THERE’S NO PLACE LIKE HOME: FINDING LIFE AFTER ANOREXIA

by

BARBARA ANN MURPHY

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

DOCTOR OF PSYCHOLOGY IN CLINICAL PSYCHOLOGY

MERIDIAN UNIVERSITY

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This clinical case study has been accepted for the faculty of

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This writing is dedicated to my mother, who would have papered her walls with this work if she had had the chance.
“I don’t know enough,” replied the Scarecrow, cheerfully. “My head is stuffed with straw, you know, and that is why I am going to Oz to ask him for some brains.”

“Oh, I see,” said the Tin Woodman. “But, after all, brains are not the best things in the world.”

“Have you any?” inquired the Scarecrow.

“No, my head is quite empty,” answered the Woodman; “but once I had brains, and a heart also; so, having tried them both, I should much rather have a heart.”

— L. Frank Baum

The Wonderful Wizard of Oz
ABSTRACT

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The effects of Anorexia Nervosa upon so many is a rather recent phenomenon. The significant associated risks require that this disorder be taken seriously for the sake of individuals who suffer it as well as their loved ones. This Clinical Case Study describes the therapy of a young woman who not only suffered with anorexia, but put herself at greater risk by also abusing insulin prescribed for her Type I diabetes to stay thin. This client sought therapy because of her mother’s concern and her ten hospitalizations that year. Although suffering greatly, she had steadfastly held to her self-sabotaging habits and need to look perfect which became the focus of the therapy.

The literature reveals that the lenses from which clinicians view and treat the anorexia after medical stabilization differ considerably. The significance and impact, as well as limitations of these methods are discussed in this paper. Heightening awareness about varying treatment options is fundamental to success rates and recidivism.

The therapeutic methods discussed include working with the client from the cognitive/behavioral, psychodynamic, and biological perspectives, as well as using an imaginal approach. It was also important to focus in the therapy upon sociocultural influences and ways that these informed and impacted the client’s experience of the world.
This study’s major learning involved looking at the client’s imaginal structure of perfectionism and her need to not make mistakes. Closely related were imaginal structures of needing to stay thin at all costs and stay numb to her feelings. This resulted in abysmal self-care routines and beliefs that she needed to both abuse her insulin and eat minimally.

*The Wonderful Wizard of Oz* depicts the myth in which this client’s story is reflected. This American fairytale chronicles a young woman’s numerous obstacles and challenges while trying to find her way back home. Similarly, the client’s struggle with anorexia and finding her way through its myriad of obstacles was a heroic journey.

The need to further research the anorexic’s proclivity to counter-dependent tendencies might help clinicians understanding of unique traits and obstacles with which the anorexic contends. Such insight could provide a greater tolerance for the difficulties in working with this population.
ACKNOWLEDGMENTS

To family and friends, here and imaginal, you know who you are . . . I could not have done it without you . . . Thank You. And to TJ . . . Who encouraged me with enthusiasm and confidence to persevere. My deep appreciation and love. . . Thank You.
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CHAPTER 1

INTRODUCTION

Clinical Topic

For the past four decades volumes have been written about the eating disorder known as Anorexia Nervosa, yet it remains, as Susie Orbach notes, one of the more challenging pathologies for clinicians to treat.¹ For one who is anorexic, the inability to see oneself realistically, or the inability to even react to the weakened and severely malnutritioned state of their body, is characteristic of this disorder. With the pride and arrogance inherent in what the anorexic considers to be an ‘extraordinary achievement’ of extreme weight loss, to the point of severe emaciation, anorexics find it difficult to allow themselves to be psychologically treated. The rationale for this is that anorexics fear that becoming “healthy” means becoming fat. Getting treatment for Anorexia Nervosa is generally avoided, says Steven Levenkron, until the person is deeply embedded in the disorder.²

According to Tony Paulson and Joanna Marie McShane, an eating disorder arises out of one’s inability to cope with intolerable feelings, negative thoughts, distress, and the anxiety one feels about relationships.³ Because of this, the anorexic’s primary focus becomes the unending struggle to control her inner and outer worlds while appearing to have it all together. This obsessive need for some sort of control leaves anorexics prisoners to their own gnawing and non-stop thoughts over the pursuit of thinness. The anorexic is consumed with such thoughts as “Should I eat? Should I not eat? I’ll feel
guilty if I do. But I know my body needs food. Maybe just a little. But only if it doesn’t have fat in it.” This contentious “inner battleground,” as termed by Melissa Schwartz, engulfs the anorexic with its constant obsessive nature. This part of the anorexic works overtime to repress her feelings and keep her from experiencing. Containing all those unprocessed feelings becomes a full-time job. Eventually, the internal well will spill over, and outer symptoms will begin to show up as anorexic behaviors. In the end states Eve Jackson, “eating problems manifest the psyche’s need to be seen, honored and loved.”

Diets, although typically normalized in our Western culture, can simply pave the way to eating disorders according to Carol Normandi and Laurelee Roark from Beyond Hunger. The act of dieting however, when referred to as a way to count calories, dictate meal portions, and control a woman’s weight, is not normal. Rarely is a self induced diet based on a natural response to one’s true physical hunger needs. In fact, 20 to 25 percent of all dieters will go on to develop eating problems according to the National Eating Disorders Association (NEDA). And yet certainly, when a diet turns into an eating disorder diagnosis, it should be cause for grave concern. Our society, however, often looks the other way, normalizing the actions of women with eating disordered behaviors; and in doing so, unknowingly perpetuates the existence of eating disorders.

Through my clinical work with eating disorders for over nine years, as well as my personal experience with these complex symptoms, it has become apparent to me that an overwhelming number of women suffer from society’s extremely limited standards of what is physically acceptable. Not having developed a sense of self or a real understanding of their likes and dislikes and needs, those who grow into anorexia have become, as Levenkron terms, “creatures of the culture” looking to the culture to fill the
void that otherwise would have been filled by their sense of self or identity. Margo Maine posits that when a person takes the approach where they believe, *If only I were skinny then life would be wonderful*, it then becomes easy for them to be lured into the harsh diet mentality surrounding them. That illusory thought has the propensity to launch women down the dangerous road toward eating disordered behaviors, and a possible eating disorder diagnosis.

Women are often moved to restrictive food intake behaviors by the intense outside pressure they feel. (Even though anorexia is also experienced in the male population, I speak only about women in this paper because the vast majority of patients diagnosed with Anorexia Nervosa are female according to Michelle Heffner and Georg H. Eifert, Ron Waldrop, Sara Dulney Gilbert, Pamela Carlton and Deborah Ashin, and many others. These authors and researchers recognize it is difficult to get statistics on anorexia because so many people hide the fact that they are afflicted by it, but according to these authors approximately 85 percent to 98 percent diagnosed are female.) Through the eyes with which we scrutinize the female body, notes Waldrop, perfectionistic standards demand our bodies are never quite good enough. Frances Berg writes,

In less than two decades, the acceptable female body size has been whittled down by one-third. Most women no longer fit that size, and trying to do so takes up more and more of their lives. Some are pushed to an apparent point of no return, by our era’s culminating demand that women give up nourishment and a large share of their bodies.

Geneen Roth speaks to how women have learned to apologize for their appetites. As noted by Susan C. Wooley, many clinicians and other professionals feel helpless when face-to-face with these clients, and are left wondering why anorexic
behavior is so difficult to stop.\textsuperscript{14} “Why won’t they just eat!” becomes a common theme. Often, there is even a level of hostility toward victims of anorexia.

This hostility is an indicator of the level of fear related to Anorexia Nervosa and the challenges, and misunderstandings with which professionals must deal. Because of this, anorexia is especially important to study. Furthermore, understanding this disorder is important because it is characterized, as stated in the current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), by “a refusal to maintain a minimally normal body weight” in fact, “less than 85 percent of that expected.”\textsuperscript{15} It also notes that the individual has an “intense fear of gaining weight or becoming fat,” is disturbed “in the way in which one’s body weight or shape is experienced,” and “in postmenarcheal females, . . . the absence of at least three consecutive menstrual cycles.”\textsuperscript{16} John Sours fills in this description by addressing other associated characteristics that include excessive physical activity, denial of hunger in the face of starvation, academic success, asexual behavior, and a history of extreme weight loss methods (e.g., diuretics, laxatives, amphetamines, emetics, starvation). Sours notes that psychological issues include deep dependency needs, developmental immaturity, and behavior favoring isolation, obsessive-compulsive behavior, and constriction of affect.\textsuperscript{17} Because of these numerous complications, and the physical, emotional, and psychological suffering that goes along with anorexia, this topic’s relevance is far-reaching. In addition, there are inordinate numbers of people suffering from Anorexia Nervosa in western cultures. Statistics vary widely from one to five percent of the female population, and as Lynn Grefe has noted, there are even contradictions in the estimates made because so many people do not report having the disorder.\textsuperscript{18}
The downward spiral into anorexia can seem rather innocuous as it is happening. When preoccupied with her weight and harshly judging and rejecting her body, a woman limits her ability to honestly and compassionately respond to the call of her daily life. She ignores her body’s needs. The use of tea, coffee, and gum chewing gradually increases, allowing her to more readily ignore her hunger cues and replace eating. Food is not something to be liked, but instead, becomes the enemy. Moment by moment, as the life force moves in and out through her body and breath, she bypasses the opportunities her body so wearily tries to communicate to her. The body’s aches and pains, for example, attempt to tell her to slow down. These signals are generally either misinterpreted or ignored all together. If paid attention to, such somatization could alert her to responding consciously to her environment. She is stuck reacting, rather than responding from her internal inclinations. In reactivity, conscious choices cannot be made. She unknowingly limits her focus to concentrating only on how to manipulate and control her body. The woman is stuck in an isolating and downward spiral. Without tending towards connection with others, the anorexic’s life can easily become meaningless; generally wrought with depression and sometimes thoughts of self-harm.

Though not specifically about Anorexia Nervosa, theory that will also be useful in this writing is drawn from Imaginal Approach resources. Some significant key concepts come from the work of Aftab Omer. Gatekeeping, a central term used in Meridian University’s approach to transformative learning, is defined as “the individual and collective dynamics that resist and restrict experience.” In the dynamics of anorexia there is often an extremely critical and self-destructive internal voice which says the anorexic can not do anything right. This gatekeeping voice thereby influences the
propensity for the anorexic to overcompensate, whereby she tries to do things perfectly. *Transformative learning* is another concept that is important in the body of Omer’s work. This term refers to “learning that engenders the emergence of human capacities in a unique and connected way.” 20 According to Omer, such a learning process involves “*transformative practices* (which) evoke initiatory experiences that integrate cognitive, affective and sensory experience and are concerned with the transformation of identity.” 21 Another important concept from Omer is *imaginai structures* which he defines as “assemblies of sensory, affective, and cognitive aspects of experience constellated into images; they both mediate and constitute experience.” 22 Translating these concepts to the anorexic’s experience, an effective program of treatment is a transformative learning process involving transformative practices including evoking, expressing, interpreting, and integrating experience. These practices give the anorexic an opportunity to begin to come into contact with her inner world where imaginal structures exist and create limitations about who and what she can be. By exploring this internal realm, she might come to know more fully her own life experience and become initiated into life in a deeper and more meaningful way.

This Clinical Case Study will show more closely how a similar sort of downward spiral prompted my client “Kate” (pseudonym) to seek help. Kate began to create significant changes for herself when she began her psychotherapeutic work. This consisted of personal therapy with me as well as within the therapeutic setting of Quest, an Intensive Outpatient Eating Disorders Program (IOP). Through Quest, Kate was able to have access to group therapy, nutritional and psychiatric consultations, mindful eating
sessions, yoga, multi-family group sessions, and weekly family counseling sessions as well as continuing her individual therapy with me.

This study also offers therapists and other professionals in the field an understanding of a broad range of therapeutic interventions in work with anorexic clients and the need for a multi-disciplinary therapeutic approach once the client has become truly diagnostic according to the DSM IV. Importantly, this study highlights a case in which therapeutic interventions were implemented in the context of an Imaginal Psychology approach. New knowledge from this study could then support more thorough development and refinement of the clinician’s knowledge, therapeutic skills, empathic awareness, and recognition of the need for collaboration, leading to better chances of successful outcomes and recovery for anorexic clients.

Personal Exploration of the Subject/Topic Choice

My choice of the topic for this Clinical Case Study has personally-compelling reasons. During my coursework at Meridian University, I kept telling myself that with my background in aviation, it would only be fitting to work psychologically with aviation professions. However, an insistent image came to me over and over again, even though I continually tried to push away, repress or ignore it. This image showed me working with adolescent girls with eating disorders.

Soon after I started noticing this image, a friend told me about an eating disorder program that a local counseling agency, PsychStrategies, was putting together. I called to inquire about working there, but was told to call back in about six months. I did not make myself a note and did not mark any calendar. Instead, I thought about how I had been
working in suicide prevention and grief counseling for three years. I told myself, “What could I possibly contribute about eating disorders?” I dismissed my own personal experience of an eating disorder and the relevance this would have to helping others.

But in fact, my own struggle with an eating disorder dates back to 1974 when at the age of 17, I left home in Chicago for a year abroad as a foreign exchange student to Brazil. My older sister, who had also studied abroad eight years prior, came home having gained a considerable amount of weight. My mother was terrified of fat and constantly on yoyo diets. She feared nothing more than having three overweight children. Fat was bad in my mother’s eyes and she did not want to be associated with it. If her children were fat, she believed this would reflect poorly on her parenting skills. She believed others might think she had done something wrong, had not paid close enough attention, or that she did not have her children under control.

Sitting with my mother, father, and boyfriend the night before I left for Brazil, my mother declared, “You’re probably going to come back a year from now, fat, like your sister did when she came home from abroad!” However, one year later, I arrived back at O’Hare International Airport at the emaciated weight of 97 pounds. No one expressed concern, shock, or dismay at my skeletal appearance. Instead, my appearance was ignored, as was everything of interpersonal significance in my family.

Looking back, I now understand that I never wanted to leave my high school to study abroad during my senior year. I was not mature enough psychologically, nor emotionally, for that challenge at that particular time in my life. I assumed wrongfully that my family expected this of me. Settling into Brazil after the initial vacation euphoria, I started becoming very depressed and homesick. Being raised where feelings other than
happiness were not allowed, I did what I could to hide these “wrongful” feelings. I was even writing letters that were being published in my hometown newspaper about the wonderful time I was having, when in fact, I was miserable.

Little by little, I started to develop a leaning towards somaticizing my unrecognized pain. I began focusing on the discomforts of my body as a replacement to feeling homesick. My Brazilian family took me to the doctor. When I got on the scale, I was eight pounds heavier than when I had arrived eight weeks prior. I calculated that to the horrific potential of a possible 52 pounds that I might gain by year’s end! I immediately felt the urgent need to control my weight and vowed I would take those eight pounds off. I now had a new focus to take my attention off my misery. My homesickness was too much for me to handle, so my mind found a way to cut me off from my feelings by giving me something to obsess about; my weight.

I also kept track of how many letters I received from, and sent to, family and friends. My need to connect to home was profound. One way that I stayed connected was by counting the days until I would return home. In Brazil, there was little, if anything, I enjoyed. I hated everything, every person, and every event. I only looked forward to going home. I simplistically believed that being home would make me happy again, and everything would be okay.

Finally, when I arrived home, my internal process and the accompanying gatekeeping voices had become quite thick through 10 months of an eating disordered practice of rigidly controlling my body. To my dismay, even though I was home, everything was not okay. My mood matched that of my environment, January in northern Illinois: lifeless, depressing, and dreary. I did not have any interests in anything. Life was
bleak. In this context, I still fought to control my body. My days were filled with numerous moments of checking my appearance in the mirror and repeatedly weighing myself. I had falsely come to believe my scale would not lie to me and would give me another day’s focus and direction.

Without thinking or considering what I wanted to do or longed for, I continued on a course of doing what I thought was expected of me. The eating disorder accompanied me as I completed college, schooled now as a pilot and flight instructor. Eventually the eating disorder was not enough to contain my internal misery. Lacking passion, purpose, and desire, I moved through expected phases of life robotically. I became so psychologically depleted and physically sick, through a compromised immune system, that my body finally collapsed. I ended up in the emergency room even unable to walk myself in. Not only was I unable to walk, I could not remember anything, and I had the sensation of tunnel vision. Emergency room staff could not figure out what was causing my condition. For years after that incident, I was worn-out, lifeless, and depressed. This puzzle remained a mystery despite unending doctor’s visits. Throughout all those years, nobody thought to ask me about my eating habits or the possibility of an eating disorder. Finally, when I turned towards getting help through psychotherapy, I began the slow and tedious recovery from my eating disorder and began unearthing who I really was. The recovery process took year, upon year, upon year, of being engulfed in grief. Once the grief surfaced, it came spilling over, and I did not immediately see the fruits of that work. It was hard to see out from underneath it without fear that it might never dissipate and release me from its grip. I felt as if I was repeating the same thing over and over again, even though I know now, and knew then at some level, that I was not.
For much of my life I have dismissed and minimized the validity and worth of my own experience, which led me to erroneously believe that none of my experiences were valuable. Due to this lack of self-trust, I almost missed the opportunity with the agency. It was a mere fluke that I called back and was told, “Oh, we’re interviewing right now. When can you come in?” I was about to discover how my history with an eating disorder, and my years through the process of recovery, would prove to be a gold mine and a passport into my professional career.

Indeed, I did get the job at this agency, and was to work there for the next seven years. Initially, I co-facilitated groups, which gave me the extraordinary privilege of working with a multitude of women from diverse backgrounds who struggled with many different patterns of eating disorders. In addition, I ran the weekly multi-family group. Running this group allowed me to plan out and present on numerous psycho-educational topics related to eating disorders, and incorporate experiential exercises. After the first year and a half, I was promoted to program manager. Even though I continued facilitating two of the four weekly groups, my work became much more complicated at this point with all the day-in and day-out rigors of running a successful out-patient program.

When I finally considered which client I might choose to write about for my Clinical Case Study, I chose Kate, because her situation was extreme and gave me plenty with which to work. Having the experience that I did with eating disorders, Kate offered me the opportunity to explore many of the complexities of Anorexia Nervosa. This opportunity has made the work of this writing interesting and challenging.
Framework of the Treatment

I worked with Kate at PsychStrategies, Inc., in Santa Rosa, California. This organization has been in operation for 16 years. During the seven plus years that I worked there, the organization offered four different treatment programs (drug/alcohol, chronic pain, head injuries management, and eating disorders). PsychStrategies had clinicians with various licenses providing individual therapy for a full range of clients. They also had in-house nurse practitioners and psychiatrists that gave medication evaluations and follow-ups.

By the time Kate’s mother contacted me about working with her daughter, I had been in charge of the Quest Intensive Outpatient (IOP) Eating Disorders program for a year and a half, although I had worked in Quest consistently for three years. Kate’s mother contacted me directly through Quest, regarding Kate’s erratic and frightening eating disordered behaviors. She was afraid for her daughter’s life. She reported to me that Kate had already been hospitalized 10 times that year. During our brief meeting, Kate’s mother told me that Kate was over the age of 18. Because she was an adult, I let her mother know Kate would need to phone me directly if she wanted an assessment for services, which she did. After meeting with Kate, my assessment was that Kate might benefit from both individual and group therapy sessions.

Kate’s first therapy session with me was on December 22, 2003. I met with Kate for a total of 105, face-to-face, individual therapy sessions for close to five years. During this timeframe, Kate was known to cancel appointments at the last minute or not even show up. Her excuses were weak and usually work related. Kate also participated in the Quest IOP program between May 2004 and August 2004. Quest provided her the
opportunity to participate in four weekly three hour groups and individual meetings with
the staff dietician and psychiatrist, in addition to her individual therapy sessions with me.
As part of the Quest program, I facilitated two weekly group sessions in which Kate
participated for the three months that she attended the program.

The primary orientation used with this client during her individual sessions was
an Imaginal Psychology approach. The work with Kate was quite varied in that it
included using art materials, yoga props, role plays, poetry, family sculpting,
supplementary audio visual materials, and many more experiential exercises that were
sometimes planned and sometimes spontaneously created. Kate’s work with me ended on
October 6, 2008.

Confidentiality and Ethical Concerns

Related to confidentiality, I obtained a written consent from Kate about using her
as the subject of my Clinical Case Study. When I asked Kate if she would consider being
the subject of study, she appeared to look flattered. I explained that in her consideration
of possible involvement, she needed to note that if I wrote about her, there was a
possibility that our work together would change. She would know that I, and others,
would be giving a lot more attention to her case. I discussed with her that when
recognizing, consciously or unconsciously, that she is in the spotlight per se, with others
watching the development of her therapy process behind the scenes, her behaviors and
things she said might end up changing. I also informed her that she always had the option
of withdrawing consent at any time. When leaving the session, she said she wanted to
participate, and when checking in with her at the next session, she was still in alignment with this decision.

Debra Zilavy, Ph.D., whose primary theoretical approach was Gestalt, worked with me as my supervisor for a period of 16 months that I saw the client. She and I met one-hour weekly for individual consultation. In addition, Erin Riley, Ph.D., who used Object Relations as her primary theoretical approach, was my prior supervisor and worked with me for the first three years of meeting with this client. I met with Dr. Riley for an hour per week for individual supervision, in addition to a one and a half hour weekly staff meeting.

By the time I was working with Kate, I had established myself as an experienced clinician and used my discretion regarding client contacts and other boundary issues. I had a good sense about when I needed extra supervision meetings, and readily consulted when necessary. Dr. Riley (Erin), in particular, made a significant impact upon my work. While she was less directive, she was extremely helpful in supporting me to create ideas for my individual work with Kate and all the experiential group work I did. Erin offered patience and reinforcement for allowing the process to unfold. Erin also supported my personal process and recognized how it might influence what I was doing professionally.

Regarding ethical concerns, several situations come to mind. Four months after initially beginning weekly, individual therapy sessions with Kate, she was admitted into the Quest IOP program. This caused a dilemma for me because Quest required the attendance of all agreed upon family members for the Friday night families group, and for weekly individual family counseling sessions. I was faced with the ethical concerns of not only working with Kate in on-going individual therapy sessions, but in addition,
working with her in a group setting, and also with her family for the multi-family group.

Working with the family and not disclosing confidential issues would need to be a priority, especially since initially gaining this client’s trust took some time.

Kate became pregnant 10 months after we began our work together, which initially raised another big ethical concern regarding the possibility of abortion. I was aware of the cultural controversy and prejudices about abortion. I was also aware of how I needed to hold this important matter delicately. She was not deciding between brands of cars to buy; she was dealing with human life and her connection to that. I wanted to remain unbiased even though I believe in a pro-choice philosophy. Included with this was her understanding that she could not conceive of children, as stated by her doctor, until she actually became pregnant. She felt irresponsible about becoming pregnant, even though her physician advised her she did not need to use birth control pills because of her Poly-Cystic Ovarian Syndrome (PCOS). I was shocked along with her that she was pregnant, and then I was saddened. I knew how much she had always talked about her longing to have a child. The doctor was strongly advising though that she should give this one up, due to the 40 percent to 60 percent chance that either she or the child would not make it through the pregnancy. My dilemma was about supporting her to the best decision in relation to her health and well-being. I was very aware that her body was severely depleted after repeated disregard of her insulin needs and caloric neglect, and that pregnancy was a serious health risk to her. Yet, she had always believed that she could never have a baby, and being pregnant was a dream come true. I wondered how I could possibly question her going through with this pregnancy when she so much wanted a baby. Kate felt very irresponsible for getting pregnant, and her shame made the
situation even more complicated. She needed to consult with medical experts and seek support from her loved ones, which I wondered whether or not she would be able to do. Ultimately, Kate did follow the advice of her medical practitioners to have an abortion, and with gratitude, relied on her boyfriend and her parents for support.

