _____________________

___________________

Client’s name, printed
APPENDIX 2

CLIENT HISTORY AND LIFE CIRCUMSTANCES DURING THERAPY

I. Mary’s early childhood
   A. Parents happily married and good relationship with parents
      1. Consistent parenting and loving environment
      2. Closest relationship with mother
      3. Father identified as not the parent of structure and appropriate discipline
   B. Mid Teen Years
      1. Mary raped at age fourteen
      2. Mother unaware of Mary’s experience
      3. Mary blames self for rape because she was intoxicated
      4. Mary’s relationship with controlling her environment begins

II. Young adulthood
   A. Full blown bulimia begins about age of nineteen after living in Europe
      1. Mary studies abroad in Europe and gains twenty pounds
      2. Mary’s’ mother diagnosed with cancer when she is twenty years old;
   B. Mary’s’ mother dies when Mary is 21 years old
      1. Much regret that she never told her mother about the rape
   C. Mary full time psychology student in San Francisco living on her own.
      1. Mary working and going to school
         a. Mary holds a job
b. Mary attends school full time

c. Mary grieves her mother’s death

D. Mary’s bulimia takes over and robot living begins

1. Mary goes to Traders Joes and shops for binge food and purges after

III. Just before therapy begins

A. Mary is hospitalized at 23 years old

B. Mary stays at Herrick hospital and is diagnosed with bulimia

C. Mary leaves Herrick and begins Quest outpatient therapy
APPENDIX 3

PROGRESSIONS OF TREATMENT

I. The Beginning

A. The first session – The Quest team meets after referral from Herrick Hospital

1. Initial impressions
   a. Physical appearance
      i. Tired
      ii. Sad eyes
      iii. Depressed
   b. Affective presentation
      i. Very sweet demeanor
      ii. Composed yet delicate
      iii. Intelligent
      iv. Articulate
      v. Receptive

2. The clients’ description of the problem
   a. Mothers death and grief
   b. Bingeing and purging out of control
   c. School and work overwhelm
   d. Feeling overwhelmed and out of control

3. Potential crises
a. Hospitalized for bulimia
b. Suicidal thoughts
c. Stress and overwhelm
d. Insomnia
e. Depression

4. Mary begins treatment

B. Mary attends her intensive outpatient program nine hours three times a week

1. Mary struggles with her eating disorder, anxiety, sleep, and depression
2. Mary sees psychiatrist and is prescribed medication.
3. Mary struggles to adjust to her new medication while delving into the emotional work on herself and her eating disorder.
4. Mary finds artwork and journaling therapeutic and healing
   a. Mary builds tool kit of self-care
   b. Mary uncovers her relationship with robot living
   c. Mary struggles with
      i. grief of losing mother
      ii. medication
      iii. lack of appetite
      iv. meal plan
      v. mindful eating practices introduced

II. The Therapy Journey

A. Mary struggles with her father’s drinking
   1. Mary begins work with codependency issues
   2. Boundary setting

B. Mary discloses rape
   1. Therapists work to provide a safe container
      a. To hold feeling she had never disclosed to anyone
      b. Provide emotional support
      c. Teach self-healing techniques of verbal modalities, artwork and journaling

C. Mary identifies her relationship with her eating disorder
   1. She calls the eating disorder Ed
   2. She names the connection to robot living
   3. Mary continues to journal and use artwork to identify, express, and reflect her challenges with Ed
   4. Mary identifies that she feels deeply connected to artwork as a self-care technique

D. Mary meets with family members during family counseling
   1. Mary verbalizes her needs
   2. Family brainstorms to support Mary

E. Mary is progressing well
   1. We begin identifying negative beliefs and cognitive distortion from the voice of her eating disorder Ed
   2. Mary continues to dialogue with Ed verbally and through her artwork

F. Mary plans for exit plan and relapse prevention.
   1. Mary creates healing space at home for artwork
   2. Mary and family plant a tree for her mother
3. Mary begins shopping desensitization program
   a. Shopping for food and making some progress
      i. But one anxiety attack and has to leave the store
      ii. We make plans to go slow in this area
   b. Mary is progressing with shopping desensitization treatment and is binge purge free

4. Mary works with boundaries in all of her relationships

5. Mary begins to successfully veer from the nutritionist’s set menu
   a. Mary uses mindful eating practice to eat without high anxiety

III. The Ending

A. Mary graduates from Psych Strategies
   1. Mary’s relapse prevention plan presented to the therapists at graduation ceremony
   2. Mary is binge-free and stable

B. Mary attends aftercare counseling with counselor at Psych Strategies

C. Mary attends aftercare with psychiatrist for medications

D. Mary decides to continue living with her father as part of her self-care
   1. Mary decides to not return to school and work in San Francisco
   2. Mary finds a part-time job

E. Mary follows up with grief counseling at hospice about her mother’s death.
APPENDIX 4

OVERVIEW OF THE JIN SHIN JYUTSU 26 SAFETY ENERGY LOCKS
APPENDIX 5

ILLUSTRATIONS – CLIENT ARTWORK

Illustration 1 – Hunger for Expression
Illustration 2 – I Have a Right
Illustration 3 – The Hardened Structure
Illustration 4 – The Permeable Bubble of Protection
Illustration 5 – The Crossroad
Illustration 6 – The Conflicted Cupboard
Illustration 7 – The Sad Infant
Illustration 8 – The Long and Winding Path
Illustration 9 – The Leaf
Illustration 10 – The Tree of Life
Illustration 12 – Child Wrapped in a Blanket
Illustration 14 – Heart Connection 2
Illustration 15 – Heart Connection 3
NOTES

Chapter 1


3. Ibid.

4. Ibid.


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22. Ibid.


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28. Mary’s definition of “Robot Living”

29. Irene Ives, supervision with author, August 15, 2008.


34. Woodman, *Addicted to Perfection*, 30-34.


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