**Client History and Life Circumstances During Therapy**

At the time that I began working with her, Kate, a 22-year-old white woman, had not yet been formally diagnosed with Anorexia Nervosa. I sent her for an assessment with the staff psychologist who made the official diagnosis. Her situation was medically complicated. At the age of 16, her primary care physician told her she had both Type I Diabetes and Polycystic Ovarian Syndrome (PCOS), making her dependent on a lifetime of insulin injections and unable to ever conceive and become pregnant.

Kate began therapy at the age of 14, eight years before I met her. One of the topics of her past therapy was dealing with being in a physically abusive relationship with a boy her age, even though she reported to me later that she only attended a couple of sessions because she “didn’t like either of the two therapists she had seen.” Oftentimes, she said, she would end up being bruised badly from him squeezing her arm. Although rebellious at age 14, Kate reported turning into a “nice and polite” girlfriend the following year when she dated another boy who was 18 years old. This relationship ended approximately one year later, though she remained tied to her façade of niceness. Concurrently, Kate began restricting her diet and caloric intake. At age 16, she was diagnosed with Type I Diabetes and at age 18, she began abusing her insulin in order to lose more weight. In her first therapy session with me, Kate said she had “blanked out”
those years, “remembering nothing else” from back then. In fact, it was all too easy for Kate to dismiss current hospitalizations and the dire physical conditions that led up to these. Kate was clearly skeptical that therapy could really help, but had come to a point of desperation and crisis in her life, not knowing what else to do.

Kate was the middle child from an intact family of five. Her sister was 24 years old and her brother was 19 when she and I began meeting weekly. Kate moved from her parent’s home during the fall of 2003, just prior to seeking treatment, when living at home became “too much” for her to handle. Kate’s father was a financial planner and stayed somewhat detached from his feelings. Although by her account, Kate and her father were especially close when she was a young child, they drifted apart. This disconnect with her father began when Kate was a very young teen. It seemed that as Kate approached adulthood, her father had difficulty knowing how to relate to her. In search of closeness, Kate turned to romantic relationships. It was at about this time as well, that her anorexia began.

Meanwhile, from about the time that Kate was 12 years old, her mother was distracted by a steady stream of foster babies. Kate often mentioned how everything was pushed aside and the babies took precedence. Even though she was not a young child at the time, Kate often expressed resentment and felt neglected during those years, as if she was not important enough to receive her mother’s attention. Yet, she longed to be a mother herself, even though she had been told that she could not conceive due to her diagnosis of PCOS.

Kate stumbled when it came to discussing her childhood. Although she had a faint recollection of becoming quiet and withdrawn around the age of five, she remembered
very little. Other than that, she reported feeling belittled and intimidated by her sister while growing up, saying that their relationship was particularly stressful. From a young age on, her sister blamed her and tried to get her into trouble. Kate felt very misunderstood by her and resented how she was treated. The constant blaming Kate felt from her sister was particularly difficult since she tried so hard to be perfect. Even so, Kate moved into an apartment with her sister at the age of 18 because her relationship with her parents had become so tense and uncomfortable. Almost five years later when treatment came to an end, Kate still found it hard to speak up to or get along well with her sister. In contrast, Kate adored her younger brother, said their relationship was and always had been good and fairly honest, and they got along very well.

When we met, Kate had been dating Mat (pseudonym) for the past few years, having met him right out of high school. By her account, she could become quite dramatic in their relationship at times, especially when she felt unsure as to his whereabouts. Kate would easily become threatened by the ghosts of her imagination, wondering if he was keeping his hands to himself on his guys’ night out. When questioned about this, she admitted that Mat had never strayed in their relationship, was actually attentive and devoted to her, and that she and jealousy were just close friends. By the end of treatment almost five years later, she shared an apartment with her fiancée, Mat, and their nine month-old son.

It was by no coincidence that Kate was working for her drug addicted aunt as a receptionist and make-up artist when we first met. Kate felt the need to fix other people, as was the case with her aunt, and make others feel good. Her bubbly cuteness and well manicured look was an attractive addition to the salon. Never was a hair out of place or a
fingernail chipped. Kate’s specialty was doing bridal party make-up that she said she was rather good at and got paid well for doing. After high school graduation, Kate thought she might someday become a cosmetologist and liked being part of her aunt’s salon. Some of our work together involved discussions of her finding another job though, since bailing her aunt out of difficult situations was not in her best interest anymore. Within one year of working together, Kate was hired as a sales representative for a major hotel chain, where she stayed for two years. With three years of therapy under her belt, and after her second pregnancy and birth of her son, Kate quit her job at the hotel and enrolled in cosmetology school, pursuing her lifelong dream.

Progression of the Treatment

Upon meeting Kate, I noticed how her attention to detail in her clothing, makeup, and hair was impeccable. Her pencil thin figure was accentuated by her two inch heels and fashion savvy wardrobe. In our initial session, that, and her rigidly haughty demeanor suggested she did not need therapy. Her look was intended to imply that she already had it all together! So I was surprised when Kate allowed herself to honestly speak her truth with me upon our first meeting wherein she described a cycle of starving herself throughout the day and sometimes two days, followed by episodes of nightly bingeing. In addition, Kate completely ignored checking her blood sugar levels or giving herself the necessary insulin required to keep her diabetes stabilized. Being diabetic, these behaviors were especially risky. A state called Diabetic Ketoacidosis can result from dehydration because of insulin deficiency, associated with high blood levels of sugar in the diabetic. In this state, the body literally consumes its own muscle, fat, and liver cells for fuel. In
fact, ignoring her insulin needs and restricting her caloric intake had landed Kate in the hospital ten times that year due to abnormally high blood sugar levels, such as 480, (where a normal blood sugar level would be between 80 to 120). By not using insulin to keep her blood sugars stable, these over-the-top numbers meant that Kate risked having her blood sugar drop drastically low at night, increasing her chances of falling into a diabetic coma. To bring these high blood sugar levels down caused Kate to have to overcompensate with her insulin and ingest higher than normal quantities of insulin prior to going to bed. Five of Kate’s ten hospital visits had been within the three months prior to entering treatment with me.

Initially, it was obvious that I needed to emphasize with Kate the necessity of stabilizing her daily and nightly insulin intake. This required, of course, that she needed to eat in order to maintain her glucose levels. This was not an easy feat for Kate, since that was exactly what she was resistant to doing in the first place. There were also two hospital visits during the first year of our working together; one involved running out of her insulin over a weekend and the other involved alcohol. These hospitalizations were two of the crises that occurred during therapy.

Another crisis issue that required immediate attention was dealing with her unexpected pregnancy. At the age of 15, doctors repeatedly told Kate she could never get pregnant, due to having been diagnosed with PCOS. After having initially used birth control pills when she became sexually active, Kate eventually chose to stop the medication since the doctor questioned her need to use it. Her pregnancy surprised everyone. Kate was so depleted by her constant neglect of her body by starving it and
abusing her insulin intake, it was questionable whether or not her body could even sustain a pregnancy without risk to either herself or the fetus.

Kate’s therapy journey was not without many bumps and bruises. If circumstances had become difficult and Kate was not using her eating disorder or abusing her insulin, she would turn to shopping and spending money she did not have. This temporary fix helped Kate cope in that moment, but not without its negative consequences. Also, Kate’s parents were not as perfect as she wanted to believe. In her attempts to continue pleasing them and showing them what a perfect daughter they had, Kate ended up leaving Quest prematurely so as to avoid anymore expense from her parent’s bank account. Her façade of perfection tended to keep Kate lying about things. If she did not think it would sound good, she would say what she thought I wanted to hear. Yes, she was checking her blood sugar levels! Yes, she was taking her insulin injections! Yes, she was eating throughout the day! Yet the decreasing numbers on the scale and Kate’s suspiciously averted glances warned me differently.

With time, the lying changed as Kate gradually began to open up more and more in therapy. Things that used to be “fine” no longer felt that way as she started to become more honest and real. Although she had a tendency to dismiss how her family members affected her, Kate eventually allowed herself to become angry as she saw more of how she was being affected by their unconscious thoughtlessness. How disturbing it was for Kate when she discovered her mother to be self-absorbed and apparently unable to hear her. Kate sadly recognized how little her mother, or anyone else in her family for that matter, really took the time to be present with her and understand what she was trying to convey. But along with this recognition, Kate began to have empathy for their lack of
awareness and attentiveness to relationships. As Kate’s inner awareness developed, she increased her capacity to be with her once intolerable feelings, and experience appreciation for who she really was.

**Learnings**

Very few things have allowed me to get so close to myself as do the snags that entrap me while working with clients. My work with Kate was no exception. There is reason why imaginal structures and gatekeepers, as defined by Omer, exist. There is also reason that my perspective in any given interaction, whether with people or things, is uniquely mine. Gatekeepers distance us and separate us from the depth of our truths, which is what they are intended to do, as gatekeeping voices are born out of pain. While working with Kate, I became more aware of these barriers to being present. I also became more aware of the imaginal structures that frame my experiences and help bring me closer to my truths.

The need to be special was one such imaginal structure. This structure likes to think of itself as helpful, or good-looking, or knowledgeable, or whatever would make me unique and different and able to stand out in a crowd. This imaginal structure likes that I am a therapist. In fact, in our very first session together, this structure immediately stepped forward when it heard Kate say, “Yes, I’ve seen two therapists in the past and neither of them was helpful.” Now this is not to say that I should not be helpful in my work as a therapist. Of course I can be. But the difference here is about bringing awareness to the situation and recognizing whether I am reacting from the stance of the
imaginal structures and possible gatekeeping voices, or responding consciously, congruent with my deeper wisdom and truth.

When I stopped to reflect about these imaginal structures to write this Clinical Case Study, I realized how the power and intimidation of money manipulated me in Kate’s situation. It created reactions that later surprised me when I realized my response was not in the client’s best interest. It was not until long after Kate discharged from Quest that I realized I had colluded with her father when he protested about spending so much money. That collusion did not serve Kate in that I never confronted her about her need to finish the full program. Other imaginal structures with which I became more familiar include the one who needs to do the “right” thing, the one who dismisses and ignores things that are uncomfortable, hoping they will go away, and the skeptic who expects the worst.

Thinking about these imaginal structures and their impact on my life and Kate’s, made me aware of the necessity of attentiveness. I am dealing with human lives in my profession. When clients come to me hoping to be relieved from their suffering, I hope I can be sensitive enough to accompany them mindfully on their journeys. I hope I can be compassionate and understanding enough to allow them the space to explore more fully who they are. When that attentiveness happened in the presence of Kate, I, too, got to know and trust more deeply.

Our lived experiences define our personal and collective imaginal structures and the lens through which we view life. Because of my work with Kate, a number of imaginal structures shifted for me. In this process, I found the ability to laugh at myself and have acceptance where I once could not. I found the ability to expect less and be
more curious about what exists in any given moment. And I found the ability to continue to find more and more spaciousness in my body. I could breathe easier.

**Personal and Professional Challenges**

Working with a client who failed to show up for sessions, glowered at me when she did, and refused to eat or take her insulin, was not without its challenges! I was intrigued with this case for a Clinical Case Study because of its complexity. Since my specialty is and was in eating disorders, I wanted to gain even deeper insights about the nuances of the therapy that both worked and did not work in the treatment of anorexia. Being aware of both effective and ineffective interventions supports my work with other clients.

I laugh still over how much Kate’s glare intimidated me initially. Here I was, a manager of the Quest program in a position of authority, and yet I would find myself stunned by her mere look. It was a challenge for me to sit with my internal response, wanting to manipulate Kate into going back to her nice and polite façade. And yet obviously, that is what she was used to, and would have been counterproductive for me to do so. To go against my reaction was hard work, but by consciously working with myself, I was relieved to find how it helped dissolve Kate’s façade. However, there were also wider implications. I found that this aspect of my work with Kate translated to my work with other clients, as well as my personal relationships. This work in the therapy room with Kate increased my ability to stay present with myself and others in many contexts.
Building a therapeutic alliance with Kate had its difficulties since she resisted showing up regularly. Getting her to be willing to track her insulin needs and feed herself tested my patience. Initially facing her hostility and piercing glare made me flinch and shrink. Coming to understand what influenced the changes I saw in Kate was important to me. As well, my work with her also influenced changes in myself. In honoring the work I do with clients, I realize a deeper understanding helps me build on my skills, influencing the next word that comes out of my mouth or the next action I am prone to take.

I would be remiss in discussion of challenges if I did not mention the effects of culture upon my work with Kate as well as my many other clients with eating disorders. We are enshrouded in a culture of thinness. This very fact makes it difficult for eating disordered clients to present themselves at the door when they actually need the help. When Kate showed up, she was so deeply buried in the anorexia that I did not know if I could bear the weight of working with her. Although the professionals that surrounded me were a tremendous source of support, I sat in fear for the first five months of working with Kate, not knowing what I would do if she could not get the financial support needed to enter the Quest IOP Eating Disorders Program.

Because the culture minimizes the effects of eating disorders, I feared that I might also succumb to that trance. I was confronted on a daily basis with the challenge of trying to stay awake to the insidious and life threatening dangers of Kate’s condition. As with most clients with eating disorders, this responsibility was a weighty one and I often felt small, tense, and doubtful about myself and my work.
CHAPTER 2

LITERATURE REVIEW

Introduction and Overview

This Literature Review is comprised of five sections that describe five varying perspectives and approaches on Anorexia Nervosa. The first section is entitled “Biological Perspectives on Anorexia Nervosa.” This section discusses physiological changes, complications, and risks that happen with an anorexic. Also discussed is the need for physical health and medical stabilization. The next section is entitled, “Cognitive/Behavioral Perspectives on Anorexia Nervosa.” Literature here points to the very specific need to develop tools such as meal plans and structures that help the anorexic client feel contained. Practitioners from this perspective do so by including specific guidelines that are aimed at working with faulty thinking. Homework and handouts support the client’s attempt at making behavioral changes.

The third section is entitled, “Psychodynamic Perspectives on Anorexia Nervosa.” Resources from this section emphasize the relationship between client and therapist as its guiding principle and that through this relationship the healing occurs. Literature from psychodynamic theorists points out how maladapted the anorexic’s relationship is with her own self as well as with food, with her body, and with the other.

The fourth section is entitled, “Sociocultural Perspectives on Anorexia Nervosa.” Here, the literature points to the impact of media and advertising on the female psyche. It addresses how brainwashed the culture has become and how it continues to take away a
woman’s self-trust. Within this perspective, there is discussion about the ways that airbrushed media images confuse women and men into believing that women are supposed to be something that they are not.

Finally, the last section is entitled, “Imaginal Approaches to Anorexia Nervosa.” The literature here points to how active imagination, or the guiding imagery, informs the clinician and the client. Although the majority of resources do not necessarily address anorexia specifically, they are still relevant to this discussion. Imaginal approaches and the theory that support them enrich both the clinician’s work and the therapeutic dialogue.

**Biological Perspective on Anorexia Nervosa**

This section will address how the client with Anorexia Nervosa is treated, by those practitioners who come from a Biological Perspective. From this perspective, one sees the person from an organic stance, and in turn, focuses on what is happening physically with the client’s body and health. The anorexic client is one suffering from a pathological loss of appetite, according to John A. Sours. From the Biological perspective, the practitioner theorizes that little, if any, psychological or emotional understanding and learning can be absorbed while the body is malnourished and depleted of necessary nutrients.

Julia Ross believes that depleted brain chemistry caused by “too much dieting and inadequate protein, unstable blood sugar, low thyroid function, hormonal irregularities, food addictions, and a deficiency of good fats” can be regulated with nutritional supplements. In addition to dieting, Ross states that people can inherit low serotonin
levels which can set off a major eating disorder or serious emotional disturbances. Ross goes on to say that the obsessive behavior of the eating disorder is caused by nutritional deficiencies that can be addressed through her 8-Step program. This program involves a “master nutritional supplement plan” that includes the addition of amino acid supplements to the diet.

An important source for those interested in the study of anorexia predates the naming of the disorder and focuses on the topic of starvation. During 1944 and 1945, Ancel Keys conducted a one year experiment with 32 men who volunteered to be the subjects of starvation. During this time period, their caloric intake was lowered by about half, while they maintained their usual daily workload. Keys and his colleagues at the University of Minnesota documented numerous signs of physical deterioration. Aside from physical complications, they also showed the emotional, social, and cognitive changes seen in anorexics today.

In his book, Keys outlined how as weight and physical size decreased, so did heart volume, pulse rate, basal metabolism rate, and body temperature. In addition, those who starved also experienced changes in their attitudes and behaviors toward food. They became increasingly preoccupied with food. Similar to the behavior of anorexics, unusual eating habits and rituals began to show up. Also, things such as coffee, tea, and a variety of spices were used to avoid feeling their hunger cues. This landmark study continues to be referred to in professional circles related to anorexia, as it demonstrates the process of deterioration the anorexic will experience caused by starving her body of needed calories.

Other research has demonstrated the severity of the psychological consequences that accompany physiological changes. In a 1997 study done at St. George’s Hospital
Medical School in London, authors Philippa J. Hugo and J. Hubert Lacey noted that disordered eating serves as a defense against the severity of psychotic symptoms. For there is a psychosis involved when a five feet, seven inches tall female weighing 97 pounds stands in front of a mirror and sees fat or bulges that must be eliminated. The American Academy of Child and Adolescent Psychiatry (AACAP) states that psychotic disorders are characterized by extreme impairment of a person’s ability to think clearly, respond emotionally, communicate effectively, understand reality, and behave appropriately. Imagining a continuum from Neurosis to Psychosis, a diagnosis of Anorexia Nervosa appears to be a movement on this continuum in the direction toward Psychosis. Continuing further, the AACAP also says psychotic symptoms interfere with a person’s daily functioning and can be quite debilitating. According to Sours, the suffering and level of functioning become debilitating for those with Anorexia Nervosa who generally fall into two categories: (1) those who practice extreme food restriction behaviors and (2) those who display food binge/purge behaviors.

Given the seriousness of the physiological as well as psychological symptoms of anorexia, hospitalization is often necessary when there are serious problems. Elizabeth Moffitt states that the heart, which is just a large muscle, becomes smaller due to restriction of food intake. Because of this decrease in size, patients may present with low blood pressure, fainting, poor circulation and arrhythmias due to electrical conduction failure. Moffitt makes a point of saying that when overall muscle mass is lost, it affects most of the body’s systems, including the brain, skin, hair, digestive tract, the bones, blood, and hormones. Congruent with Keys study, Moffitt cites many a patient she has had to diagnose with malnutrition, bradycardia, or amenorrhea due to their
malnourished state alone. Moffitt agrees with Sours assessment that the goals of treatment when hospitalization is necessary are “stimulation of appetite, reduction of anxiety, and acceleration of positive metabolic processes.”  

While considering the client in an organic context, the clinician is aware of the harm that can be done when caloric intake is restricted, or when certain food, like fats for example, are eliminated altogether. Anne Katherine notes that prolonged starvation seen with anorexics can cause brain damage and brain atrophy. Debra L. Franko emphasizes medical complications and notes that Anorexia Nervosa is a serious psychiatric disorder with a substantial risk of mortality. Frances M. Berg states that over 30 health complications alone are directly attributed to severe caloric intake and weight loss through semi-starvation behaviors. Pamela Carlton and Deborah Ashin write that “eating disorders are severe psychiatric illnesses with potentially devastating, life-threatening medical consequences.” They have also addressed how missing three consecutive menstrual cycles, one of the DSM IV criteria for diagnosing anorexia, is abnormal and a wake-up call to the seriousness of this disorder for any professional or those in denial about an eating disorder. The physical body shuts down what does not need to be working in order to preserve its internal organs.

Theorists from the Biological Perspective recognize the risk to clients or patients in a starvational or semi-starvational state, so the focus is directed on medically stabilizing the body. Debra L. Franko and Jane Erb note that this primary focus on medically stabilizing the patient first and restoring physical health is necessary before psychotherapy can be effective because “starvation impedes the capacity to make use of psychotherapy.” In this regard it has been noted by Adrian Grounds that those in a
malnourished state frequently experience dehydration and electrolyte disturbances which can cause the onset of transient psychiatric disturbances.  

Several authors provide further evidence for the necessity of stabilizing the patient before attempting to work with them psychologically, noting that “transient schizophrenic-like episodes occasionally occur in severely emaciated patients.” Research by Escande et al., Bedoret et al., and Cramer and Bovet du Bois, also supports this observation. Fortunately, research by Grounds suggests that psychotic episodes tend to be short-lived and remit completely with weight restoration, thereby increasing the client’s capacity to work psychologically. Practitioners from the Biological Perspective assume that working with a client psychologically after weight restoration lends itself to greater chances of a successful outcome.

Because rapid weight loss has deleterious effects, the management of physical symptoms sometimes requires hospitalization. Thus G. Terence Wilson, Kelly M. Vitousek, and Katharine L. Loeb advocate that inpatient treatment is important for malnourished, anorexic patients. They claim that Anorexia Nervosa is a special problem in that patients oftentimes do not respond to standard treatment and require professional expertise and sustained intervention that only inpatient treatment offers. Kim McCallum, et al., suggest that malnourished patients with active eating disorders should receive specialized 24-hour monitoring to address the medical complications associated with Anorexia Nervosa that contribute significantly to the high mortality rates. The authors note that heart failure can be induced by malnutrition, dehydration, and electrolyte abnormalities, and those with a body weight below 80 percent of ideal body weight (IBW) “should be closely monitored until symptoms have resolved.”
specialized care they describe includes such things as “monitoring of hydration status and fluid retention, frequent lab tests, bathroom monitoring for fall risk, exercise protocols including bed rest, vital signs, and the monitoring of blood glucose and tolerance of nutrients through meal support.”

Biological Perspective also includes contributions less obviously related to physiology. Trisha Gura writes in her article, *Addicted to Starvation*, that those with anorexia share certain personality traits, namely chronic anxiety, perfectionism, and a focus on the attainment of goals, and suggests that there may be a genetic predisposition to these traits. Research continues regarding the possibility that a tendency toward obsessiveness and a rigidly perfectionistic worldview commonly seen in those with anorexia may lie in altered forms of genes. On one side of the conversation, Kendler questions this theory stating that, “traits or disorders do not have a true heritability.”

Colin A. Ross is another who disputes the idea of heritability and the repeated claims in the literature that say there is a substantial genetic link to those with eating disorders. He states that these research studies come to erroneous conclusions when the raw data is not focused on, as he believes it should be. Presenting a differing view, a researcher who continues to explore this question is the internationally known and highly published author Walter Kaye; his research has for years been to explore the connection between a genetic predisposition and the personality of individuals with anorexia.

Of course another important contribution of the Biological Perspective is related to medications. Due to their physically fragile condition, most anorexic patients are evaluated for medication management as a supplement to close medical monitoring. Researchers continue to explore possible medications that will help support anorexies and
address symptoms that tend to co-exist for them, namely persistent depression, anxiety, or obsessive-compulsive symptoms.\textsuperscript{31} Initial trials of Olanzapine (i.e. Zyprexa), which is an anti-psychotic, have shown the possibility of decreasing “depression, anxiety, and core eating disorder symptoms” while increasing the patient’s weight.\textsuperscript{32} Sours experience of working with this population allowed him to observe that anorexic patients tend to be typically adverse to weight gain and the stigma of being on a drug which they take as an inference that they cannot do it themselves.\textsuperscript{33} Gura comments that “An eating disorder exists on a foundation of denial and deceit.” \textsuperscript{34} It is thus common that after hospital or in-patient discharge, anorexics will discontinue medication use that encourages weight gain support, without disclosing this information openly to those treating her.

There are important factors that must be considered pertaining to the physiology of anorexics when prescribing medications. Nicole C. Barbarich, et al., found that because those with Anorexia Nervosa are below their IBW, medication such as antidepressants like Prozac, (selective serotonin reuptake inhibitor - SSRI’s) remain ineffective until after weight restoration.\textsuperscript{35} Although Richard E. Kreipe and Susan M. Yussman have written that “medications are of little value in the treatment of Anorexia Nervosa,” the Food and Drug Administration (FDA), has approved antidepressants, like Fluoxetine (Prozac) for the treatment of co-morbid conditions like depression, anxiety disorders, and obsessive-compulsive disorders.\textsuperscript{36} Treatment of such co-morbid conditions might in turn have other therapeutic effects.

Another medication therapy that highlights differing views pertains to hormone replacement therapy (HRT). Some physicians prescribe estrogen as to induce monthly menstrual bleeding and/or improve bone mineral density yet according to the American
Psychiatric Association, there is no evidence demonstrating its efficacy. In fact, the
American Psychiatric Association recommends that efforts be made to increase a client’s
weight before HRT is offered, for fear that an anorexic’s denial will prevent her from
seeing the need to increase her weight if her monthly periods are induced prematurely.

Likewise, Tess Lusher states that most antidepressants used with anorexics are
ineffective because the medication needs to be able to bind with protein, which anorexics
do not get enough of given their limited diet. Until they become close to their ideal
body weight, it is unlikely medication for depression is of any help. Lusher acknowledges
that the anorexic might be able to benefit from medications designed to deal with other
c- existing conditions such as insomnia or obsessive thinking.

In summary, from this perspective the consequences of anorexia are assumed to
be diet related or genetically related, including the genetics that influence one’s
environment. The reality is that medical stabilization is necessary with this population.
Anorexic clients face high risks and need to be monitored. In addition, their bodies and
brains need to be fed in order to work with them psychologically. Because of an
anorexic’s tendency towards counter-dependency, she is less apt to be willing to try
medications. Because she is malnourished, it is unlikely medications will have much of a
positive effect on any depression she is likely experiencing anyway. However, though
stabilizing the client medically is imperative, focusing only on the physiological is not
enough because it does not address the emotional needs. It does not consider the whole of
the person. When an anorexic goes into the hospital, the staff might be successful at
putting weight on her body. However, if the treatment does not go any further, as soon as
she leaves the hospital she is likely to lose the weight again. Thus, the anorexic person cannot be viewed as merely a physical entity.

Cognitive/Behavioral Perspective on Anorexia Nervosa

From the Cognitive/Behavioral Perspective, Christopher G. Fairburn’s view is representative when he describes that clients suffering with Anorexia Nervosa are operating from a contingency of false beliefs, which would continue indefinitely unless intervention occurs. Anorexia has been described by Stephanie Tierney as a tool “enabling individuals to attain a sense of control over their environment, with food restraint used as an expression of that control.” According to Dennis Greenberger and Christine Padesky a Cognitive/Behavioral practitioner seeks to help the client bring heightened awareness to her thoughts, moods, behaviors, physical reactions, and environment, past and present, so as to enable the client to feel some sense of control in her life. Greenberger and Padesky encourage helping the client understand her problems so that she can recognize her options and choices when responding to these thoughts through conscious actions.

The basic premise of cognitive behavioral therapy (CBT), developed by Aaron T. Beck in the 1960s, is the idea that if the client changes the way they think by looking at things more realistically, they will feel better emotionally, and will change the way they act, behaving more functionally. Beck, et al., note that therapists working from the Cognitive/Behavioral Perspective hold as their goal to help support and teach clients to learn how to question their own thoughts, beliefs, and attitudes relevant to their
disorder. From this perspective, if the self-questioning does not occur, the client risks remaining bound to their eating disorder by automatic patterns.

A useful contribution from the Cognitive/Behavioral Perspective pertaining to anorexia are hands on tools, such as using food logs and meal plans which are described by Sara Dulaney Gilbert and Mary C. Commerford. Since the initial aim of CBT with anorexic’s is to improve and restore normal eating patterns, food logs help the client keep track of food intake, including tracking the time of day and how much is eaten. Another such tool, described by Arthur E. Jongsma, Jr., L. Mark Peterson, and William P. McInnis helps the client to track thoughts and feelings associated with mealtimes so as to identify distorted thoughts regarding food and weight. Through using such tools, the CBT clinician challenges the client to monitor her behaviors, and so create change for herself by changing self-destructive repetitive actions and replacing them with repetitive healthy behaviors, actions, and thoughts.

While such hands-on tools might be assigned as homework in the outpatient setting, they might also be included in inpatient treatment. One method often used for therapeutic meal planning at inpatient facilities like Remuda Ranch in Arizona and Virginia, or Center for Discovery in California, is implementing an exchange system for carbohydrates, fats, and proteins. Such programs discourage counting calories because calorie counting is generally a problematic obsessive-compulsive symptom with the anorexic already. Sours agrees with such a collaborative approach to meal planning between nutritionists and clients because it encourages anorexics to take a healthy interest in the body and recovery process; when a daily caloric intake is established and nutritional needs are met, the patient can begin to develop inner controls.
Schaefer and Thom Rutledge point out the necessity for the food plan to fit the client’s current needs, and that the food plans change as they change. Schaefer and Rutledge also suggest watching out for the possibility of the obsessive side of the anorexic latching onto this as a new system to perfect.

Another popular method incorporates consideration of the loved ones of an anorexic patient. Based upon the assumption that family and friends have power to promote or inhibit a person’s recovery process, James Lock, et al., developed a family-based treatment approach called the Maudsley Method. Specifically geared for the young anorexic teen still living at home, Lock et al., came up with detailed and specific guidelines for each successive therapy session to be used by the therapist for out-patient treatment. Lock and Daniel Le Grange then followed it up with another book specifically for the parents, with comprehensive instructions for helping their child. However, Laura Collins, a mother who implemented the Maudsley Approach of Behavioral Change to help her 14-year-old daughter recover from anorexia, cautioned that making all her daughter’s decisions was “surprisingly exhausting” and not an approach for those who are afraid of their child’s response to the parent being back in charge of them.

Barbara McFarland points out that the Cognitive/Behavioral therapist is more directive and active, utilizing highly goal-driven interventions geared toward producing change. By detouring a client away from their false beliefs and destructive, habituated behaviors, and focusing instead on their strengths, resources, and competencies, McFarland says that an anorexic client can begin to develop a sense of control, mastery, and self-confidence in their lives. Refocusing the client in this way takes their
perfectionism out of the realms of an eating disorder.\textsuperscript{58} This refocusing is accomplished by both the therapist and the patient specifically negotiating what the focus of treatment will be. By implementing techniques that are affirming to the client, the therapist continues to go back and identify what has been functional and positive for the client.\textsuperscript{59} McFarland suggests helping clients categorize actions as “observing, reflecting, or doing tasks,” in that order, as a way to empower them by raising their awareness of what is possible and achievable within the contexts of their current situations.\textsuperscript{60}

In a critique about Cognitive/Behavioral techniques, Fairburn concluded in his 2005 study that it is barely possible to have any sort of evidence-based treatment for anorexia, and that new forms of treatment are needed.\textsuperscript{61} Fairburn has since come out with what he terms “enhanced” CBT treatment (CBT-E), suggesting there be a tailor-made treatment for each anorexic’s own individual pathology.\textsuperscript{62}

To summarize, theorists from the Cognitive/Behavioral perspective emphasize that with consistent and on-going support, homework, and the application of practical hands-on exercises, the client can begin to feel hopeful about the changes she sees with her condition, and build on those changes. There is a strong emphasis from this perspective on the food itself. This is done by restoring food habits and putting structure on the food and its variety, consistency, and normalcy. The danger with such focus is that the client already has built in food rules that have continued to get more stringent and rigid over time. It is possible that the imposed rules of the treatment will become the new set of rules or new guidebook, but that nothing will change psychologically. In fact, it is likely that the anorexic will whittle away at these rules as well, becoming cut off from a normal way of eating. The recidivism rate for those who are treated with the Maudsley
Method is quite high, because as these young girls mature, the underlying causes for their anorexia have yet to be addressed. Although initially, this perspective can give hope to a client and the feeling of some accomplishment, these positives end up being brief unless these techniques are accompanied by deeper work. Even though the false beliefs or thoughts are worked with, the things that created the internal chaos that led to anorexia are left untreated. With this perspective, the guidebook is in place, the anorexic has her roadmap, and she starts to feel some success. It gives her hope and a place upon which to stand. She thinks things are going to be under control again, however, the chaos will eventually re-emerge if left untended.

**Psychodynamic Perspective on Anorexia Nervosa**

Unmasking what lies at the roots of the anorexic’s presenting symptoms, her “disturbance in physical health,” according to Em Farrell, and giving meaning to the symptoms is the task taken on by psychodynamic practitioners. Representative of the Psychodynamic Perspective, Farrell contends that the therapist’s task is about getting to know something of their client’s “internal and external world; the individual’s experience of her life.” Similarly, Adam Phillips addresses how symptoms serve the sufferer, in that symptoms “are opportunists: they do all the work they can.” Angela Failler suggests that since the main symptom of anorexia is self-starvation, the psychodynamic therapist would “explore what refusing to eat accomplishes,” as well as how the symptom serves the sufferer. Rather than just learning about the symptom though, Failler makes the point that such therapeutic work “requires an openness to, and interest in learning
from the symptom,” as if the symptom were a disguise for something with which the anorexic is unable to consciously deal.67

A useful principle that can be applied to psychotherapeutic work with anorexics comes from Heinrich Meng and Erich Stern who in 1934 stated that every organic pathologic process has psychological components.68 In other words, they were describing the phenomenon in which a “disorder of ego development” could manifest itself as a biological disorder.69 This idea is not unlike that of D. W. Winnicott who wrote about recognizing that a disturbance in physical health is one criterion of psychologically ill-health.70 Likewise, according to Sigmund Freud, symptoms function to “relieve the tension associated with the repression of a particular wish by displacing libido (energy) from the original site of conflict to an alternative, ‘safer’ site.” 71 In applying these ideas from Freud and Failler, it could be said about the anorexic that her symptoms serve the purpose of helping to relieve internal tension. The symptoms stave off something that is unconsciously perceived as threatening.

In looking at the client’s symptom as something to learn from, the therapist using the Psychodynamic Perspective would not be pushing for the anorexic to eat, but instead, be questioning what this refusal to eat is about. Kim Chernin suggests that this resistance to eating has something to do with close relationships, often relationship with mother, as the anorexic keeps herself “separated from the mother through her slenderness and her stubborn refusal to eat the family’s food . . . yet is aligned to her by the failure of her development, her increasing dependency, her exclusive preoccupation with food as a means of expressing herself.” 72 Chernin also describes how in using the body to express meaning, the anorexic tries to defeat the mother’s intention of “turning the daughter into
an object that will reflect glory upon the mother.” This interpretation suggests that the anorexic’s symptoms are in some way tied into the needs of others. Chernin’s observations are similar to those of Winnicott, who observes that a child’s depressive symptoms are often attempts at reparation for a parent’s depression. So in order to learn from the symptom, the clinician would need to question how the symptom might be an expression of what is not being directly addressed in the anorexic’s relationships with others.

From the Psychodynamic Perspective, an eating disorder masks what is really going on inside the client. The eating disorder “is a tenuous short-term solution for buried long-term pain,” note Lindsey Hall and Leigh Cohn. They continue this thought by saying that “(a)n eating disorder is a feeling disorder because it helps you handle your feelings.” In bringing curiosity and empathy into the therapy room, the clinician can help the client begin to feel safe enough to unravel the circumstances that have led to this client’s inability to deal with her intolerable feelings. When working with the anorexic client, the therapist understands that difficult feelings are bound to emerge. The therapist also realizes that more than just the outer symptom has to change, for long lasting change to occur. Just because the anorexic client gains weight does not mean the problem is solved.

Although Winnicott did not discuss eating disorders, his theory can be applied to thinking about anorexia. Winnicott noted that “abnormal quantities of unconscious conflict may cause even more severe physical disturbances” which is certainly demonstrated by the severe physical disturbance in the appearance of an anorexic. Given this observation from Winnicott, getting to the actual symptom or unraveling why
the client has become anorexic can be daunting for many a clinician. Symptoms may reflect the degree of significant early trauma and the associated unconscious internal battle. Donald Kalsched’s describes the disturbing inner world of patients with a high degree of trauma which includes an aggressive “Protector/Persecutor” presence with which it is difficult to intercede. Drawing upon Kalsched’s thinking it becomes apparent that this protector/persecutor presence exists with anorexic clients. This aggressive presence attacks the client from within, so that they unconsciously become their own worst critic. As the clinician begins the task of unraveling what lies at the roots of this outwardly disturbing disorder, it is necessary to tease out these aggressive internal presences. The clinician also needs to be prepared to notice how the symptom will want to express itself through the therapeutic relationship.

Psychodynamic theorists who have specifically considered eating disorders and anorexia bring understanding to particular symptoms. According to Hilda Bruch, anorexics tend toward being abnormally considerate, cheerful, and grateful out of a need to please others, so getting to the truth of the matter requires painstaking patience for the clinician. In essence, the clinician must have the ability to become an inquisitive and watchful detective. Bruch says most people would prefer to be around someone with those easy-going traits, so the anorexic develops an unconscious strategy used to reassure and make others feel good. This strategy allows her to avoid any possibility of conflict, but in doing she then fails to be in touch with her own needs. Because she brings herself falsely into relationship, she is left without the ability to create any depth of truth or real intimacy. That depth can only be created through vulnerability. Thus Bruch notes that the real work for the client begins as she sits face-to-face with the clinician. As
previously noted, the psychoanalytic practitioner focuses on healing through honest relationship. This honesty in relating encourages the client to emerge from her false front and deal with her feelings of rage, anger, secrecy, fear, betrayal, powerlessness and many others.

However, honest relationship is a great challenge for anorexics. Glenn Waller, Emma Corstorphine, and Victoria Mountford describe the anorexic client as being emotionally inhibited because relationships have failed her. They state that the anorexic’s need to withdraw is the result of emotional abuse originating from emotional invalidation. In an emotionally invalidating environment within which the client may have been raised, like Bruch, the authors emphasize that “being happy and getting on with things, regardless of the situation” seems to be unconsciously stressed by those around her. This invalidation leads the anorexic to dissociate from her negative emotions so that she ends up lacking any sort of emotional awareness. William N. Davis describes this lack of emotional awareness as representing “an effort to maintain a psychological status quo,” and engendering denial. He goes on to describe how in the process the “symptoms become more and more preoccupying,” and eventually become the “predominant psychological force in an eating disordered person’s life.” Waller, Corstorphine and Mountford, note that with this emotional inhibition in place, the anorexic is able to deal with the dysfunctional emotional environment by unconsciously blocking her own emotions. Creating authenticity then within the confines of the therapeutic relationship is a necessary goal from the psychodynamic perspective. In this therapeutic setting, the client has a chance to achieve connection with another,
simultaneously breaking the pattern of isolation which she unconsciously, but
desperately, wants to do.

Diverging from the traditional psychoanalytic approach, Davis makes a case for
stepping out of the normal psychoanalytic neutral role which he describes as passive-
reactive, when facing these anorexic clients. He notes that in her past, the anorexic
developed a complex, intense, and obsessional intrapersonal relationship with her
symptoms, which became then her “primary object relationship.” 90 Davis says that
because the therapist is asking the client to lose the only “real” relationship in her life,
“the ordinary boundaries of psychodynamic psychotherapy do not offer the therapist very
effective weaponry in this kind of clinical war.” 91 Instead, Davis offers the approach
whereby the clinician takes full responsibility for success or failure of the therapeutic
relationship by managing and taking the lead in treatment; in so doing, the therapist
demonstrates the possibility for her to engage new relationships and distracts her from
her single-minded obsession with her symptoms. 92

Similarly, Steven Levenkron addresses the need for the therapeutic relationship to
be built on trust, attachment, and dependency, as a healthy parent-child relationship
might be. 93 He emphasizes the importance of the patient-therapist relationship, as do
many others mentioned from the Psychoanalytic Perspective. Levenkron states that the
general relational pattern for an anorexic will be one of distrust, nondependability, and
hostile attachment, which she will then try to transfer onto the new therapist, expecting
the therapist to respond to her as negatively as others have. This transferential
expectation, as Levenkron names it, puts the client in the position of walking into
treatment not as a patient, but as “an investigator of the therapist’s character.” 94 Like
Davis, Levenkron believes the way to handle this is by taking charge of the therapeutic relationship, openly addressing at the onset the transferential expectations and how the relationship in the therapeutic setting will differ. He also believes the task of working with the anorexic client is not for the fainthearted therapist because the recovery relies on the deepening of dependency which is only successful by “challenging the anorexia head-on and grappling with all of its demons.”

To better understand how both Levenkron and Davis view the psychoanalytic perspective in challenging the anorexic, it will be helpful to turn to theory about psychoanalytic use of transference and counter-transference as a tool in the therapeutic process. Freud first brought in the term *counter-transference* in 1910 while addressing colleagues about his thoughts of where psychoanalytic therapy was headed. He described this phenomenon as something to be wary of and to overcome; he recognized it as coming from the patient, unconscious of their own feelings, and so tending to arise in “the physician” who could then be aware for the patient.

A more recent description from Michael Gorkin is that an analyst’s counter-transference is information that helps the analyst to better understand the patient and his own transferences; the silent information rather than that which is being spoken directly. Gorkin states that “the analyst’s reactions, including some emotional reactions, could be of use in understanding the patient, and the patient’s transferences and the analyst’s counter-transferences are linked in an ongoing and reverberating manner.” Gorkin describes how tuning into the counter-transference then gives the therapist more tangible information in understanding the patient. This information can then be addressed and spoken to selectively, or “metabolized” silently, with the therapist’s active
awareness as “(h)is emotional participation with the patient then becomes a tool in the service of the treatment.”  

Gorkin feels so strongly about making use of the counter-transferential experience that he says resisting the counter-transference experience “is to lose both contact with the patient and probably the chance to help him.”

In using counter-transference when working with eating disorders, Marion Woodman suggests that the analyst can recognize “through her own body responses” the actual level of awareness in which the client sits. The analyst is helping in the healing process by holding the tension of shadow material consciously. Woodman observes that the client may already feel that “she and her body are enemies.” There is then an important message that in accepting the client, the analyst is also saying she accepts the client’s body.

Susan C. Wooley also brings understanding that it is not just the story or content that the analyst needs to respond to. She makes the point that the client will more effectively show the therapist what is wrong with their relationships than tell them. Aligning with Woodman, Wooley suggests that it should be the responsibility of the therapist to be mindful that the content can easily overwhelm and suppress the awareness of the feelings in the therapist, indicating the need for the analyst to pay particular attention to the counter-transferential experience. Woodman believes that ultimately the responsibility of the healing process rests on the client for both her own destiny and her own transference, whereas the responsibility of the counter-transference in the healing process rests squarely on the shoulders of the analyst.

In summary, the psychodynamic clinician addresses the difficulty in close relationships for the anorexic. The therapeutic relationship is looked at as the context for
healing. Theorists from this perspective emphasize that it is imperative to be mindful of building the relationship on trust. Transference and counter-transference are important concepts from this perspective where the clinician is aware of what the client might be projecting onto the therapist and vice versa.

**Sociocultural Perspective on Anorexia Nervosa**

The Sociocultural Perspective is significant because literature from this perspective describes ways that people view the world socially, economically, ethnically, educationally, linguistically, and historically. Anorexia, as a fairly new cultural phenomenon, yet affecting so many people, is an important sign of the times. Even though theorists writing from this perspective may not be writing about psychology, their writing is important because it influences our understanding of this modern day plague.

Since the 1970s, media critic Jean Kilbourne has researched and analyzed the influence of media and media images in our culture, and produced such films as “Slim Hopes: Advertising and the Obsession of Thinness” and the DVD series “Killing Us Softly: Advertising’s Image of Women.” The media, in all its various shapes and forms of coming to us and infiltrating our lives, has a profound influence. In fact Kilbourne notes that the media’s influence can have such devastating effects, that it not only creates an environment that causes eating disorders, but also perpetuates them. For example, in “Killing Us Softly 3,” Kilbourne describes how almost any body part can be altered these days, making it rare to see a “real” person in an advertisement. This perpetuates false and unattainable standards of beauty; beauty standard criteria virtually no one could meet. Marya Hornbacher describes the media as being immoral and
irresponsible as it saturates society with “images of death” somehow come to be worshipped, and worse, create a belief that “thinness is a strange state of grace.”  

While the personality of an eating-disordered person plays a huge role, and while the family of an eating-disordered person plays a fairly crucial part in creating an environment in which an eating disorder may “grow like a hothouse flower,” Hornbacher believes “the cultural environment is an equal, if not greater, culprit in the sheer popularity of eating disorders.”  

While individual ads may not be seen as a big issue, Kilbourne points out it is the cumulative, unconscious impact that has an effect on attitudes toward women, and in women’s attitudes toward themselves.

Sharlene Hesse-Biber’s book, aptly entitled *Am I Thin Enough Yet?*, draws a link between industry and women’s self-image and addresses how profiting from women’s bodies has become an industry in itself. Like Kilbourne, Hesse-Biber states, “If we examine the American food and weight loss industries, we’ll understand how their corporate practices and advertising campaigns perpetuate the American woman’s dissatisfaction with her looks.”  

Courtney E. Martin concurs with this, stating, “A huge business is built on making us feel unattractive.”  

Both Martin and Hesse-Biber highlight ways that the American family, schools, popular culture, and the health and fitness industry all, consciously and unconsciously, undermine young women’s self-confidence as they inculcate the notions that thinness is beauty, that a thin woman is a valued woman, and that a woman’s body is more important than her mind.

The most striking aspect of this defined feminine cultural ideal “is that it is reminiscent of adolescence; the shape is a version of an immature body,” writes feminist cultural critic Rosalind Coward. Coward points out that the classically “feminine” girl
“is an image which connotes powerlessness,” which is no coincidence “since the cultural ideal amounts to a taboo on the sexually mature woman.” With the objectification and dismemberment of women’s bodies in advertising as a way to sell products, Kilbourne and Coward agree that the devastating messages, “built on a disgust of fat and flesh,” influence women of all ages. These images and accompanying messages create self-doubt and self-hatred, undermine the way girls and women judge and scrutinize themselves, and continue the on-going cycle of repression.

When girls grow up believing, as the media resoundingly bellows, that they have to be tall and skinny and blemish-free, it is no wonder they begin feeling inadequate about themselves and the bodies they inhabit at ripe young ages. “The marketing of inadequacy also undermines our view of ourselves and how we understand our worth in the world,” states Martin, and “instead of relying on our own perception, we look outside ourselves for constant affirmation.” In looking outside herself, a young woman then compares her image to the American icons of beauty; the airbrushed model exuding sexiness on the cover of Shape, or Vogue, or Cosmopolitan to name a few, or the flirty Hollywood image gracing People magazine’s cover, tilting her head while smoothing her hair into place, overcome by a beckoning look of “Aren’t I cute and helpless?” When weight loss is regarded as an accomplishment, and as Esther D. Rothblum says, when what is beautiful is considered good, the devastating cycle of lowered self-confidence and self-esteem already have a firm hold on a woman’s sense of well-being.

According to Joan Jacobs Brumberg, the popularization of adolescent female weight control came out of a subtle but important change in the 1940s, when buying things for herself for the first time became “intimately connected to breaking out of the
A young woman’s entrance into the consumer culture was portrayed by advertisers as an important rite of passage. The magazine *Seventeen* first came on the market in September of 1944. Brumberg points out that in its first four years, *Seventeen* published many articles about nutrition, but not until 1948 did the magazine proclaim being overweight to be a medical problem and “began educating its young readers about calories and the psychology of eating.”

Naomi Wolf says that the words dieting and slimming “are trivializing words for what is in fact self-inflicted semistarvation” and yet by the 1950s advertisements for “diet foods” such as Ry-Krisp were offering assistance to help tame the natural appetite, as magazine publishers told their readers that “Nobody Loves a Fat Girl.” Roberta P. Seid points out that health and vigor have been redefined as society has introduced the progressively smaller female stature with the emergence of a fitness ethic, dignifying diet obsessions and the fat-free body. Such redefinition has silently spoken to women that they must manage and control their bodily behaviors, or else become the ridiculed spectacle of a society that touts willpower as its most sacred and primary virtue. Similar to Seid, Brumberg suggests that this new focus on controlling one’s figure in the post-war era “is a prime component of the modern dieting story and a critical factor in explaining anorexia nervosa as we know it today.”

Since the 1960s, the ideal female body size has become considerably slimmer. In addition to the emphasis on body size, nutrition, and caloric intake, since the middle to late 1970s a new emphasis on physical fitness has been added to slimness, compounding the problem, yet justifying it in the eyes of those with anorexia. These two phenomena continue to encourage women to strive for the so-called perfect body. Wolf suggests that
there is no coincidence between the emergence of the feminist movement and the increase of restricting eating disorders in the 1970s.\textsuperscript{126} Wolf theorizes that the patriarchal creation of an unobtainable physical ideal caused women to invest more time in diet books and aerobic classes, distracting women from professional and academic pursuits.\textsuperscript{127} The cultural admiration for extremely thin women implores adolescents and women to strive for an unachievable physical perfection, creates a situation where “today’s anorexic is thinner than ever before.”\textsuperscript{128} Even an increasing number of middle-aged women are developing eating disorders in response to the sociological pressures to look young and to maintain unrealistic bodies, says Trisha Gura.\textsuperscript{129} Brumberg goes so far as to say “anorexia nervosa has become the characteristic psychopathology of the female adolescent of our day.”\textsuperscript{130}

Although a vast amount of research indicates that those afflicted with anorexia are influenced to some degree by the media, there are those like Pamela K. Keel who speak otherwise and even reject the idea altogether. Keel uses evidence from historical accounts of self-starvation; tables of the studies of the incidence of Anorexia Nervosa from the 1940s to the 1990s; and her review of research showing that “excluding the criterion of weight phobia for a diagnosis, anorexia nervosa has been found with equal frequency in Western and non-Western cultures including those with no or very little exposure to those Western ideals.”\textsuperscript{131} Keel briefly touches on the media’s collusion in creating body dissatisfaction and the drive for consumption, and considers the sickening litany of facts that demonstrate the existence of anti-fat prejudice, but does not address the internalization of the slender beauty ideal and its possible impact on the anorexic.
In considering a Sociocultural Perspective in the treatment of anorexia, a therapist may explore how gender role and culture impacts a woman’s view of herself. As Wolfe states, “If a woman can be made to say ‘I hate my fat thighs’, it is a way she has been made to hate femaleness.” When sitting opposite an anorexic client, it can be daunting to come up against the cultural icon messages in the interest of capitalist marketing while feeling undermined by “the potency of contemporary visual culture” as Brumberg describes. The therapist must first assess for themselves the extent to which they may have bought into the beauty ideal. Then, the attention needs to be shifted from the client’s body, to the client’s brain. The therapy will be served by a choice not to waste either emotional or creative energy on the issue of the client’s own bodily inadequacies anymore, and instead, focus on her ideas, her work, her activities, thoughts, and goals. To gain back her sense of control and power, the client must not rely on her beauty where her sense of accomplishment and satisfaction then depends on the approval of others. As Martin says, the work is about distinguishing between one’s own truth and “the dominant culture’s dangerous view of beauty and ambition.”

Rather than colluding with the client’s lists of accomplishments and applauding her overzealous need to sculpt her body, the therapist encourages the telling of her story. This allows the anorexic to admit to her own vulnerability, invites her to yawn when she is tired, cry when she is sad, and be real. Martin believes that in allowing a place for the anorexic to look at what “ugliness lies beneath her prettiness,” and what things scare her that hide out under her mask of invulnerability, both she and the therapist begin to collaboratively discover her hidden strengths; the power dwelling within pointing to great opportunities and potential. The question for the client becomes, “What have you lost
by dwelling in the world of anorexia that the media and culture have tried so hard to keep you from looking at?” Martin recognizes how her starving voice will “sound less like a whine and more like wisdom” if we translate her aches into the language of emotion.\textsuperscript{136}

To summarize, theorists from this perspective recognize that the woman’s body has become a repository for attack and criticism. Media continues to perpetuate a culture that enforces the slender ideal, continually whittling away at a woman’s stature in the world. Obviously, this influences how an individual woman perceives herself; wanting to feel accepted and loved, sculpting one’s body can become seductive through an abnormal relationship with food, exercise, and her body. Eating disorders are born and bred out of the dieting mentality within which girls are born.

**Imaginal Approaches to Anorexia Nervosa**

Sources that highlight Imaginal Approaches support the therapist in responding to a deep truth and the reality of the relationship that lives between the therapist and the client. This section of the literature review presents examples of Imaginal Approaches that are relevant to anorexia and, or, specific in describing the work with the anorexic. First to be considered here is theory from Aftab Omer, whose thinking helps to contextualize or define the Imaginal Approach. A significant source here is Barbara Stevens Sullivan, who artfully describes how to work with the full person, legitimizing their pain and suffering, tending to those shadow elements often too easily overlooked or ignored. Other important sources to be considered in this section include Geneen Roth, who brilliantly weaves symbol and metaphor into her writing as she taps the mythic realm, inviting the reader to fully engage emotionally. Marion Woodman and Linda
Schierse Leonard bring recognition of addiction into this process. Additionally, both Kat Duff and Michelle M. Lelwica tend to the sacred, spiritual process that lies dormant within the disease or illness itself.

The concepts and principles that Omer has conceptualized are useful in understanding imaginal work with anorexia. One relevant concept to anorexia is that of *gatekeeping* which Omer says “refers to the individual and collective dynamics that resist and restrict experience.” Gatekeeping is relevant to the anorexic because she remains imprisoned by it. Over time, her relationship with the gatekeeper has become her one and only relationship, keeping her tied to the anorexia and preventing her from functioning with integrity. Through an Imaginal Approach of self-exploration in a therapeutic setting, the client develops more of a relationship with the *Friend*, another concept from Omer. By the Friend, Omer is referring to the “compassionate objectivity” one experiences in those moments when aligned with the “will of the Cosmos.” Gatekeeping is related to another phenomenon that Omer describes as *imaginal structures* which “are assemblies of sensory, affective, and cognitive aspects of experience constellated into images; they both mediate and constitute experience.” As the person works with and becomes more conscious of the internal gatekeeping, they become aware of the internal structures that limit their experience. Out of this increased awareness there develops room to question what their relationship is to the gatekeeping. This objectivity allows for curiosity and expanded inquiry in the process. Telling her personal stories to those with whom she feels heard and seen safely without judgment, supports the detangling from the client’s relationship to the gatekeeping. As these gatekeeping thoughts become more apparent to the client, she begins to develop *reflexivity* which is the ability to observe herself
objectively and compassionately, providing room for choice and action. As the objective observer to her inner life, she has the capability to learn from her life experiences. In his teachings, Omer conveys the importance of making meaning from our experiences, otherwise, we suffer.

One way to create meaning with the Imaginal Approach is through the use of myth. Angeles Arrien says that the study of personal and collective myths is in fact the search for deeper connection with one’s own nature and place in the world. Delving into a greater intimacy with myth provides a vital linkage with creating meaning and understanding more fully who one is. However, there can also be a danger to myth when there is unconsciousness about its possible impact. This is pointed out by Michelle M. Lelwica who says, “Myths are not simply stories we believe in, they are stories we dwell in. We grow up surrounded by them, but we are often unaware of their power.” Susie Orbach, who, as well, writes of the anorexic’s struggle as being a metaphor for her internal experience, says that not only is the anorexic acting out her own internal, unconscious experience, but she is also acting out that of the culture’s. The anorexic is living out her own myth and greater cultural myth unconsciously, and it is up to the clinician to help her find her way into its deeper meaning for the roots of her illness to dissolve.

Likewise, Geneen Roth addresses how individuals unconsciously learn to believe false stories about themselves, and so become “cut off from the integrity of [our] deepest desire – wanting to be loved.” Influenced by those around us, individuals learn to believe they are the stories, along with the accompanying layers of images that others have created about them. Roth truthfully explores how she has had to unravel her own
personal myths and stories in her own on-going journey of self exploration and recovery. Through the use of metaphor and descriptive imagery, Roth draws the reader deep down into the roots where her eating disorder developed. In doing so, she exposes what Omer calls the imaginal structures that “mediate and constitute experience.” Roth’s writing models an Imaginal Approach for the reader.

Like Roth, Woodman approaches the task of meaning making through the use of metaphor, which she believes is the language of the soul world. She stresses her belief that storying has more of an impact than abstract analysis or theory “which removes one from the actual feeling,” and metaphor is the “essential ingredient” for the transformational process to occur. In her writings, Woodman has the capacity to immerse the reader through intrigue and curiosity without placing definitive or highly restrictive meanings in metaphors. Drawing upon Shakespeare’s *Hamlet*, Woodman explores the flight from the feminine. In story form, Woodman claims the body is more likely to respond, and “sooner or later it’s going to get through to consciousness,” animating the healing process for the anorexic. Extrapolating from this, the clinician must be aware that in order to work effectively with Anorexia Nervosa, the practitioner must work imaginally, otherwise the client white-knuckles recovery. Clinging willfully to the theoretical recovery information that becomes her new guidebook of rules, the client becomes unable to allow any transformative process to unfold.

Using myth to approach meaning making, Arrien addresses the role of the Muses as “the divine forces in the form of women that guide us in the making and remaking of the human spirit and the world.” The role of the Muse is not only to inspire, but to call forward one’s authenticity, gifts, and talents. This inspirational role of the Muse, as
Linda Schierse Leonard points out, can sometimes be misused for destructive purposes, as is true in the case of the anorexic.\textsuperscript{150} Although the Muse is the one, as Leonard explains, who values creativity, she sometimes sacrifices her own to others, also true for the anorexic.\textsuperscript{151} Susan Kolodny speaks to the dynamic of those inner voices which plague or obstruct creativity and keep this Muse captive.\textsuperscript{152} Leonard depicts how the Muse symbolizes the transcendent energy that cannot be controlled. Although Leonard is talking about the addictive process, this also relates to the anorexics own experience. For although the anorexic is not addicted to food per se, the obsession with the process is an addiction unto itself as discussed by Carol Normandi and Laurelee Roark.\textsuperscript{153} When sacrificing one’s own creativity, a disconnect occurs between her internal experience and the external actions she takes and presents to the world. Leonard points out how the addictive process is a misguided attempt to escape from the cage of a life unlived because of abandoning one’s own path, and certainly, one’s very nature.

One particular aspect of the anorexic experience highlights the necessity and effectiveness of the Imaginal Approach: that is, the experience of alexithymia. Carolyn E. Cochrane, et al., define alexithymia as “a diminished capability to verbally describe feelings” and they note that clients with eating disorder have a high degree of alexithymia.\textsuperscript{154} In another study on eating disordered patients and alexithymia, it was concluded by David L. Beales and Ros Dolton that in treating the patient, there needs to be recognition that “focusing on the outward symptoms of distress fails to deal with the underlying emotional disconnection between the symptom and the meaning of that symptom.”\textsuperscript{155} With this in mind, it can be understood that the anorexic uses food, or the obsession with the thoughts of food, as a means of negotiating the precarious terrain that
exists between her inner and outer worlds that she finds difficult with which to come to terms. The symptom blatantly exists yet is dismissed. No meaning has yet to be created from its presence, and certainly, even the words are buried with which to describe it. Joy Schaverien parallels Beales and Dolton’s discussion about alexithymia, noting that the anorexic is considered to be functioning at a pre-symbolic level. Because of this difficulty of both accessing and describing feelings, Schaverien makes a case for the use of art in the treatment of anorexia. Unable to express her internal feelings and experiences, Schaverien says that for the anorexic, the art object may temporarily and unconsciously become a substitute for the use of food. Basically, the art object becomes an object of transference. Schaverien maintains that a movement toward symbolization begins when the need for concrete expression can be converted from an obsession to a use of art materials, using the imaginal realm for this expression.

To further complicate therapy for the anorexic, Barbara Stevens Sullivan adds that “The world presents itself to us through the medium of our psyches as an emotional experience.” Those with anorexia are cut off from their emotional experiences. Keeping this in mind, Sullivan says that “unprocessed emotions destroy the possibility of rational thought.” In working with an anorexic client, the therapist must be aware of how the client’s unprocessed emotions are intervening with the client’s ability to express herself rationally. Weaver says that in general, considerable progress must first be made with an analysis of the personal psyche, before proceeding with the depth work using active imagination. This would also be true in the case of the anorexic.

Similar to Schaverien’s thinking about the use of art is Rachel Naomi Remen’s teaching about using storytelling and art for healing purposes. Remen notes that it is
through sharing and receiving personal story with each other that connection, meaning making, and healing take place. “Sharing our untold stories can ease our loneliness and restore energy” says Remen. She further notes that these communally oriented processes are inherently transformative. This is an important consideration when thinking about the anorexic’s tendency to minimize her life experiences and abandon connection with others.

Another source from an Imaginal Approach is Rix Weaver who says that “it is acceptance and love of the shadow that have the transforming effect.” In other words, Weaver is pointing to the necessity of looking at oneself and those parts of oneself that are difficult to own and accept, and instead, are often projected onto another. Weaver describes using active imagination as one way to explore these depths. She distinguishes active imagination from idle fantasy. In the case of the former, there is full co-operation of the participating ego, while the latter is not purposeful for deep healing. She maintains that in the world of objective reality, idle fantasy does not lead into action. Instead, actively engaging the imagination “leads beyond to the structure of the psyche,” leading into and revealing the non-personal realm. This non-personal realm refers to the arena where myth, fairy tales, and specific forms of religious beliefs and rituals can be found; “the forms upon which consciousness rests.” Concurring with Weaver, Sullivan speaks to the process of using what is basically an Imaginal Approach and how it allows one to recognize the otherness of the psyche. In her writings she states that “the psyche surrounds [us] and [we are] subject to its laws rather than vice versa.” It is a common experience to try to put something that has been well thought out and planned into action, only to find that some counter decision that is usually unconscious to us keeps us
from acting freely. For example, an anorexic struggling with these two opposing sides of herself might remark on how she wants to gain weight but just cannot make herself eat, when no medical or physical complications are keeping her from doing so. In using the Imaginal Approach, it is possible to openly engage these two contending forces, the two opposing sides of oneself, to make each of their struggles clear to us. Allowing in all aspects of one’s self, even those that are despised, opens the door to wholeness. “Every inner element is precious” declares Sullivan, “because each form that the self takes is an organization of energy that can potentially be transformed into something valuable.”

A therapeutic difficulty with the anorexic is how she will often not admit to or even believe that she, too, carries insecurities she dislikes about herself, or naively believes she must get rid of these despised aspects.

Kat Duff is no stranger to the transformative possibilities inherent in working with one’s shadow elements. Through her own journey of personal healing from Chronic Fatigue Immune Deficiency Syndrome (CFIDS), she became aware that the work of spiritual transformation springs from those places we feel most inferior or debased, also referenced by Sullivan. Duff goes on to address the physical, emotional, and psychological healing process as alchemy. She refers to her illness as a surprising catalyst that started her on a spiritual path and practice.

Ultimately, the recovery from Anorexia Nervosa through an Imaginal Approach is about discovering one’s own spiritual process. “The peace we seek is already within us” says Michelle M. Lelwica, and the Imaginal Approach aims at developing this deeper connection by delving into the depths of one’s inner world where the image guides. As Roth notes, “If you are willing to engage with yourself rather than run from yourself, and if you are willing to be
steadfast and not get seduced by the newest greatest diet, you already have what people
go to India to get … What (you) came here to get rid of (your eating disorder) is itself the
path to what many people call God.”

In this portion of the Literature Review I have provided an initial overview of
some relevant terms from Omer’s conceptualization of Imaginal Psychology. Also
important to thinking about anorexia is the understanding about myth provided by Arrien.
Roth, Woodman, and others describe metaphor and point to its significance in effective
psychotherapeutic work. Art and storytelling hold a significant role from an Imaginal
Approach. Finally, the literature points to the deep healing potential and transformative
process possible in working with anorexia imaginally.

The depth of richness derived from Imaginal Approaches needs to be
underscored. The imagery which guides does not lie. Because of this, the depth of healing
that can occur is powerfully transformational. An Imaginal Approach holds an all-
encompassing view; it reaches up, it reaches down, it reaches inward, it reaches outward.
It trusts in something intangible but real, that is tapped into the guiding forces of the
universe. Because of this, it is only within ritual that this power can be accessed.

Conclusion

This literature review has looked at treating the person with Anorexia Nervosa
from a multitude of theoretical viewpoints. From these varying lenses, the way in which
the client is viewed and thus treated is far-reaching and extensive. Each has its position
about what is deemed important and what necessitates change. Each wants to be able to
lend a hand, support, and help the anorexic through the difficult task of the recovery process.

The Biological Perspective reminds the clinician how it is important to remember the danger associated with a body and brain that are starving. A body will be breaking down when it is at 85 percent or less its ideal body weight. These clients are at risk and need to have sufficient caloric intake for things to begin to change. It is crucial from this perspective that the anorexic is hospitalized or monitored from a medical physician. Medication is less helpful with these clients, although it can serve to support any co-existing conditions needing to be treated such as obsessions, difficulty sleeping, and anxiety. A Registered Dietician who is familiar with eating disorders also needs to be on-board in the treatment plan, as a structured meal-plan needs to be in place to help the anorexic begin the process of re-feeding. The Biological Perspective is about taking care of the anorexic’s physical body and bringing it back to a physical state of health.

From the Cognitive/Behavioral Perspective the clinician is trying to bring heightened awareness to the client’s thoughts, behaviors, and reactions. The therapist is directive with the client. It is an active, hands-on approach. This perspective specifically gives the client instructions, homework assignments and hand-outs. Meal plans and food logs are incorporated into treatment. Associated thoughts and feelings in relation to mealtimes are also recorded. An important concept from this perspective is false cognitions that create the accompanying behaviors. By looking at thoughts and thought patterns, this perspective hopes the client will feel better emotionally, and thus begin to change the way she acts. The Cognitive/Behavioral Perspective hopes to help the
anorexic begin to attain a sense of control over her life, and leave behind the need she feels to control her food intake.

In summarizing the literature from the Psychodynamic Perspective it is important to remember how the therapist sees the symptom of anorexia as the disguise for something else. This gross disturbance in the physical health of the client points to an unconscious, internal conflict. The food becomes a means of self-expression. The symptom initially helped to relieve the internal tension, but in doing so, eventually created a discord of its own. From this perspective, it is believed that the healing comes out of a deepening relationship of dependency with the clinician. The clinician relies on both transference from the client and counter-transference in the therapist, to help inform. This feedback tells the clinician about what is being left unsaid by the client. Psychoanalytic practitioners are divided in their views of where the responsibility lies in the healing process. Some believe the healing rests squarely on the shoulders of the client, while others believe the therapist is to take full responsibility for either the success or failure of the therapeutic relationship.

The Sociocultural Perspective allows us to see the vast influence of media images and messages. These messages impact and sway the overriding attitudes toward the female body. This perspective voices how the female then begins to look outside herself for affirmation. In doing so, she becomes a pawn in a consumerism culture where others profit from women’s bodies. She is drawn to wanting to look, act, and think according to the images and ideas espoused by the media and advertising. As the female image has increasingly become smaller, more women become prone to the diet mentality; the threshold to eating disorders. The Sociocultural Perspective points out this internalization
of the slender beauty ideal and how it creates a culture where women are more prone to restricting caloric intake and starving themselves.

Imaginal Approaches bring in a greater depth of understanding by working with images. As the practitioner works with the client, the image guides and directs the work. This can be done through the processes of storytelling, art making, through song, dance and other artistic expressions, as well as the word itself. Because an anorexic client tends toward alexithymia, Imaginal Approaches are especially valuable. This gives the anorexic client a means for expression when words fail her. Imaginal Approaches can allow recognition of the symptom as a guide to the transformative process, leading one to the threshold of spirituality.

In conclusion, it is important to say that Imaginal Approaches allow the influence of what other perspectives have to offer, while recognizing that these perspectives have limitations. It is like the difference between going to the farmer’s market compared to a restaurant. At the market it is possible to find free samples, experiment, and taste a variety of foods. Inversely, at a restaurant the person picks one dish which is limited by the particular cuisine and the chef’s choices, culinary influences, and training. Imaginal Approaches are more holistic, using the experience and expertise of others but not being limited and contained in a stringent, one-sided way. Rather, it offers more possibility. The next chapter depicts an Imaginal Approach in use.
CHAPTER 3

PROGRESSION OF THE TREATMENT

The Beginning

With clammy palms, and my fear that my feeling of dread showed on my face, I sat face-to-face for the first time with 19-year-old Kate, wondering how long this 50 minute hour was really going to take. It was three days before Christmas. Kate had just been discharged from her tenth hospitalization of the year, five of which were in the last three months. Her impeccably tailored clothing failed to hide her thin frame. I wondered if making it to New Year’s Day without an eleventh hospital visit was even a viable treatment goal.

Diagnosed at age 16 with Type I Diabetes, Kate discovered she had the perfect tool in hand to shed unwanted pounds off her petite 5’2” frame. By either under-using or omitting her insulin altogether, Kate could use her new diagnosis as a means of weight control. By reducing the required insulin dosage, her blood sugar would rise and spill over into the urine, resulting in weight loss. However, this biochemical process is very dangerous, because reducing insulin causes body tissues to dissolve and be flushed out in urination. Life-altering complications can occur from this kind of behavior, like blindness, kidney disease, impaired circulation, nerve death, and the resulting necessity to amputate limbs. Death, then, can become the ultimate life-altering complication.

In addition to being diagnosed with Type I Diabetes, Kate inadvertently found out she had simultaneously been diagnosed with Polycystic Ovarian Syndrome, (PCOS).
Having medical problems was a lot for Kate to bear at the age of 16; especially with parents that glossed over the impact it was having on her. But her labs did not lie. No one really bothered to tell her at the time what having PCOS really meant. However, during a medical visit two years later, Kate found out that having children would not be an option to her. Prior to this discovery, she had always looked forward to having her own children and being a mother. This news brought her nothing but despair. Four years later, giving me these details as we sat face-to-face, Kate’s despair was still palpable.

When Kate’s dream of becoming a mother was crushed, she began to fixate on remaining very slim instead, and manipulated her insulin to do so. Kate was desperate. Controlling her body became her new goal, even with the high price she could pay for such destructive behaviors. Having a high risk client who manipulated her insulin for increased weight loss indicated her nonchalance and disregard for her very life. I knew I would have to look good and hard at this case to see if I really wanted this medically compromised client fit into my already busy workload.

Kate appeared to be suffering from an eating disorder in which she severely restricted her caloric intake and regularly abused her insulin as a way to regulate her weight. In this first session, she glibly described a cycle of starving herself throughout the day and sometimes two days, followed by episodes of nightly bingeing, as if it had no effect on her what-so-ever. Yet her body language and significant sighs hinted otherwise, and it was clear to me that her neglectful behaviors had eroded her self esteem and occupied her thoughts and emotional energy most of the time. Additionally, the symptoms of depression and anxiety she appeared to be experiencing were draining her. Socially, Kate’s capacity to function had likewise been compromised as a result of her
eating disorder. Her well put-together look could not hide her distress. Her medication noncompliance coupled with her understanding of the grave consequences this self-abuse could lead to, pointed to Kate’s excessive level of internal conflict. Yet Kate’s distress might just be the key to motivating her to learn management and recovery techniques which would enhance her ability to effectively function in all areas of her life. At least, that was my hope. At the end of this first session, I closed the tall, floor-to-ceiling wooden door behind her. My eyes led me over to the phone, where I immediately called my diabetic supervisor to schedule a consultation.

In our initial meeting together, Kate had explained to me that she had seen two other therapists for a couple sessions each, and had only come to see me because of her mother’s prompting. Running an Intensive Outpatient Eating Disorders program, Quest at PsychStrategies, I often met one or both of the parents prior to ever meeting the actual client. Kate’s mother and I had met to discuss what the program might be able to offer her daughter, as she had been upset about Kate’s numerous hospital visits and the associated weight loss. Being 19 years old though, it would be up to Kate to actually decide if she wanted to schedule her own appointment. Her previously limited therapeutic experience left her skeptical about what could really be accomplished in the therapy room. And besides, most clients with anorexia falsely believe the therapist just wants to fatten them up. Kate was no different. Her daily objective was focused on trying to rigidly control her weight. Never having dealt with the impact of both the Diabetes and PCOS diagnoses, Kate used the eating disorder to keep herself disengaged from the shifting currents of her internal discontent and chaos. Her obsession with her body was
giving her a modicum of relief. With this in mind, I approached the waiting room to see what lay in store for our second session.

Seated stiffly in the chair, Kate appeared the same as before. Her profile was remarkably postured, as if I might not be surprised to find a cameraman from Cosmopolitan or Vogue facing Kate’s posed form from the other side of the waiting room. Her French manicured fingertips were extended around her designer bag neatly placed on her lap. With knees crossed, I noticed how her leg nervously bounced back and forth, revealing the pointed toe of her high heeled shoe, peaking out from underneath the tailored seam of her woolen pant leg. It momentarily reminded me that the glossy magazine covers conceal the darker truths of what is really contained within. Kate’s shiny, almost sparkly hair, tightly bound in a glamorized ponytail, allowed for me to see the detailed and intricate coloring applied to the contours of her eyelids, cheeks, and lips. She not only worked as a receptionist and bookkeeper in her aunt’s beauty salon, but also applied makeup for bridal parties. She was a make-up artist on weekends, and from what I observed about her own makeup application, probably a good one at that. Kate acknowledged my simple greeting with her much practiced tight-lipped smile, bobbed her ponytail, and followed me down the hall.

Poised as if ready to defend herself I knew that initially building trust with Kate would take some time. So I sat back in my chair, in no rush to accomplish anything. In fact, holding the space for a client to come in and address deeper issues that can be difficult to go through, can be regarded as a privilege or an honor from the eyes of the therapist. The degree to which this serves the client can be enough to allow insight and awareness to develop to have authentic, genuine, honest relationships. I reminded Kate
that the first couple of sessions I would be collecting information about her history. I added that during the next few weeks she and I would mutually decide if we wanted to work with each other. This prompted Kate to quickly reply, “If I didn’t like you, I wouldn’t have come back this week.” Without applying any pressure or making the assumption that we were to have on-going meetings, and by letting her know it was her decision, not her mother’s nor mine to make, Kate readily made a decision on her own to keep seeing me. Kate was already expressing her own will; a lost skill since her early teens. As I saw it, she was already making progress.

During this second hour I listened as Kate stumbled from one subject to the next, unsure of how much information to divulge. I pried and poked for more details. She appeared a touch miffed as she let out a haughty sigh, so instead, I decided to hold back my comments and temporarily become the mirror she so obviously needed. Occasionally replying with a simple “uh-huh” or a mere nod of my head, Kate went on to tell me about a physically abusive relationship she had with a boy her age at 14. She briefly touched on how she saw him for about a year, and played down how she would be badly bruised from him squeezing her arm so tightly. Kate sarcastically informed me about her older sister who mistakenly got pregnant and had a two year old daughter, Kate’s niece. Just like her rigidly held posture, Kate’s reporting was very matter-of-fact. Stolidly, Kate described the connection with her sister to be tenuous at times. She felt as if she was always walking on eggshells. Kate’s face appeared discouraged, relaying how she felt deeply misunderstood by her sister and family in general.

As we neared the end of the hour, Kate sheepishly divulged how she was “starving herself all day.” Her willingness to be open and honest suggested to me that the
underlying need for her story, with all its complications and frailties’, had to be told and heard. However, she waited until she felt safe, just before the end of our session, to candidly reveal this difficult information. This was only our second meeting together, so as Kate went on to explain she had only eaten a few pieces of candy yesterday, and resisted checking her blood sugars last night until bedtime, I wondered if seeing me only once a week would do her justice. Then, I was astounded when she added, “Yesterday when I finally checked my blood sugar it was at 480, so I took 30 units of insulin.” Wow! Now I realized how much she had come to minimize and dismiss her body’s insulin needs and how dangerous her situation really was. A normal blood sugar level should be between 80 and 120. These high blood sugar levels would cause her to have to overcompensate with her insulin, giving herself a significantly high dose of 30 mgs prior to going to bed. When a diabetic injects such a high level of insulin as she had, they put themselves at risk of having their blood sugar drop drastically low. If this had happened while asleep, Kate could have ended up in a diabetic coma. Looking up at the clock, I felt perplexed about the direction to go. I had a therapy group waiting to start at the end of the hallway, and a high-risk client facing me who was clearly in a state of severe denial. I wondered if my first therapeutic goal of keeping her out of the hospital was too lofty. She might need to be admitted after all before the ball dropped in Times Square.

As our second session came to an end, Kate was well aware of my serious concerns about her nonchalance toward self-care and the danger that put her in. I also let her know that I felt we could successfully work together, but I would not be willing to do so if she was not willing to seriously work with her insulin neglect. Kate felt challenged by the word neglect. She believed herself to be a responsible person and wanted nothing
to do with being seen as irresponsible. Now she had something to prove. She agreed to immediately go eat lunch, check her blood sugar afterwards, and leave her numbers on my voice mail before two p.m. After she left, I wondered why I suggested she call me with that information. I did not want to be perceived as over-involved or needing to micro-manage Kate’s life, as her mother did. I found I needed to question some things to be sure. Was I needing to be reassured? Did I need to feel some modicum of control in this story that was revealing more and more chaos after only two sessions? Could I possibly be creating a role for myself in this client’s personal drama? With detailed notes to take and much to reflect about, again, I picked up the phone, realizing the need for my own consultation.

Retrieving my voice mail later that evening, Kate’s message, left at 2:15 p.m., stated that her blood sugar was at 148. Although she was taking insulin for it, I made a mental note of how high it actually was. Also, we had agreed that she would call me before 2 p.m., so I wondered if she had been resistant to calling me and how important it would be to talk about the possible power dynamic we might be creating between the two of us. If I got into a role of telling Kate what to do as did her own mother, it would be easy for Kate to eventually become defiant and resistant. She could end up feeling she was being manipulated by the constraints of more adult rules, rather than learning to trust her own inner wisdom. Before the voice mail ended, Kate added that she was interested in coming into Quest, the I.O.P. Eating Disorders program I managed. I was both delighted and surprised. She was making the suggestion to get more help and support for herself. It turned out after all that it did not have to come from me or from her mother’s
coercion. It was an empowering decision for her to decide to get more support on her own.

It would be another month before I would see Kate again. This became a recurring pattern. Kate would open up and let herself be seen, then have a seemingly legitimate excuse to miss her appointment every second or third week. Never once did she appear flaky by just haphazardly missing an appointment by being forgetful, although she feared I would see her that way. After some months of this, we eventually agreed on meeting every other week, seeing if this would allow her to keep her scheduled appointments, which, for the most part, it did. It also helped to slow the process down for her, which I believe she was unconsciously attempting to do with her ‘legitimate’ excuses.

During this third session, Kate addressed her fears of “not getting any better.” She feared she would “fail” doing therapy “correctly” as she felt she had done years before. In fact, Kate feared falling short of most of her lofty expectations. Within this, her perfectionistic tendencies emerged, drawing out her dichotomous thinking of things being right or wrong, good or bad, and basically black or white. I questioned if there could be room made for the unknown. This reminded Kate of something that happened after our previous session. Apparently she had decided to relay all the details of our meeting to her mother, and upon doing so, began to cry. Because of this vulnerable interaction with her mother, Kate spoke critically of herself to me, saying that others have much bigger problems compared to hers. She felt whiny by even complaining about her own problems, let alone crying. The session ended with Kate in tears. She was beginning to
show some trust in our relationship, by opening up enough to be vulnerable with me and showing her tears.

Obviously, Kate had tried to tough it out for many years. In fact, it was later revealed to me that when Kate was first diagnosed with Type I Diabetes, she decided to become the perfect patient. Creating a color coded chart she judiciously filled in daily, Kate felt well prepared for any doctor’s visit. She explained, with pride, how good she felt then. As Kate got older and her responsibilities increased, she felt more and more pressure to prove she could live her life perfectly, continuing her role as the model child. The pressure took its toll on Kate. Now, she easily ignored her daily insulin requirements, and sometimes let her prescription for insulin run out completely.

Due to complications with Kate’s insurance company, it was not until the following May, (five months from starting individual therapy with me), that Kate actually entered the Quest program. Meanwhile, I watched as Kate’s resistance to eating heightened and her weight dropped. Although she was now openly exploring a variety of topics with me, she remained guarded about talking about her weight loss and her avoidance of eating.

**Treatment Planning**

Clients who are in denial about their eating disorders walk a fine line, teetering on the possibility of physical complications arising in any given moment. The clinician needs to pay attention to keeping them medically stable, even in the midst of such neglect, deprivation, and physical abuse they inflict upon their bodies. Kate was no exception to this. For sound treatment she really required a team of professionals to help
guide and support her for far more hours than what her weekly 50 minute session with me could provide. She needed a medical doctor to oversee her physical status and be ready to intervene with a higher level of medical treatment if necessary. Kate also needed a dietician versed in working with eating disorders; group work, to be able to learn to deal with the complexity of relationships; and family therapy, to explore some of the underpinnings of old issues that undoubtedly fed her current behaviors. She was requiring far more than I could give her as a solitary practitioner. As we progressed through our first few months together, it was showing up in her worsening condition.

Right from the beginning, I knew that developing trust with me as her therapist was of the utmost importance, given the skepticism with which Kate presented, and the previous so-called “failed” therapeutic relationships. Prior to each session I would try to remind myself of this. I was aware of the importance of how this pointed to the importance of listening rather than speaking. Kate was used to a family that would give directions and tell her what to do instead of being with her, listening to her, and respecting her needs. She needed someone to be curious about her needs, and to feel heard, seen, and understood.

It disturbed me that Kate gradually lost weight over the first six months of meeting. We talked about getting rid of her scale, or purposely storing it in a difficult to get to location. She would obsess over her weight, weighing herself numerous times throughout the day. That number became her new God. She worshipped that number and handed her power to it every time she jumped on that scale. That external number took the place of her own internal confidence, as if her self-esteem could be weighed. So instead, I would weigh her weekly while having her stand backwards on the scale. This
helped to take its power away, and we worked instead on how she experienced not knowing what she weighed. Initially, Kate continued to lose weight, but eventually stabilized and then gained to a normal weight. In March of 2005, 15 months into our meetings together, she joined a health club, and we agreed that she would tell me when she would weigh herself. Since her weight was stabilized, this was not problematic.

I came to understand how Kate’s relationships with her primary care physician and diabetes specialist were enshrouded in deceit. Kate not only lied to her doctors, but also to her family, friends, boyfriend, and of course, to me. Therefore, case managing Kate’s treatment became difficult to include outside professionals. For example, when she would find herself vomiting during the middle of the night due to poor insulin regulation, or becoming woozy or fainting for the same reason, Kate would get herself to the emergency room. There, she was treated intravenously for Diabetic Ketoacidosis. She would then lie to those treating her so that she could be quickly released. When we first met in December 2003, Kate had been admitted to the emergency room five times since September. After being released to go home, she would then postpone or cancel follow up doctor’s visits. Kate wanted to wait to make an appointment until she could show how well she had been taking care of herself, for fear of getting reprimanded for the opposite. It became hard for me to solidify any sort of treatment plan, since her doctors remained out of the loop for the most part. I was eager to get Kate into the Quest program for this reason.

Initially, it was important to emphasize with Kate, the necessity of stabilizing her daily and nightly insulin intake. This required, of course, that she needed to eat in order
to maintain her glucose levels. This was not an easy feat for Kate, since that was exactly what she was resistant to doing in the first place.

At the second session, I stated to Kate how she was a high-risk case and clearly in a state of severe denial about her condition. I only agreed to work with her if she showed continued movement with her eating disordered behaviors and use of insulin, and a motivation to stick with the therapeutic process. I outlined the need for an agreement where she would begin giving herself the much needed nightly shots of Lantus, a long acting Insulin, to help maintain steady blood sugar levels. Kate would also need to keep a snack on her nightstand in case of finding herself with low blood sugar in the middle of the night.

I also suggested to Kate that she carry snacks with her at all times. Decreasing her time between meals was a priority, and her goal was to eat something every two to three hours. I was aware that working with Kate’s discomfort when eating would need to be emphasized in order for me to support this goal. This is where the dietician’s weekly group, the Mindful Eating segment, and the weekly individual sessions with the dietician in the Eating Disorders program became especially helpful. Kate was very resistant to eating anything during the day, except for her incessant coffee intake. Within the safety of a therapeutic setting with others though, she was eventually able to address and practice this. She was also required to provide the dietician with her daily food intake and portion sizes.

Along with addressing issues about food, it was important to address issues about Kate’s negative body image. She had a tendency to hold her posture quite rigidly and to observe herself in any mirror or reflective object that she came upon. I suggested she go
out and shop for a few new outfits that were less fitted, as her tight fitting clothes
reinforced her need to look pencil thin. Since shopping was something she liked to do,
she readily complied with this idea. By purchasing looser fitting clothing, it encouraged
her attention to be taken away from places her clothes were feeling tight, and to allow for
weight gain. Kate continued to look well-groomed, but became less obsessed with her
physical shape. At one point she remarked, “Although I could use a few new things to
wear, I would rather start to pay off my debts.” Her difficulty with spending money was
not initially revealed, but eventually found its way into our conversation. It showed up
when 15 months into our work together, Kate wanted to move into an apartment of her
own, but was having trouble due to her bad credit history.

Three months into treatment it was obvious how Kate was vested in getting
herself help compared to her strident unwillingness upon our first meeting. She would
regularly inquire as to the status of the insurance company financially supporting a higher
level of care (HLOC). She had gotten both her medical doctor and diabetes doctor to
advocate for her as well. It seemed that the more unlikely her insurance company would
support a HLOC, the more Kate wanted the help and increased treatment of the I.O.P.
program. Kate’s involvement in the treatment planning led me to believe she was ready
for the journey which was about to unfold. Taking responsibility in her own recovery
process helped things begin to move along.

**The Therapy Journey**

During the initial three months of Kate’s therapy process, both her history and her
resistance to feelings guided the course of treatment. For any real work to take place it
was necessary for trust to develop. Reflecting back to her that she was not wrong and that she did not have to be doing things perfectly was crucial to creating this trust. Kate was so used to being told what to do, and then somehow made wrong in the process, that it was difficult for her to have faith in her decision making process. When she would pull for the answers, I would have to be careful not to tread there, but instead, encourage her to come up with options for herself. I needed to convey that her opinions counted.

One such example was around her consumption of daily caffeine. By our ninth session, Kate’s increased motivation to take responsibility in her own healing process showed in her willingness to give up caffeine. She had been drinking 12 shots of espresso and one Frappuccino daily instead of eating. Basically, coffee replaced eating and allowed Kate to withstand any feelings of hunger which in turn made it easier for her to limit herself to one evening meal. During the year prior to our therapy sessions, she had been relying on Sominex for her nightly insomnia, which the caffeine intake was clearly creating. Even though her body showed signs of withdrawal as she dealt with headaches and some body shakes, Kate continued to be persistent in her perseverance to end her caffeine addiction. So much so, that a month later, Kate discussed how she felt she could not resist her $4.00 Starbucks one day. She apparently proceeded to buy one and sat with it for 10 minutes before deciding to throw it away, still untouched. Soothing herself via her morning coffee ritual eventually turned into drinking one to two cups of hot green tea instead.

Working with Kate’s resistance to feeling was no easy feat. A cold and ruthlessly piercing glare appeared when Kate did not want me to either confront or challenge her. For some time I was not aware of my fear when I had become her target. Unexpectedly,
Kate’s disparaging sarcasm and contempt would ooze through in any given moment. I found it distressing that I often backed away when I noticed her contemptuous look appear, since I did not present myself as fragile in our relationship.

Upon reflection, it was easy to understand how Kate’s rage was born. Kate’s family was all about how it presented to the outside world, important to appear close and open while actually the opposite was the predominant mode of behavior. Mom held all the emotions, including being the only family member allowed to get angry. Mom and dad expected Kate to be cute and well-behaved growing up, and silenced her when she “complained” or was upset. There was a lot of tension between Kate and her older sister, and Kate and her mother. It was apparent that as a child, Kate did not have the experience of the mother or the father that saw her. The message was somehow given that it was wrong to have anger, sadness, and other perceived human imperfections and messiness. So there would be a terribly distraught part which felt betrayed for not having been seen, and in turn, learned instead to feel bad about herself. She could not look at her parents with any sort of psychological understanding that the parent was also imperfect. So rather than learning how to speak up, Kate had learned to push away all her feelings, and with this, mastered a false smile. Her defensiveness was palpable in the therapy room. The same defensiveness she had come to depend on to hold down her intolerable feelings. But as her defenses began to crack, Kate’s piercing glare intensified. It was obvious she did not want to explore much of any feeling state.

My way of working with this was to continue to stay present with the anger, acknowledging it, recognizing its subtleties and merely noting them without judgment. I expressed curiosity about her glare, or what came to be known as “that look.” Kate was
rather unaccustomed to her “look” being normalized. It was also unusual to have someone wanting to know more about it without being critical. By allowing her anger to be explored without making her wrong for it, Kate began feeling. She feared however, the consequences of showing her sadness or anger. Kate felt flawed for even having those feelings, let alone expressing them. She believed that the repressed grief would be too much, and the highly organized, functional, and put-together persona she had held together for years would become threatened. So instead, her glare would tighten and try to make it something about her and me. Or, she would take it out on herself by severely restricting her caloric intake and neglecting her insulin injections.

Despite my internal reaction, I was able to bring curiosity about this frequent hostility that would erupt when we sat together. I would say, “Oh, I can see that look on your face right now,” then ask her to tell me more about it. Such interventions and acknowledgments seemed to help normalize the angry feelings and Kate started to recognize how irritated she actually was with her mother. I was relieved by this breakthrough.

Four months after initially beginning weekly individual therapy sessions with Kate, she was admitted into Quest, the IOP Eating Disorders program. It turned out that her insurance company denied paying for Quest, so her parent’s decided in early May that they would pay for her treatment out-of-pocket. It was important for Kate to have increased support, and her parents knew it. She needed to stop both the eating disordered behaviors and the pattern of consistently abusing her insulin. She also needed to take some of her therapeutic experiences into her everyday life to feel as if she was making some progress.
One of the four weekly groups in her treatment plan was a family based educational component, meant of course, for all family members to attend. The purpose was to educate and support her family in learning how to best support Kate in her recovery. As her individual therapist I was acutely aware of Kate’s need to feel she was not imposing on any of her family members, so I was not surprised to find their attendance to be spotty at best. I questioned Kate about how she saw this as an imposition to her family, in that it was a previously agreed upon treatment recommendation of weekly meetings. Of the 10 Family Educational Groups Kate attended, her parents attended five, her brother attended four, and her sister never showed up. Although questioned, Kate could not admit to how this may have affected her, defensively saying instead that she “didn’t care if they showed up or not.”

Once enrolled in Quest, Kate’s treatment plan was changed to more specifically meet the needs of doing intense group work. The Mindful Eating segment in Quest, would help support Kate with her discomfort when eating and the fearful relationship she had to food. It also provided her the opportunity to address her obsessive thoughts that would generally keep her from interacting with others while eating. Meeting weekly with the program’s Registered Dietician challenged Kate to become more accountable. A goal was set to decrease the time between meals and increase Kate’s variety of foods. She was required to actively keep a daily food log, including the time she actually ate, what and how much she ate, and what she was feeling at each sitting. She was advised to turn the television off and sit at the table during meals. By the end of treatment, lunch and dinner had become fairly consistent, but she had not been able to regularly eat breakfast. Kate
was still monitoring her desire to skip meals, but no longer needed to consistently report on her intake as she became progressively more responsible.

Kate’s initial experience in the group setting in Quest was to withdraw and become quiet, unless directly spoken to. She volunteered that she generally felt numb until one day when a visualization was done. In this group visualization, the topic of loneliness was introduced. Kate described the profound imagery that appeared for her. She realized that part of her loneliness was linked to keeping her inner world a secret from others. Afterwards in an individual therapy session, Kate stated, “When I see huge clumps of hair in the drain after my shower, I know I should be upset about it, but instead, I’m relieved. It means I’m not getting fatter.” This was challenging for Kate to admit to me. But once that information about her internal thinking process was revealed and shared, Kate had begun the process of becoming aware of her internal gatekeepers that fueled her anorexia. This proclamation allowed Kate to see just how entrenched she had become in the eating disorder over the past few years.

Just one week into group work, Kate was able to articulate how she had learned to play a “victim” role. She boldly admitted to being “fake,” because no one would love her if she showed the “real me.” Within two weeks of entering Quest, Kate’s resistance to eating began to shift. She started to eat more frequently, rather than the one nightly meal she reported generally allowing herself. Of course, this would also benefit her diabetes management. She was aware she had been striving toward an unattainable goal; the airbrushed, media depicted female. She was also willing to explore more of her past and the incongruity between her idealization and actual experience of family life.
Three weeks into the program, and five months after beginning her weekly therapy sessions with me, Kate began to get in touch with her angry feelings about her mother. While rolling her eyes upward toward the ceiling, as a teenager might do in a display of disgust, Kate said, “I’m starting to see how flawed my mother is. She’s totally self-absorbed and everything’s about her!” We then explored how this was for her as a child. Kate was able to recall how her mother seemed to have the final say on how she looked, what she said, and how she acted. Understandably, Kate was terribly insecure about breaking out of this habituated mold. She feared the consequence of mom’s silence and cold shouldered rejection she had come to know all too well.

Kate’s irritability seemed to heighten with each new insight. It was too hard to imagine getting angry with her mother, so her fury was misdirected toward her boyfriend. Kate’s initial responses needed to be questioned further. She hid behind the well-known mask she grew up with, reacting from how she thought she was supposed to act, rather than how she actually felt or what she was actually thinking. I learned to gently prod Kate to redirect her to work with the feelings associated with her past. With mom and dad on a pedestal, Kate still had a lot of work to do. Because she was connecting with her angry feelings, I began to role-play with Kate in group. This gave her an opportunity to practice speaking truthfully to a surrogate mother without becoming enraged and dumping her anger onto her real mother. With each subsequent role-play, she felt less and less guilt about these feelings of hers. She became more comfortable with her own anger, and with six months of therapy under her belt, and one month of group work, Kate was able to confront her mother. This turn of events was significant to her recovery process and I felt hopeful when hearing about it. Although Kate was disappointed with the first direct
discussion with her mother, not feeling seen or understood by her, future conversations they had, produced varying results. Often times Kate would come into therapy after one of these discussions feeling good about herself and encouraged. Likewise, so did I.

At this point, Kate started feeling more compassion toward herself. She recognized now how her mother had probably responded to her similarly throughout her childhood. Kate knew this had influenced how she had learned to shut her world out. She understood how she was on her own with her intolerable feelings as a child. She saw why she tried so hard to control her environment. At this point, I recognized the need for us, as a staff, to continue to reflect back without analyzing, giving Kate some semblance of the mothering she had never received.

Six months after starting her individual treatment, and one month of being in intense group work, Kate had successfully remained out of the hospital and emergency room. Then one day, Kate nonchalantly announced to the group members while doing an art project, “I want to adopt, since due to the PCOS, I cannot have my own children.” She also stated with sad emotion, how she had asked her boyfriend if this would be a problem for him in the future, and his answer was “yes.” It was shortly thereafter, that Kate ended up in the hospital again, the first time in six months, due to ignoring her body’s insulin needs. Up until this episode, Kate’s parents and brother were showing up for the weekly family groups. Her family had been unable, however, to schedule a time when they could all meet for their first family therapy session. This incident was enough to get them to come in the following week, haunted by the specter of Kate’s possible death.

During this family meeting, the family therapist described how the discussion began with Kate’s recent hospitalization. Her brother talked about how sad he would be
to lose her, and how mad and disappointed he felt when he heard she was back in the hospital. Kate’s mom said she was frightened but also paralyzed by feelings she could not quite articulate. She was somber and teary-eyed as she addressed her helplessness, in the face of her daughter’s disconcerting behavior that landed her in the hospital. She also realized though that Kate had disclosed to the hospital staff that she had an eating disorder, unlike any of the previous hospital visits. With this new information, the doctors changed her course of treatment and were better able to support Kate’s real needs. Kate’s dad admitted to feeling frightened, and said he understood how hard it was for Kate to make the many decisions she must make each day just to stay alive. When he looked at her, he stated how he was able to see the many aspects she deals with each and every day to fight the anorexia. Kate was getting the acknowledgment she so craved from her family, but at a high price to pay.

The previous week, Kate had been unable to address her intolerable feelings related to her inability to have children and the response she got from her boyfriend. Instead, she restricted her caloric intake and abused her body’s insulin needs. The drama this created was enough to distract her from the real issue. Now she was feeling safe and secure, surrounded by all her family members professing their deep love for her. Temporarily, the real issues could be forgotten and avoided. Although Kate had detoured around the issues of insulin dependence and the consequences of having PCOS, this hospitalization was directly speaking to the need that these issues now be addressed.

This on-going irresponsible behavior with her insulin abuse was cause for great concern. For the next few weeks, Kate came to therapy looking fatigued. When challenged, she admitted to having gone back to restricting behaviors. She also admitted
questioning whether or not she really wanted to keep on living, although she did not have any sort of suicidal plan. It was hard for her to feel the anger she had about being diabetic and having to take insulin. It was hard for her to know what to do with all the feelings coming up in regard to her family relationships. And it was hard for Kate to have hope that all of this could someday change.

Kate used the next few weeks in her family therapy sessions to begin to confront family members on various issues. But her energy continued to wane. By the third family session, three weeks after her hospitalization, Kate’s father mentioned the heavy financial burden of the cost of the program. He stated he was no longer willing to support all the therapy sessions when “she wasn’t getting any better.” A week later, after being encouraged to “share her news” by her sister, Kate announced in their fourth family therapy session that she intended to end Quest that week. She felt she could do better now on her own. She was sending out resumes and searching for a new job. She planned to continue recovery in the Aftercare group and individual counseling. Kate said she hoped to eventually find an outlet for her creative side. Her mother and father said they were very encouraged by her “positive attitude and communication.” They expressed their desire to allow Kate to live her own life without interference.

Kate showed up for one last group. She was in her 35th week of a 48 week program, and nowhere near where the staff determined she needed to be for discharge. None of her family members showed up on the night of her graduation from Quest. Kate and her sister, however, used the remaining five family sessions she was entitled to, over the next six months. She also continued to see me for individual sessions for the next four years.
This abrupt ending in the Quest program was disconcerting, especially with the progress Kate had been making. Kate expressed to me how angry she was that her parent’s were “putting the money issue in her face.” This, of course, was when Kate made the decision to leave the program. She was unable to tolerate making her parents upset. Her parent’s upset about the money they were spending to keep her in the program fed right into Kate’s sense of being a burden. It was also very difficult for her to have made so much progress, yet be experiencing what she termed as her “parent’s resentfulness” because she “hadn’t gotten any better,” even though they stated otherwise in the last family therapy session.

Kate’s family appeared threatened by the therapeutic process. The change Kate exhibited in her willingness to speak directly, honestly, and openly with them was too much for her family to handle. I questioned if we, as a staff, had missed something regarding the family group and the family therapy sessions. It appeared that the family was somehow vested in keeping Kate identified as the sick one needing treatment, rather than looking at it as an opportunity for self-growth, better communication, and ultimately, deeper familial connections. They had basically given Kate the cold shoulder. They shut her off from any support because she was going against the unspoken family agreement that you hold in your truth, unless it was something nice to say. It was obvious now why Kate had perfected her mask.

I was left not knowing quite what to do. Face-to-face with Kate the following week, I was aware of the disconnect I felt with her. She continued to talk about how utterly amazed she was by the changes of internal awareness because of her time in Quest, but never spoke about what really happened. I was suspicious she was frankly
feeling like a failure. She had just spent thousands of dollars of mom and dad’s money, yet knew she had disappointed them. I also assumed she would be afraid to speak truthfully about her own disappointments about the Quest program, since I was the Program Manager. Kate learned to believe she could be in control of others feelings by omitting and avoiding speaking directly about difficult matters. I was no exception. In fact, because of our therapeutic alliance and her projections of authority onto me, it was a greater risk for Kate to speak her truth. I do not recall ever having challenged Kate about this, which I now believe to have been counterproductive in our work together.

Kate terminated her involvement in Quest the end of July. Her inability to face me surfaced in her infrequent therapy sessions with me, although we had already been meeting for six months. She only met with me once in August and once in September. The absence was blamed on her new job and long work hours. It was an old habit of Kate’s to avoid relationships through her “stringent work ethic” as she termed it. At the beginning of October, I met with Kate, after not having seen her for three weeks. I had received an urgent voice message from her to be sure we would be meeting. Sitting rather rigidly in front of me, Kate boldly spilled out how she had taken a few sick days due to nausea and vomiting. She felt bad doing so with her new employer. After visiting her doctor, she was utterly shocked and outraged by the news that she was pregnant! Simultaneously, she was ecstatic, knowing now she could actually become pregnant. Having been repeatedly told for many years she was sterile due to having PCOS syndrome, Kate found herself muddled in layers of confusing feelings, overwhelmed andnumbed by this news. Her doctor stated to Kate, that given the condition of her body due to her anorexia and insulin abuse, either her life or the baby’s life would be at risk if she
went to term with this pregnancy. The doctor, a specialist in difficult and/or complicated pregnancies, approximated a 40 percent to 60 percent chance of losing one of their lives due to both liver and heart strain on her already compromised body.

I questioned what appeared to be a lot of dissociative behavior during our session. Given that her Primary Care Physician used to chide Kate about using birth control since she was told she did not need it, I guessed Kate was repressing some angry feelings. The exact thing she always dreamed about had come true; she had become pregnant. And yet, here she needed to make a very difficult decision about possibly ending the pregnancy. This crisis had no time to wait either, as she was already 11 weeks along and would need to make her decision pronto. The consequences of anorexia and insulin abuse were in her face.

Although it was 11 months now of working together, Kate continued to frequently cancel. Our next session was three weeks later, four days after Kate went through with an abortion. She expressed to me how her parents and boyfriend had been supportive both pre and post abortion. She and Mat were planning a trip in a few weeks to Disneyland to get away from the heaviness of the situation. Although Kate had not yet cried during our session, she reported having done so at home. She recognized she was not in total acceptance that the procedure had been done. Followed by this, Kate then recalled the actual difficulty of “hearing the whoosh in the tube as the fetus was extracted out.” That memory was enough to throw Kate into tears.

Kate was still reeling from the reality that she was not sterile, and felt terribly irresponsible that she had gone off birth control and conceived a child. This was a child she always wanted to have, and had to give up. Kate struggled with her unbearable
feelings, covering them up with actions that created drama in her outer world. Coming to terms with being a Type I Diabetic and having an eating disorder did not come easy for her. The more anxiety she felt, the more excuses she made to miss her appointments with me, and she was the first to admit it. One month after her abortion, Kate was back in the hospital. She spent Thanksgiving weekend there because she decided to have a drink, which does not bode well with having Diabetes. Although Kate was upset with herself, she tended to want to dismiss the whole incident.

Kate had not yet developed the trust that she could get through a catharsis, pick herself up, and continue to move forward with her life. Instead, she felt wrong about herself but was unable to say so. Afraid I might pick on her as her mother would do, Kate would make excuses, which appeared to be legitimate, about her need to miss therapy appointments. Initially, I did not think much of it. Kate had such solid reasons for missing sessions, such as not wanting to leave a business meeting early, having to fill in for an absent co-worker, or needing to work late because of a project that was due. I started to look at the bigger picture and question her cancellation tendencies when Kate disclosed how manipulative she had been during her numerous Emergency Room visits. Even though she may have had serious symptoms related to abuse or misuse of her insulin, she generally used the Emergency Room for stabilization only. Kate never disclosed to the doctors about having an eating disorder, refused hospital admission, and sauntered on home ready to go back to work the next day after having been physically replenished through IV treatments.

It became apparent to me how threatening it actually was for Kate to even show up for our weekly appointments. She had learned the art of hiding those parts of herself
she deemed unworthy or too needy, and chose to show a convoluted perfectionism instead. I think Kate expected yet one more adult who was going to tell her how to act, or what she “should” be doing to live a successful life. I did not make Kate wrong, but instead, was accepting of who she was, tears and all. Her pain was so deep and so voluminous, that once she would feel seen without judgment, it became too much for her to handle.

With close to one year of therapy behind her, Kate was able to recognize the actual anxiety she experienced before every therapy session. In trying to work with this, it became apparent to me that scheduling our appointments to meet every other week allowed her to continue showing up. Although I did not feel this to be ideal, and my first preference was to get her to meet weekly, I knew that pushing her to do this was apt to fail miserably. She already felt burdened by her life’s responsibilities and was more likely to just quit therapy if pushed too hard. When Kate did show up for a session, I began to acknowledge her for this, saying something like, “I see you made it here today. How were you able to do that, given all the responsibilities you’re attempting to juggle?” Then, at the end of each session, I asked her to address one thing she could take with her from having met with me. Sometimes we would even be able to laugh together at the recognition that she was able to get to the end of the session still having both arms and legs attached! Recognizing how she was able to show up each time she did so, and how she was able to walk out feeling it was time well spent, eventually helped Kate also assert herself with her boss by letting him know she had a standing Friday appointment. It was at this point, 14 months into treatment, that she was able to meet weekly.
Throughout the next three and a half years of our working together, Kate made some substantial strides, even given her propensity to minimize and dismiss her feelings. Although ending with Quest prematurely, followed by the shocking news of her pregnancy and then abortion, Kate eventually rekindled her determination to continue meeting with me. She did not give up on herself or the therapy process. It seemed in some ways, as if the unexpected pregnancy was a catalyst for change.

Eventually an issue that became part of the treatment plan was Kate’s propensity to spend money. She had hidden this problem from me for 15 months until it was time for her to move into an apartment of her own and her credit rating stopped her. Kate had a need to talk about these circumstances and how they impacted her which meant she had to let me in on her troubles with money. She was quite ashamed about it. Her money situation was out of control and was the antithesis of what she tried to project.

Kate’s ability to value her needs became a significant change in our work together a year and a half into her treatment. After living with her sister and niece for five years, Kate did move into her own apartment. She asked and felt supported by her parents when they co-signed her new lease. Kate focused on decorating her new apartment, followed by future career interests, and then, what she desired in relationships with others. Having been in a position of consistently stressing the need for self-care, I was glad to see Kate turning a corner. In the past, I would point out the incidental things she did in the interest of self care, that by-and-large she glazed over and generally tended to ignore. Now, in contrast, she was bringing these things to my attention, and feeling proud of herself for her accomplishments.
Two years into our work together, Kate became keenly aware that if she could possibly have a baby someday, it would not be with a man who used marijuana on a daily basis, as did her boyfriend Mat. I was surprised when Kate came in one day and announced that she had broken up with him. Although I was excited by this news, I quickly assumed they would be back together by our next meeting date, if not by that evening. My skepticism was thick, having heard story after story about rebounding back to his feet feeling distraught and not able to “live without him” after every prior dispute. I wondered how this would play itself out, given that Kate generally made excuses for Mat’s behaviors whenever his name was brought up. Usually, she tended to blame herself for their conflicts, unlike her approach to other relationships where generally, the blame would be put onto the other. When Kate continued, week after week, to set a limit with Mat, I became pleasantly surprised at this turn of events.

Without Mat in her life, Kate quickly discovered how difficult evenings had become. She found herself relying on the television and binge foods to help her fall asleep. I encouraged Kate to go back to logging her food intake, not to shame or guilt her, but instead, to bring increased awareness to her behaviors with which she was struggling. I also reminded Kate that fixing consistent meals she desired, and feeding her body that intuitively knew when it was hungry, was another way of taking care of her physical needs, and would less likely set her up for binge behavior.

Struggling to take care of herself brought up how lonely she was feeling. I challenged Kate to use this new available time to fill it up with herself, refocusing again on what she needed and desired, and where she envisioned her life going. We reassessed her values together, and created goals from those. I encouraged her to begin planning and
creating what she wanted for herself, without having to rely on going back to Mat to self-
distract. Kate was eventually ready to move the television out of her bedroom, and
worked on self-soothing techniques. She also got a gym membership and began working
out two or three evenings a week, and fixed meals with foods that appealed to her and
filled her up.

Two months later, and more than two years into the therapy process, Mat started
making overtures to come back into Kate’s life. Seeing how much progress she was
making, I became apprehensive when I heard this news. After a few phone conversations,
they decided to meet up after all. I was glad to hear how she had continued setting limits
with him, and was clear that she was not interested in getting back together if he was still
using marijuana. To Kate’s surprise, and mine, not only had he discontinued his drug use,
but had sought out and was attending weekly therapy since their split. Two and a half
years into treatment, she eventually moved into another apartment with her fiancée Mat.
Having an awareness of her needs allowed Kate to more readily confront issues with
those close to her. Two years and seven months later when our work together ended and
we had been meeting for almost five years, Kate was proud to say that Mat had continued
with his therapy and had not returned to any drug use.

Legal and Ethical Issues

Four months after initially beginning weekly individual therapy sessions with
Kate, she was admitted into Quest, the Intensive Outpatient Eating Disorders program.
Quest required the attendance of all agreed upon family members for the Friday night
families group, and additionally, for weekly individual family counseling sessions. I was
faced with the ethical concerns of not only working with Kate in on-going individual therapy sessions, but in addition, working with her in a group setting, and also with her family for the multi-family group. Working within the group, and working with the family while not disclosing confidential issues would need to be a priority, especially since initially gaining this client’s trust took some time.

Another development that required thoughtful consideration from an ethical point of view was Kate’s parents’ decision to stop paying for her treatment. I was not clear enough at that point in the treatment that I was the voice or advocate for Kate. Yet, she was in no position to advocate for herself with her parents since she was beholden to them for money for her treatment. Legally, my not advocating for Kate could have had serious implications because oftentimes Kate would express her anger by taking it out on herself through restrictive measures pertaining to food or ignoring her insulin needs. Ultimately, I could have been held responsible for potentially serious consequences.

My client’s first pregnancy initially raised another big ethical concern regarding the possibility of abortion. After she saw the specialist at Kaiser who consults with patients who have difficult and/or complicated pregnancies, Kate’s ‘decision’ became less of a decision, given her compromised physical condition from her recent history of anorexia. The pressure though to decide on going full-term or having an abortion was heightened due to the limited timeframe she had in which to act on this. Obviously, this was also complicated by the fact that Kate was flooded with intolerable emotions. This left her feeling extremely vulnerable, fatigued, and wanting to put any sort of decision off until feeling less burdened. Although we had to process her decision to have an abortion
and the deep grief she experienced afterwards, Kate again became pregnant one year later when she was decidedly healthier, and delivered a baby boy in October 2006.

**Outcomes**

Working with Kate for almost five years allowed me to witness the roller coaster ride Kate’s life was taking her on, and her struggles to keep from gravitating to the extremes. Many times she made progress, only to digress in some other aspect of her life. As her attention and focus shifted, the very thing she thought she had under control would seamlessly sneak in the back door when least expected. For example, eating regularly and giving herself insulin injections three times a day helped her to fall asleep without using any medication or having the television on in the background. Unconsciously, her focus then shifted to verbally attacking her boyfriend and obsessively working ten hour days. This led to extreme fatigue and migraines, causing Kate to naturally want to eat less. Then the obsessiveness would shift back to eating disordered thoughts. Eventually Kate was able to recognize her attacking behaviors and remove herself from the argument, later returning to apologize and discuss the issues responsibly. She was also able to readily recognize eating disordered thoughts before they turned into behaviors.

As part of the evaluation process for the Quest I.O.P. Eating Disorders Program, Kate completed the Sheehan Anxiety Scale, and the Beck Depression Inventory, both self-report questionnaires which measure the degree of perceived depression and anxiety that the subject is currently experiencing. These revealed that upon entering into Quest, Kate’s symptoms of anxiety fell within a range slightly above the mean when compared
to a non-clinical sample. Her symptoms of depression fell within the range of “borderline clinical depression” according to the six levels of depression interpreted by the Beck Depression Inventory. Kate was also administered the EDI-2, a self-report inventory normed on college aged women that measures both eating disordered symptoms and other characteristics that are often associated with a clinical eating disorder. Kate’s results revealed nine out of 11 sub-scores falling within the clinical range. These scores indicated that Kate experienced an abnormal drive for thinness and was extremely dissatisfied with her body size and shape. Also, that she tended to feel very ineffective in making changes in her world, tended to have unrealistic expectations of herself and possibly others in general, and had difficulty forming and maintaining trust in interpersonal relationships. These scores also indicated Kate had difficulty identifying and coping with her various emotional states, experienced unusual fear regarding the responsibilities and decisions inherent in becoming an adult, and tended to feel insecure in social situations. Kate’s sub-scores also indicated, however, that she was able to regulate her impulses relatively effectively. These results are consistent with someone with a clinical eating disorder as well as other co-morbid conditions such as depression and anxiety. Upon being discharged from Quest, Kate’s scores on both the Sheehan Anxiety test and Beck Depression Inventory showed improvement. Her depression was considered in the range of “mild mood disturbance” and her anxiety had dropped to the mean.

Over the course of treatment, Kate discovered that her parents, although good intentioned and loving, were not the perfect and always supportive parents she had falsely believed them to be. Her father, who generally appeared with somewhat muted affect,
was regularly absorbed in his work as a financial planner, gone from the home long hours. In general, his tendency was to be dismissive of his daughter’s and others’ opinions and feelings. Closer to her father as a young child, Kate avoided him as she grew older and became more intimidated by him. During her 20 years of living at home, Kate’s mother took in numerous foster babies to tend to until permanent homes were found. Initially in treatment, she condoned her mother’s actions. Later, Kate tapped into her resentment of her mother’s time and attention spent with all these babies instead of with her and her two siblings. By seeing her parents as infallible, it kept Kate from feeling how their actions had affected her over all those years. Once she took some time working with her anger toward them, it became easier for Kate to forgive her parents for their human frailties and imperfections. This allowed her to feel forgiveness toward herself.

The other issue that Kate began to recognize was her outright devotion to pleasing her mother. As she gradually began to open up in therapy, moving from everything being “fine” to the occasional complaint, Kate discovered her mother to be self-absorbed. She discovered how her mother was unable to hear her. Instead, by the client’s report, her mom would turn it into a discussion about her own process; as might be expected in a peer relationship rather than that of mother and daughter. By Kate becoming aware of just how enmeshed she was with her mother, it allowed her to begin to stand back and separate herself out. Kate started having her own opinions. She began to recognize her own needs. Although initially difficult for Kate to speak her voice, eventually she learned ways to deal with the discomfort of doing so. Her eating disorder no longer needed to take the place of her voice.
Toward the end of the treatment discussed in this study, Kate’s abuse of insulin abated and her eating habits had changed. Lunch and dinner became fairly consistent, but Kate still had difficulty regularly eating breakfast. She was still monitoring her desire to skip meals, but no longer needed to report on her intake. As she became progressively more responsible, Kate kept her increased weight gain within a normal range.

Kate had come to recognize the value that therapy had in her life. Kate’s therapy also helped her to realize she could turn to others for support rather than believing she needed to do it all herself. When she was pressured to decide on having an abortion, due to the limited timeframe she had in which to act on this, Kate discovered how her family and boyfriend were able to be there for her without judgment. Learning how to set limits was another benefit Kate derived from therapy. This not only included friends and family members, but her boss as well.

She addressed what she needed on a regular basis, and more easily questioned the other when tested. Her relationship with her sister remained a difficult one, but Kate continued to try working on it by inviting her sister to sessions with the family therapist long after she left Quest. She was aware her sister was important to her, and Kate had a need to resolve conflict with her.

Because of setting a limit with Mat over his marijuana use just two years into therapy, Kate ended up marrying a man who sought therapy on his own, quit using marijuana, and was still going to weekly therapy sessions when Kate and I ended our work together. Also, because she had worked so hard to improve her insulin use and food habits, Kate became pregnant for a second time, and I was able to continue my work with Kate even after she gave birth to a healthy baby boy.
CHAPTER 4

LEARNINGS

Key Concepts and Major Principles

A number of psychological concepts stand out from having worked with my client, Kate. I will begin with those from Omer, which include gatekeeping, imaginal structures, and initiatory experience. The concept of gatekeeping is described as “the individual and collective dynamics that resist and restrict experience.” ¹ Think of gatekeeping as resisting experience by these interjecting thoughts that distance the person from their felt-sense understanding of the event. Next, Omer defines imaginal structures as “assemblies of sensory, affective, and cognitive aspects of experience constellated into images; they both mediate and constitute experience.” ² Unlike gatekeeping voices that tell you not to trust or believe in the experience you are having, simply put, imaginal structures are the beliefs themselves in the form of images.

Omer says that “the term initiatory threshold refers to transitions that require a transformation of identity to complete and integrate.” ³ The complex and difficult experience of learning to pay attention to one’s inner world causes the initiate to be fragile and disoriented. This is especially true at this threshold, in that the gatekeeping becomes more pronounced. At this initiatory threshold the anorexic is not what she once was, and not yet who she is about to become.

This process of looking within is replete with what Omer calls “partializing and gathering.” ⁴ Omer’s concept of partializing and gathering can best be thought of as a
necessity in the transformational process wherein one shakes loose the old paradigm allowing a new lens to begin to develop. (Relevant to Omer’s conceptualization is Kalshed’s observation that integration of parts of one’s self is not possible without a process of breaking down the constraints of one’s persona.\(^5\)) The partializing and gathering process is one that requires caution because these imaginal structures are what have basically held a person’s being in place and allowed them to feel safe in the world. Thus, the feeling of safety can be stripped away.

It is not possible to do such transformational work without vulnerability. Although, like many of these concepts, vulnerability is multidimensional, the basic concept of vulnerability can be thought of as being open to or allowing oneself to be susceptible to experiencing the immediate feelings that arise, rather than suppressing or defending against them.\(^6\) Those with anorexia avoid vulnerability.

Similar to Omer’s theory of gatekeeping, Kalsched speaks of the protector that turns persecutory, victimizing its host.\(^7\) He describes how the host can be paralyzed by voices or thoughts from this aggressive, persecutory part. The anorexic has a mean, inner-critic or persecutor that keeps her tightly controlled and coveting perfection.

Woodman writes about the anorexics’ addiction to performing perfectly.\(^8\) She defines perfection as the goal-driven, achievement oriented part of oneself that obliterates the intuitive feminine aspect of one’s nature. Having been given the message that her feelings, thoughts, and behaviors were unacceptable, the anorexic unknowingly learned to hide her inclinations, desires, and yearnings. She does not trust herself. In her perfectionistic role, she can no longer trust anyone else either. Because of this, she develops a false pride. Solely left to her own resources the anorexic falsely believes she is
to accomplish and carry-out all manner of things herself. This set-up is defined as counter-dependency, another concept relevant to anorexics described by Janae B. Weinhold and Barry K. Weinhold.\textsuperscript{9} This counter-dependency dissolves as one becomes more aware of their unmet needs and no longer hides, denies, or ignores them.

A major principle of anorexia is that the anorexic is stuck believing that her life will be better if she continues to work hard at staying thin. Failler addresses the symptom of thinness, as do many other popular authors such as Bruch, Brumberg, Chernin, Costin, Coward, and Hesse-Biber, to name a few.

A number of additional principles about anorexia and the treatment of anorexia will also be useful in describing the work with Kate. The significance of somatization is written about by Sours, saying that the defenses and coping mechanisms of those with anorexia remain infantile.\textsuperscript{10} Thus, they are subject to taking on the undigested and unconscious emotions of others more easily. Winnicott points out that those who have not developed good coping strategies, have pent-up feelings that become expressed psychosomatically, or through the body as various physical symptoms.\textsuperscript{11} Those with anorexia demonstrate this point.

Another important concept from Winnicott is that of the false self.\textsuperscript{12} When a parent has the final say on how the child should look, what the child should say, how the child should think, and how the child should act, the child develops a façade that ultimately defines who she thinks she is. This costume or mask becomes so in-grained, the child forgets how to be her authentic self. She unconsciously fears rejection without her mask. The good and obedient mask of the anorexic gives such an example of the false self.
Another principle relevant to the anorexic is that she is numb to her feelings. Waller, Corstorphine, and Mountford identify this as being “emotionally inhibited.” 13 Normandi and Roark believe that the client’s capacity to be with, to feel, and to express intolerable feelings is directly related to recovering from her adversarial relationship with food.14 The anorexia has become her defense or coping mechanism that keeps her feelings at abeyance.

What Happened

While working with Kate over the course of nearly five years, there were many things that happened which were significant. However, four defining moments in particular created shifts for Kate that are relevant to the learnings of this study. The first was when I discovered her propensity to lie. Kate had developed a habit of lying with regard to her health, her eating habits, and showing up for our appointments. At first I did not notice Kate’s lying. However, as more was disclosed and I started to notice discrepancies, I began to notice that the lying was more significant than just the occasional lie. When she disclosed how she had lied to emergency room doctors, I started to see the big picture of how lying had permeated the rest of her life and relationships.

The second thing of significance was about Kate’s dogged resistance and determination to appear strong and put together to the outside world. Not only did this show itself through her impeccable attention to her clothes, makeup, and hair, but also through a ‘look’; a rather piercing glare in fact. Through her consistently sarcastic attitudes and responses, and her intense glare that in capital letters said, “STAY AWAY,” Kate worked hard to keep up the façade of strength and perfection. This was no less true
in the therapy which meant that Kate did not want to cry or become emotionally affected. She worked hard at being nice and polite and well put together, but anything close to a challenge or questioning caused her to become gnarly and prickly.

The third significant shift occurred during Kate’s course of treatment while attending the Quest I.O.P. Eating Disorders program. During this time, Kate began noticing her anger and speaking her mind. Her parents were upset because they were spending their hard-earned money on the program and all Kate was doing was getting angry. Kate reacted to their disapproval and announced that she was quitting the program, applying for jobs, and moving on with her life. Though she continued in individual therapy with me, I did not confront her about the way that she slipped back into the façade of perfection in order to please her mother and father.

Kate’s unexpected pregnancy, followed by a rather traumatic abortion, created a watershed for her. It opened a door for her to begin to envision possibilities and take note of her reality. Her loneliness surprised her. She noticed that she would binge in the evenings and use the TV to numb out. She started to take more heed in the things that she had learned from the dietitian. She agreed to have breakfast and stuck to it which helped her eat more consistently throughout the day. She realized that she did not want a boyfriend who smoked marijuana everyday because someday he could be the father of her child. She saw the benefit of setting limits for herself and for others in relation to her.
Imaginal Structures

How I was Affected

Initially, when Kate would cancel our appointments, I would be disappointed. Even so, I gave her the benefit of the doubt and did not want to question how she might be manipulative or dishonest with me. Instead, I wanted to believe that she felt safe enough to disclose why it might be so difficult to show up for therapy. In effect, I was lying to myself just as she was to herself. After a few cancellations, I began noticing how on the day of her appointments I would become apprehensive, wondering if I was going to receive yet one more voice mail. Some internal sarcasm would emerge just prior to realizing I saw her cancelled sessions as my own personal flaw. Possibly something I was doing wrong, rather than her own patterns and challenges needing to be met and worked with, or a combination of both. I had been dismissing that it affected me, and pretended, as she did, that things were as she stated and that her reasons were valid.

There was one way in which Kate would respond that was especially difficult for me, and eventually became known as “the look”. She had a penetrating glare that would pierce through me, making my chest tight for a moment as I would try to rebound from the silent assault. A feeling of fear would arise in me coupled with the momentary feeling of wanting to engage in battle, even though there would often times be a feigned smile on her face immediately following her glare. Her smile was confusing for me as I would literally be left with a physical feeling of a sharp piercing in my chest. In this spot, my breath would get stopped and stuck, as if a stone edifice suddenly blocked it from moving any further. As I faced that glare, a tightening and contracting sensation happened in my
upper body. I was cut off from the chest down, leaving my breath with a limited space to move. There were a few times I experienced a fight or flight reaction, feeling filled with shock and fear.

After the unexpected pregnancy and abortion, I was concerned for Kate’s psychological and emotional well-being. To my surprise, she used this new information as a way to refocus on her own health and future. When Kate moved into her own apartment, I was feeling some relief, and also encouraged by her willingness to take action in her own best interest. Not only was I surprised and pleased to witness such a breakthrough for Kate, but skeptical at the same time. Because Kate’s life had endured so many crises, I sometimes felt I was holding my breath, waiting for the next one to occur. It seemed to play out that every step taken forward would often times find us turning a corner and stepping into yet another abyss. At times I would find myself sitting poised in my chair, anticipating the worst. I felt a pressure to keep up with her insulin use, her weight, how she slept, and other tangibles of her life. Simultaneously holding the appreciation for the work she was doing along with the skepticism was tiresome. At times, it was seductive to just go along with the part of her that said “everything was fine.” This momentarily relieved me of the pressure that was inherent in her situation. I found myself wondering if this was the same pressure she felt to perform and have her life looking like it was going “just right.”

When Kate announced she was leaving Quest, I was stunned. However, I did not let Kate see or know of this. I was aware of the fact that Kate’s father had announced his disapproval about all the money that they were spending and her lack of progress. A confusion started rambling around in my head as I tried to make sense of these things. I
had been raised in a struggling working class family and I had a strict value pertaining to money. I felt guilty charging my client and taking their money for this expensive program, an astronomical $1,000 a week! I noticed how I wanted to support Kate and was not quite sure what that looked like. Second guessing her would have been how her parents handled things, which left Kate with a tremendous amount of self-doubt growing up. My intent was to assist her in her process, and I did not have enough distance to know quite how to do that. Like a runaway freight train, I was caught up in the momentum, unable to take a breath and observe what was happening. I found myself blithely going along with all of Kate’s “progress,” giving reason to leave the I.O.P. program early. Energetically, I felt an inward disturbance that seemingly had wings of its own with which I was unable to disengage. Being swept up in this felt as if something else was making decisions for me, as I found myself agreeing with things that did not feel congruent.

My Imaginal Structures

As I have reflected on my work as a therapist I have realized that my imaginal structures as discussed by Omer, define how I see things and inform how I look at things. They inform my opinions. These imaginal structures do not allow me to be with a client in the purest sense but rather in ways that are colored by my own life history and experience. Often times in my body, I will be informed by my somatic responses, as both Sours and Winnicott note. Imaginal structures clue me into what sort of gatekeeping voices, that Omer talks about, might be present. These gatekeepers speak the false beliefs. This points to where I might be judging or trying to make things go my way
rather than be present for the client. Checking in with myself allows me to notice my internal agenda that keeps me from being present with how things really are. Imaginal structures want things a certain way and try to make things be that way.

In reflecting on my work with Kate, I began to realize that an imaginal structure of mine about being special was at play. For example, if I confronted Kate on her pattern of lying in order to miss therapy appointments, I would have to admit she was doing the same thing with me as she habitually did with others. I was no exception then and certainly not the special therapist I unconsciously wanted to be. Like a proud mother, I wanted to show everyone what a good therapist I was by how well my client was doing. I knew that Kate had had a number of short-term failed attempts with other professionals and I wanted to be the one with whom Kate would be successful and forthcoming and able to continue her therapeutic work.

The roots of this imaginal structure began early in my own history. Spending a lot of time working with my father around the house on maintenance projects, automotive projects, or yard projects, formed a close bond between the two of us. But unbeknownst to me, my father had a number of affairs over the years and I took on the appearance of the “other woman” in my mother’s eyes, and bore her wrath for all of the other women. Like the myth of Hera and Zeus, I had unknowingly entered into dangerous territory. My mother was especially rigid, mean, and punitive with me. She hurled her abuse in my direction when I least expected it and without prompting. As my mother scapegoated me, I unconsciously worked hard to stay close and special to my father in order not to be ostracized from the family entirely.
Another imaginal structure that arose in my work with Kate was about doing the right thing. Kate’s glare, “the look”, was a reminder to me of my mother’s glare, that black-eyed, almost demonic look that said so much. . . . “Don’t get out of line. . . . Don’t say the wrong thing. . . . Don’t you dare. . . . Don’t ask questions.” While growing up, I was often a repository for my mother’s litany of undeserved reprimands. Because of these gatekeeping voices, Kate, in effect, became my own mother standing there piercing me. One way that I dealt with this experience was to always try to do the right thing. There was an urgent and vigilant need not to get out of line.

Sometimes the response to the gatekeeping would be colored by a different imaginal structure. Just as I became paralyzed by my mother’s glare when I was a child, so I would become paralyzed by Kate’s defiant stare. The old false beliefs with my mother’s words attached would emerge, silencing me as well. Not only would the “do the right thing” structure be present, but also another imaginal structure actively had me believing that if I ignored it (whatever might be scary, terrifying, or untenable), it would most certainly go away.

Roots of the imaginal structure that ignores the untenable go back to my relationship with my mother. Her lecturing and yelling and blaming was so thick and so heavy, I would just tune her out. I would do everything I could to stay perfectly still and wait for it to end so I could just walk out of the room before she could get at me again. She also physically abused me and there was always the fear that verbal abuse would turn physical. My efforts all went to contain, contain, contain, so I could get through the moment. I could hear myself thinking, “If I don’t hear what she is saying I can hold it
together, I can just stand here. I won’t make things worse that way. I won’t get in more trouble.”

The need to do things “right” was a serious issue in Kate’s house, as it had been in mine. Paradoxically when Kate turned a corner, I would find my own internal imaginal structure that was highly skeptical. This unconvinced part of me would question everything. Then, it would anticipate the worst. From this structure, there was a great burden to bear and it was exhausting to do so.

This skepticism served me as a child, helping me stay alert in a predictably, unpredictable environment. Memories of walking home from school surface, wondering what sort of mood I might find my alcoholic mother in. I learned to expect the worst at a young age. It would perplex me that I could so easily become the recipient of her rage attacks. Unknowingly, an innocent look or word was enough to load the gun. The erratic, volatile environment included the actions of my father as well. Although I was never the recipient of his terrifying rage, it was alarming to witness. I always feared that someday it could veer my direction; even accidentally. I was precocious enough to understand early on to watch out for myself, and vigilantly contain everything I could around both parents so as not to get into trouble. Not only did this include my words and actions, but my thoughts and desires as well. I learned not to need anything, except for the need to be prepared. Since situations could easily turn from good to awful, the imaginal structure that came into place would say, “Hey, we can’t trust this situation . . . so let’s not get fooled.” As a result, the hyper-alert skeptic was never too far to be found, and when least expected, even sitting face-to-face with my client in the therapy room.
The exhaustion of this imaginal structure took on a very somatic heaviness throughout my body, making me want to bring a pillow with me wherever I would go, and feeling as if I could not keep my head up. The one identified with this imaginal structure just wanted to lie down and sleep. In fact, the fatigue felt so real that I often wondered if I was coming down with something. This imaginal structure tried to convince me that I needed to call in a substitute to facilitate group work, and on a rare occasion, I did. Ironically, I began to notice that when I led group despite these feelings, about halfway through the group session, I would notice feeling that the heaviness had dissipated.

Confronting my imaginal structure around money has always challenged me. I struggled with money in my own life, and then all of a sudden, here I was dealing with clients about money. Innocently going along my merry way, it hit me hard when I was confronted with the fact that Kate’s family was spending $1,000 a week and that her intimidating father did not like it. Seeing through the eyes of this imaginal structure, I agreed that Kate’s father had a legitimate complaint. It was a conundrum about how to measure progress in terms of money. The gatekeeping voices would join Kate’s father in his queries: “His daughter was getting angry so how could she possibly be making progress? She was supposed to be getting better. She was challenging them, she was confronting them, and she was angry… and angry didn’t mean better to him.”

From this imaginal structure there was an impulse to hide because of how much money Kate’s family was investing in the program. The work that I was doing felt like it did not have tangible value. From this structure I had to justify buying anything, and certainly did not deserve to spend money. Likewise, it was hard to receive money without
deservedly earning it. Growing up, my mother told me that if I were to ask for anything in the grocery store, she would send me to the car. Being the obliging child that I was, I never asked. This imaginal structure says, “I can’t have anything. I can’t ask for anything. I can’t spend somebody’s hard earned money. We don’t have money to be throwing away.” Another image related to this imaginal structure is that my birthday was right before school started. It was only then or at Christmas time that I got a few new clothes, including socks and underwear. Everything had to be practical, nothing frivolous. These clothes had to last without attention to what my body was doing. I remember wearing shoes at about eight years old that made my feet bleed. My mother just told me to put band-aids on the wounds. The “value” I learned to place on money was excessive, and in this particular case with Kate, kept me from confronting the real issue at hand.

These are among the imaginal structures that shaped the ways that I saw and responded to Kate. I was surrounded by a wealth of heartfelt people including my supervisor and a highly accomplished staff, which helped me develop disciplined psychological practices in relation to my imaginal structures. Yoga and meditation practices also supported my ability to be present with my client and myself, gatekeepers, imaginal structures, and all.

**The Client’s Imaginal Structures**

Kate had a tremendous amount of anxiety related to showing up for therapy. Just as I had an imaginal structure about not making any mistakes, she had an imaginal structure about doing things perfectly, which applied itself directly to wanting to do therapy perfectly. In fact, this imaginal structure lied in its attempt to cover up how it felt
it was failing to do things perfectly. Woodman speaks of this perfectionistic tendency in anorexics. Because of this perfectionism, Kate tried to prove to me, week after week, that she was doing it correctly and making progress. Imagine the amount of pressure Kate might have felt with both of us falsely believing we could make no mistakes!

Therapy though, can sometimes be rather messy, and in Kate’s world, this imaginal structure allowed no room for “messy.” It wanted only to be seen as the perfectionistic but actually non-existent person. Kate was after progress, and the way this imaginal structure defined progress did not allow for any falling apart. Vulnerability though, is key to making progress as pointed out by Roth. Falling apart, or any sorts of feelings that might end up leading Kate there, were considered messy and wrong by her. According to this imaginal structure, being perfect meant not having feelings, or at least, being able to contain them if she did. In fact, from the perspective of this imaginal structure our session was “a waste of time” if Kate spent it being angry or sad, and “not getting anything accomplished.” Because of the inner turmoil that led her to therapy in the first place, Kate tried to keep everything neat and tidy and under control in her outer world. To the contrary, my definition of progress included the ability to fall apart and express repressed emotions. My definition included being vulnerable. So when Kate began feeling her feelings, gatekeeping would arise and would berate her by saying she was out of control and weak. Then, unconsciously under the gatekeeper’s influence, Kate would find a way not to show up the following session.

Kate’s gatekeeper made Kate believe she was weak if she showed her feelings. Another strong imaginal structure that frequently showed up was the one that distanced her from others with that piercing glare I’d come to know so well. From this perspective
of the imaginal structure, she had also perfected a cold, false smile that was used interchangeably with the piercing glare. Either way, the mask or façade Kate had perfected was tied to keeping me and others at arm’s length. Winnicott describes this artificial façade as the false self. The purpose of all this was to keep others from feeling warm and fuzzy around her, so in-turn, she would feel less vulnerable. The unconscious goal was to avoid vulnerability at all costs. This imaginal structure kept Kate defensive. It was cool and distant, and often glaringly sharp in its attempts to keep me away from her vulnerability. The less vulnerable she felt, the less likely difficult feelings might emerge.

Kate’s actions suggested that her internal structure was saying, “I really don’t want you to see me. . . . I don’t want to fall apart. . . . I don’t want to feel vulnerable. . . . I can’t receive your acceptance of me and my feelings. . . . I don’t know how to be with my feelings, and don’t trust that I can.”

I came to understand that there was an internally demanding, stern, and strict taskmaster form of gatekeeping that took over Kate’s ability to respond consciously to others. Instead, it turned everybody and everything into a bull’s-eye for her sarcasm. In turn, she experienced sarcasm from others when it was not intended as such. Her internal gatekeeping not only kept her emotionally inhibited, as noted by Waller, Corstorphine, and Mountford, but was divisive in her relationships with others as well. Kate was unaware of these coping strategies that had worked to keep her numbed from her feelings and distanced from others for a very long time.

I recognized how the therapy was having its effect on Kate when she started bringing more of herself into the room. The defensive imaginal structure that had Kate glaring or smiling coldly, would give way to tears. I would then run up against the next
defensive structure about being weak. This one declared that Kate could not appear weak and had to figure out how to do everything on her own. In this imaginal structure Kate did not want anyone to feel sorry for her. There was a gatekeeper tied to this structure that thought being empathic, even if coming from me, was coddling and wrong. It had Kate believing this would not allow her to work through her difficulties. It was the angry gatekeeper’s way of saying, “Don’t trust empathy.” Sadly, Kate had learned to associate weakness with vulnerability. The real message underlying this false belief stemmed from Kate’s deep fear of really feeling understood and being seen, unlike what her parents were able to do for her. Hence, the imaginal structure was in place as a way to protect Kate from falling into her vulnerability; a tenuous place she had learned to avoid at all costs.

This façade Kate learned in childhood protected her and allowed her to cope with her intolerable feelings. If Kate could begin to let me in, I could be there with her in those moments when her challenging feelings might arise. The difficulty would come in trusting that she could be in that young, vulnerable, raw place, where all the pain was stuffed from those moments of betrayal, and not have someone try to talk her out of it or make her wrong. Because she had not yet had that experience, it was too difficult to trust, so instead, the anger would come in to protect her as Kalsched described. The part that originally helped her to cope eventually became this persecutory voice. Although it suited her while young so that she could survive her household, it eventually became this derogatory persecutory part that held down what was going on energetically inside of her.

Kate’s strident attempts at proving she could do it all herself had, in actuality, propelled her into becoming very co-dependent. This tug-of-war between co-dependency
and counter-dependency is written about by Weinhold and Weinhold. The harsh
gatekeeping that led Kate to believing she could not trust others held in place an imaginal
structure that kept others out. This imaginal structure carried a false pride that had Kate
believing she had to do it all herself. Kate’s history showed she was not aware of her day
to day needs. Because of this lack of awareness, Kate was unable to ask for help from
others that she actually needed. Unable to take care of her own needs, and unable to ask
for help, she would eventually be overwhelmed and end up in the Emergency Room.
There, she was forced into a situation where everything was taken care of for her. Her
loved ones then understood how inadequate her self-care skills actually were and would
implore Kate to let them help. Yet, her imaginal structure persisted, having her declare
emphatically how she did not need to be there and did not want others’ help.

This imaginal structure about doing it all by herself worked in tandem with the
imaginal structure of co-dependency. Even while Kate could be so stridently counter-
dependent, there were other times when her co-dependent imaginal structure would take
over. Kate’s boyfriend Mat was one caught in this co-dependent web. Because he
appeared in general to be a stabilizing influence in Kate’s life, Kate was afraid of
bringing conflict to him, as she was with so many others. Her gatekeeping voices told her
she could not handle her feelings if Mat, or others close to her, were to become upset or
angry with her. She might feel wrong or bad about herself then, and might think she was
unable to cope with her own intolerable anger in return. Consequently, afraid of being
rejected, and ultimately alone, Kate would become chameleon-like in her actions, trying
to please Mat at all costs even though her guesses on how to do so were often incorrect.
This co-dependent structure would not allow Kate to be in touch with her own needs. As she became stronger, Kate began setting up her life more in accord with what she wanted for herself. The co-dependent imaginal structure gave way as she articulated her needs and desires.

I became aware though of another imaginal structure that made Kate believe she had to stay thin at all costs, as outlined by Failler and others. As Kate began to make progress about her needs, she also began to consciously experience self-sabotage. This imaginal structure had such an influence over Kate, she would severely abuse her insulin use in an attempt to lose weight, forego eating throughout the day, and drink substantial amounts of caffeine drinks in an attempt to stave off her hunger. However, self-sabotage came through in relation to her boyfriend as well as her relationship to her diabetes self-care. It came through with her neglectful restricting habits and by not taking her blood sugars. It showed up when Kate admitted she did not even know where her glucometer was, and when she neglected setting up logs. This self-sabotaging imaginal structure confused Kate. She would say, “When I found out I was diabetic I was the model patient. I brought detailed charts of my progress to the doctor. Now, however, I can’t trust myself to follow through anymore.” As an example, we had agreed that Kate not work so much, yet she would hear herself disgustedly saying, “I would try to set up limits so I would not work overtime. Yet as the work hours ticked by, I found I couldn’t even be accountable to my own agreements with myself.” The saboteur seemed to be around every corner she turned.

So when Kate told her boyfriend Mat that she was unable to see him any longer if he continued using marijuana, I questioned if she could sustain setting that limit. I
worried about the effects that self-sabotaging might have on this situation related to Mat. I believed Kate was not yet grounded enough in her own life. Since Kate’s imaginal structure undermined her best intentions and left her in confusion, I did not know how long she would be willing to maintain this boundary before going back to what was familiar. I found myself wondering how she could be making important life decisions on her own if she was still so confused about this self-sabotaging structure.

The life event of recognizing that she could indeed become pregnant was a true turning point for Kate. The work of the therapy supported Kate in allowing space for the “I want life” imaginal structure. I was relieved in our work together to finally see this imaginal structure appear. This helped to allow Kate to more easily take action in her own behalf, and begin to substitute healthy habits where she had once been neglectful in her self-care. This same structure was the one that allowed her to be clear with maintaining the limit with Mat, feeding herself more consistently, extracting the television from the bedroom, and regularly using her insulin no matter what it meant with regard to pounds she might gain. It allowed her to go out and buy new clothes after she gained weight and not save the old ones. This “I want life” imaginal structure was a true blessing.

New Learnings About My Imaginal Structures

My personal imaginal structures about perfection, not making mistakes, and about being special helped me to see Kate’s similar structures. It allowed me to see her actions with compassion rather than criticism. It also allowed me to be more compassionate with myself and understanding of the pull I was feeling to perform perfectly as a therapist. The
reality is, I did not want to be performing, so could start to inwardly chuckle at myself when pulled to do so. It also opened my eyes to how messy doing therapy can actually be. Instead of berating myself, I began to take each session and see what I could learn, and move into the next session with greater awareness and understanding. After all, it is through relationship that we have the opportunity to see more deeply within.

With this awareness about how “the look” was affecting me both somatically and affectively, I would generally find myself just trying to consciously breathe and create space in my body. It took a real cognizant effort on my part to be willing to move closer to the glare, and actually give it permission to be there, without pushing it away. The internal stone edifice would crack more and more with each successive, conscious breath. This attentiveness to my breathing helped me to be more aware and present with the feeling instead of running from it. This presence also allowed me to be inquisitive with my response, rather than saying something that might otherwise shut her down. All of this made it easier for me to outwardly acknowledge that she was feeling angry. I continued to feel a tension though, anticipating that she might blow up at me, and was left feeling uncertain as to how I would deal with that.

Since this realization, I have brought greater awareness to my work with defiant clients and those who are angry or rageful. This sort of client can unexpectedly attack via verbal outbursts or through body language. I have learned that their contempt, defiance, and anger are generally reflecting the difficulty they are having in letting others affect them. It is hard for these clients to let others in, as they have been wounded by those close to them somewhere in their pasts. Often I have found how distrusting these clients can be toward others, myself included. My capacity to tolerate that distrust and sharp
anger has been increased, informed by my conscious work with Kate’s glare. I have also learned the necessity of setting limits with these clients so that both of us feel safe in our work together.

My relationship with my own internal skeptic has changed as well because of so closely looking at my work with Kate. Tending towards being naïve and gullible over my life, I have come to appreciate that this imaginal structure helps me to question things, and not necessarily take things for face value. It is when I get lost in its story that I become weighted down and depressed. That, in turn, has taught me to ask for help from others, rather than stoically believe, as does another imaginal structure this has led me to, that one rises above all this by “pulling oneself up by their bootstraps.” I will name this one the imaginal structure of rugged individualism. Although to a great extent I have worked with my tendency toward counter-dependency, it was not until this writing that I became so aware of how closely tied together these two imaginal structures really are.

Being unconsciousness about the imaginal structure about money, gave away all my power to it. Through my own therapeutic experiences I have come to deeply appreciate the value of therapy. Yet when faced with having to put a label on the tangible value it was giving Kate, I was stumped. I didn’t know how to mirror back that therapy is expensive and that the results produced are not formulaic. Living in a world where an aspirin can relieve a headache within minutes, and technical gadgets connect us with information or people instantaneously, has its impact on client expectations. I have since learned how to approach this logically with clients, where I am better able to point out progress that otherwise can so easily be overlooked session after session. I also recognize that it is an individual process, not to be compared with others or put onto a timeline,
measuring one’s progress linearly as our brains would like us to believe. When a client has learned to distrust her own intuition, trusting only the “should’s” and “should not's” being externally fed to her, coming back to know herself can be painstakingly slow. And ultimately, the healing process cannot come from a textbook. As with my own therapeutic work, working with Kate has allowed me to appreciate the laboriously difficult process of coming back to oneself wholeheartedly. And yes, although eating disorders can be very expensive per-se, I now have a very different comprehension of this reality.

**Primary Myth**

Ding, Dong! The witch is dead!
Which old witch? The Wicked Witch!
Ding, Dong! The Wicked Witch is dead!15

The Wonderful Wizard of Oz is a delightful American fairy tale written in 1900 by L. Frank Baum, and made into a movie by MGM in 1939.16 It depicts the life of a Kansas farm girl named Dorothy who has become disenchanted with her life, wishing for something more. She and her beloved dog, Toto, are blown away in a tornado. Their house comes to rest in the Land of the Munchkins situated deep in the Land of Oz. When the house lands on the Wicked Witch of the East, Dorothy has unknowingly killed the ruler of the Munchkins, making the Wicked Witch of the West ragingly vengeful. In an attempt to find her way home, and with the blessings from Glinda, the Good Witch of the North, Dorothy and Toto begin their journey in this strange land down the Yellow Brick Road. Here, she meets some very unusual characters that join her in her search for the Wizard of Oz in the Emerald City, the one who may be able to help her find her way back
to Kansas. Before doing so though, she is met with some dangerous challenges she must first overcome.

The initiatory experience, or any path of self-discovery, is strewn with numerous difficulties and obstacles. In The Wonderful Wizard of Oz Dorothy finds herself chaotically thrown into a strange and unusual experience, beyond her normal state of reality. Arriving with a thud in the Land of Oz, Dorothy saw and experienced things differently than ever before. The sights, the sounds, and the things people said were confusing and initially mystified her. She innocently faced a challenging and arduous journey that lay before her. And so it was for Kate when she set foot in my therapy office. She did not know what to expect. She did not know who to trust. She did not know what to do or where to go. All Kate really knew was that she was dissatisfied with her life and her exhausting hospitalizations and wanted something better for herself. At the onset, her eating disorder was her Toto, the one precious thing she could count on that was familiar and could comfort her in times of distress. However, the eating disorder eventually became a dodgy saboteur, isolating her from her process of self-discovery. Like Dorothy who had not yet discovered the comforts of her own internal peacefullness, Kate was about to embark on a journey to do so.

Week after week, and month after month, Kate would put on her Ruby Slippers and we would walk the Yellow Brick Road together, confronting those things lurking in the shadows that were too difficult to do alone. Dorothy’s magical Ruby Slippers helped to ground her, as they were the means to eventually return home to herself. This was symbolic for the therapy room for Kate because it became the means for reintegration of those split off parts of herself. The comforts of the known were left behind in that room
as we ventured on this “Yellow Brick Road” of consciousness into the darkness of the unknown. Like any initiatory experience, hers was filled with adversity and difficulty. I was asking her to give up her battle with insulin use as a way to control her weight. Abusing the insulin also served to distract her from her intolerable feelings. It was as if I was asking her to retrieve the Wicked Witch’s broomstick. How could one even consider such a formidable task? Yet the good girl who behaves according to outside influences must own and come to terms with her dark side, least she never find her way back home.

The diverse characters Dorothy met along her journey were representations of parts of her unconscious. Looking inward can be confusing; and so it is by seeing how others from the outside affect us, we are schooled about what resides within. Her inner wisdom could only become accessible when she could see how she was viewing her life internally from those things she stumbled across externally. When Dorothy came across a talking Scarecrow, she saw a bright but helpless and confused creature stuck on a pole and unable to move freely about. Bringing this metaphor to my client Kate, she too was stuck rigidly in her maladjusted defined roles, and despite knowing she was intelligent, felt helpless as to how to escape or change. She believed, as did both the Scarecrow and Dorothy, that if somebody else could give her the answers, her life would retain the order she longingly desired. Then everything would be okay.

The next character that Dorothy came across was the rusted Tin Woodman, otherwise known as the Tin Man in the 1939 MGM film. Once his oil can was discovered, and his limbs and other moving parts were re-oiled, he was able to speak to his need, his longing, and his deep, deep desire to have a heart again. It seems he was once a man of flesh and blood, but an old witch put a spell on his ax which then turned on
him and repeatedly attacked him. Eventually his whole body, part by part, had to be replaced with metal. Tragically though, the tinsmith forgot to give him a heart. Similarly, when Kate came to me, a disconnect occurred between her head and her heart. These blocked feelings had made her body tense and stiff. Her outer shell was hard and tough and mechanical. She had become armored, like the Tin Woodman. What Kate did not realize, is that she had come to therapy to find her heart again.

Dorothy is horrified when she comes across the Cowardly Lion who attacks her little dog Toto. Because the lion is so big, and Toto is so small, Dorothy reprimands the lion for assaulting and frightening him. Admitting that he is nothing more than a Cowardly Lion, he begins to cry, lamenting about his feelings of inadequacy when he is supposed to be King of the Jungle. Kate, too, was frightened; terribly fearful of what people would think of her and that she might appear to be doing her life the wrong way. Kate’s similar lack of confidence produced a false bravado. In her efforts to compensate for this lack, she would lash out to protect herself from feeling any vulnerability. Her own fears created insensitivity toward others. Kate discovered it was not courage that she lacked when she began to face up to her own arrogance and other distancing manipulations.

The Wicked Witch of the West was threatening and dangerous to Dorothy and her companions. Her mission was that of power, and to get the magical Ruby Slippers off of Dorothy’s innocent feet. She would go to almost any length to accomplish this task. Her shrewd and devious ways left the four travelers ill-at-ease, anxious, and jumpy. They never knew when or where the witch would strike next. The Wicked Witch represents the struggle Kate had in coming to terms with her internal shadow elements; those things she
found least desirous about herself. These denied and ignored parts of herself had taken on a destructive force in her unconscious. Kate became a prisoner to her own shadow. She was overwhelmed by the crippling and damaging energy from within, that she could no longer control, and which was ruining her life. It was only by accepting and coming to terms with these foreign and unwanted parts of herself that Kate was able to consciously change her responses.

The four traveler’s reach the Emerald City, hoping to receive from the Wizard of Oz what they have gone searching for; brains for the Scarecrow, a heart for the Tin Woodman, courage for the Lion, and returning home to Kansas for Dorothy. They are shocked to discover they must first pass the Wizard’s test. They must retrieve the Wicked Witch’s broomstick! The treasures they hoped to claim could only be received by accepting this heroic journey put before them. To return home, Dorothy must first face her repressed anger, fear, and insecurity to recognize her inner strength and truth. She and her companions are confronted with moving into unfamiliar and exceptionally challenging territory, just as I was in working with Kate. Often I would find myself feeling relieved when Kate had an insight or shift of awareness, and then discover another unexpected disaster or crisis at hand. I would falsely believe she and I had gone through enough, only to be tested again and again.

Despite much effort and many disappointments, by persevering along the Yellow Brick Road together, Kate’s vulnerability and kind-heartedness began to shine through. Her sensitivity to her inner world was being fueled by her willingness to look at and be with those disturbing dark places within. Her ability to tolerate uncomfortable feelings was allowing her to be present with herself and others. Just like Dorothy, as Kate was
turning toward her challenges, she experienced greater self-acceptance and was
developing an understanding of what it metaphorically means to return home.

**Personal and Professional Development**

Working with Kate gave me the opportunity to get to know myself more deeply.
 Every time I would tend to my internal somatic reactions while seated across from her, I
became more informed about those places within. Every time I would note what words
responded from my lips, I would touch upon yet another piece of myself. And every time
I noticed my thoughts, my insight would intensify. My expanded curiosity began to
surprise me when Kate would throw her punches and I would no longer see them as such.
I realized I was no longer threatened by her highly charged responses. Instead, I was
inquisitive. And because those piercing arrows no longer felt wounding, I could relax
more and be compassionate with my presence.

I found then, that rather than being inclined to follow Kate’s overindulgent
storyline, (like a binge) I would begin to openly question the subtle expressions that had
just crossed her face. I became familiar with the grimace or frown, or piercing glare that
at one time may have deterred my questioning. The eye-rolling no longer insulted me, but
instead, became a signpost pointing to an unexplored feeling just waiting to be noticed. I
found courage to be with formerly dangerous territory. I am now grateful to be less
afraid, but more respectful of those dark places and their potential dangers. It was a relief
to find myself becoming more and more trusting of going into unknown terrain. Little-by-
little, the elasticity to separate myself out from taking things personally appeared; all of
which allowed for the process to deepen. Of course, these learnings have not been limited to the therapy room and my work with Kate.

I now find I can consciously work with the internal need to be right, or to show how smart I am, for fear of being seen as less than credible. There has become an increased capacity to forgive myself when I find I am projecting these falsehoods onto others. I like people more and are less threatened when I do not know what to say or do. Finding words to express my experience has been difficult for me. I am learning to trust that the necessary words do come if I wait. I am learning to speak up, and then, learning to speak only what needs to be spoken.

As an example, I am recalling a recent phone conversation with my older sister of eight years. Growing up, she helped to shield and protect me from my mother’s violence. She became my voice, so it has always been difficult to express my own voice around her. Also, she tends to be very opinionated and protective of such. Both she and my older brother maintained a fairly antagonistic relationship with my mother until my mother’s death. I did not, as I had learned to take responsibility for my reactions to my mother rather than placing the entire onus on her. In responding differently to her and letting her know when I was not feeling respected, our relationship changed. When I heard my sister lamenting to me how horribly my mother treated our brother until the very end, I found the courage to speak up. I pointed out that although my relationship with mom had also been oppositional in the past, I learned to respond differently to her: thus, was no longer treated disrespectfully. Surprisingly, she agreed. I was able to confront the part of her that colludes with my brother.
Applying an Imaginal Approach to Psychotherapy

The interpersonal experience of the therapy is touching the patient deep inside his soul, and it is there, in the dark, that important changes are occurring, not in the problem-solving content of the hour.17

One of the most difficult concepts to absorb about the Imaginal Approach is that it is not goal oriented. Instead, it is process oriented. And without an agenda in hand, a therapist often times feels at a loss. It is who I am with the client that ultimately matters; not what I say.18 Looking more closely at this, it does seem absurd to want to be hurrying a client along. Where would I want them to be going? Who am I to think I know what is best for them when their separate, human experience and undertaking is different than mine? And ultimately, the end is death anyway; so why rush it? Besides, not all things have a tangible answer. Just as feelings are intangible, so is the Imaginal Approach.

Generally, with the experience I have in not only working with clients and groups, but in my own history of personal psychotherapy and group work, I will have an understanding of the general direction the client may need to go in order to make some progress. My job though is not to superimpose any expectations onto the client. Rather, it is my job to wait and see what arises. The art of letting things happen is a difficult one. And yet, the unfolding process can be rich with surprise and intrigue. The experience itself is the point.

When using an Imaginal Approach, I must first value the fact that the client is walking through my door, thinking that I will know what to do to make things better for her. She is putting herself into my hands. She is asking me to honor and respect the very life she is handing over to me. With every word I utter, every nod or movement I make, she is being influenced, and I must be aware of the impact I will have on this person’s life
and treat this situation honorably. There is little room for being opinionated in this process.

It is not my job when using the Imaginal Approach to dissuade or encourage clients to see things a certain way. In fact, it is better to wait altogether for the insertion of interpretations, if any. If a client can come to some sort of understanding on her own, through my attentiveness and openness to her process, she is better off. And although I might summarize what I am seeing and hearing her say, it is not my job to tell her anything. It is my job to listen. As I listen to a client, I must then be aware of how they are affecting me. In allowing this to happen, a trust and reassurance develops. This allows the client to more readily drop into their own felt-sense experience. It is there, that the client will learn in the experience itself. I have found that intellectualism can impair, if not ruin, this process.

As simple as this approach sounds, it can be a very strenuous and grueling process. In fact, as Weaver points out, there is a great deal of failure in this work. But I have found that it is in the very acceptance of the failures, in the messiness of the chaos, and in the repetition of sinking into the unknown that the birthing of who this person was originally intended to be emerges. And that is the ultimate beauty of the Imaginal Approach. Bringing in the gift of sincerity and integrity, I become the midwife to the unfolding of the great mysteries that lie both within myself and my client.
CHAPTER 5

REFLECTIONS

Personal Development and Transformation

Most of my life I have been gripped by a fear of doing things the “right way.” Writing this clinical case study has been no exception. The problem with looking at things as either the “wrong way” or the “right way,” is that it leaves out “my way.” As I perused book shelves in prestigious and not so prestigious libraries, attended lengthy conferences and wordy seminars, and met and worked with a highly experienced staff and supervisors over these past few years, I came across clinicians doing it all sorts of ways. Although I have learned diverse theories and techniques, listened to varying views and opinions, and been privy to numerous beliefs and attitudes, I have ultimately had to come back to myself to see what works best for me, in behalf of my clients. Of course, learning from others has helped to inform and clarify what I am experiencing; and for this, I am grateful.

In studying and reflecting on my work with Kate, I have come to appreciate the courage that it takes for both the client and the clinician to walk into that therapy room week after week, and remain seated for the duration of each 50 minute hour. I have come to realize that as I subject myself to each client’s individual and unique experience, I continue to increase my own capacity to be with what is, rather than how I might prefer things to be. Remembering working with Kate’s piercing glare, I am amazed at the transformation that occurred. I recall experiencing the sudden arrival and immediate
takeover of feelings in her presence, often times left disoriented by the whole experience. And yet, by allowing myself to be metaphorically dismembered by the experience, while simultaneously observing it, ultimately changed something in me, as it did in her.

My attempt at coming to completion with this clinical case study left me at times, in dismay. I changed schedules, changed jobs, dropped responsibilities, and even stopped pleasurable activities. I angered friends and family. I humbled myself where I once had confidence, questioned my financial priorities, questioned my convictions, and lost trust in my ability to follow through. All my trying seemed exhausting, and at times I felt unrelenting despair. My competent, able-bodied self could no longer do what I had known it to be capable of. Furthermore, there was no explanation I could give to the outside world, as this was no longer about surface appearances. There came a turning point in this experience where I realized I was not wrong in how I had been doing this. I recognized how it was all happening as it needed to. And through all that, I learned about such things as the necessity of stillness and the rigors of waiting without knowing. I learned about the power of forgiveness. And I also learned some things about having a patience and tenderness for life as it is. I came to understand as well, should I ever forget these learnings, I know I will be reminded.

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

In my work with Kate, as well as in the work of creating this Clinical Case Study, my understanding of myself has evolved. Because of this, so has my relationship to the topic of Anorexia Nervosa. When I began to learn more about myself through my relationship to Kate, I began to know the character of anorexia with greater depth and
breadth. I could feel its very fibers. I could taste it. I could see more of the intricacies of how it is woven together to create the product that it creates; the anorexic.

One example of this deeper knowing is related to my own imaginal structures surrounding perfection, discussed in the Learnings chapter. I still know the voice of anorexia inside of me and this part had an influence on Kate’s therapeutic process as well as on the work of this writing. Anorexia always says, “You can’t make any mistakes. They want you to be perfect. You have to do it their way, not your way. Therefore, you need to sacrifice your way to please others.” I have come to better understand that the anorexic, having learned to sacrifice her own needs, tries to keep others around her happy. At all costs, she will speak what she feels needs to be heard, even if those words are spoken to her therapist. Her goal is to do therapy perfectly and be the client who does not cause any problems. She is a model client, even if it puts her life at risk. As was true with Kate, she did not yet understand the accumulated costs of living a lie.

Another very important element to what I now know about anorexia is related to how I work with clients’ anger and the gripping and unwitting meanness that can take over in the therapy. Earlier on in my work and before the deep reflection that this Clinical Case Study has afforded me, I was startled by that anger and would want to covertly stop it myself. I recognized that the client could sense that impulse in me and that ultimately they were not feeling wholly received. There was an unspoken taboo. There was a subtle message that the client was getting, “The therapist says it’s okay to be angry, but it’s really not allowed.” As I began to work with this dilemma in myself, one of the phrases that I would consciously hold internally was from Eckhart Tolle; “Can I be the space for this?” Rather than being dominated by my emotions then, I could access a place in myself
that was more centered, grounded, and calm. I simultaneously began breathing into the gripping feeling in my body when I felt the anger from the client. Staying with and elongating my breath would become key to working with my own resistance. I would notice where my breath was pinched or stuck. I also learned viscerally about how the intense power of anorexia takes over and permeates the space. In its presence, the air of meticulousness, arrogance, and disgust is palpable in the room. It becomes its own entity. From this place, the anorexic might think, “Everything and everybody is a waste of my time. This is beneath me.” Yet, this arrogance stays hidden from the anorexic’s awareness. It is a very measured arrogance which is at odds with her perception of herself as nice. She does not understand how stuck she is in the self-deception of niceness. I get a reminder of this process now and then when I notice a particular counter-transference with anorexic clients that has me wanting to get up and reach over and shake them by their little necks. In that moment I can ask, “Where am I deceiving my own self?”

While writing this Clinical Case Study, I have also been able to more closely examine the link for me between trust and skepticism, which has in turn helped me see the same link for anorexics. I am more familiar with the voice that says, “Don’t trust her. She doesn’t know what she’s talking about. Look at all the waste of time, being with them. I could do this better by myself. I could do this better on my own.” At times in my life when I did not have other resources, this skeptic helped keep me from feeling misunderstood. Back then I would not have been able to withstand the implications, because when one feels understood, the possibility of vulnerability emerges. Then one might cry or fall apart. In better understanding the anorexic, I now know that the skeptical part keeps her elevated above having to feel emotion. The skeptic’s very nature
is dismissive, which makes it hard to get to the truth. The skeptic also mirrors an aspect of the anorexic’s experience. She, herself, is afraid of being dismissed. When dismissed, she then feels misunderstood. Yet, this is what she has always known; it is predictable and feels familiar. It also continues to keep her distanced. Paradoxically, the anorexic longs for this vulnerability and the ability to be real and no longer dismiss her experience and how she feels. This is typically why, when an anorexic utters a truth, tears rush out; there is such a relief with the release of truth.

Another gift of this work has been about self-trust. Without growing self-trust, I might not be able to do the work that I do with anorexic clients. Trusting that my work with any given client is valuable, even given all my peculiarities, idiosyncrasies, and all that makes me who I am, is fundamental to this work. My work does not have to be the way some other therapist would do things; does not have to be their words, body language, or theory. What comes from me is asking to be trusted as okay in itself. This process parallels the healing journey of my anorexic clients who are so distanced from trusting themselves. Instead what stands in the place of self-trust are rules, should’s, should not’s, and self-doubt. The internal gatekeepers rule. As I grapple with issues about self-trust and self-doubt I am able to see and understand more deeply the struggles of my anorexic clients.

The work of this therapy with Kate, and the discipline of writing, reflecting, and writing some more, has helped me cultivate a profound sensitivity. Sometimes even just the slightest nuance catches me. I have learned things about anorexia that I could never have learned from a book. Because of exploring the related imaginal structures in myself, I came to understand how the relation between language and the body is crucial in
understanding how the anorexic affects her own transformation. When I notice a shift in the eyes for example, a sigh, a nod, or a non-chalant movement in the foot, I recognize the client is speaking. The somewhat detached and unspoken words are finding their voice through the body. As she holds her breath or swallows hard, or as the intonation of her voice elevates, she is often unconsciously pushing the truth away. The hesitations that seem to interrupt the flow are generally those of self-doubt and self-questioning; the anorexia, again, halting the truth from showing itself. Initially, communicating with any depth of connection in therapy is quite limited for her until she starts bringing her story to life and discovering the myth she has been living.

**Mythic Implications of the Learnings**

To gain a greater perspective from which to view anorexia and what it holds for the culture on a larger scale, I turn to the story of Iphigenia from the Greek myth the Illiad. Reflecting this greater perspective, Sam Keen states, “A myth creates the plotline that organizes the diverse experiences of a person or a community into a single story.”

In the beginning, the story of Iphigenia gives the description of the Greek Warriors with a fleet of 1,000 ships unable to sail off to the Trojan War because of the unprecedented calm weather. As the story goes, the fleet sits in the harbor day after day, while the army of men becomes more and more tired, hungry, and restless. The commander of the army, Agamemnon, is told that the oracle said he must make a sacrifice to the Gods for the winds to begin blowing again, so his army can sail off to war. Of all things, the sacrifice turns out to be his daughter, Iphigenia. Agamemnon realizes that although he is also being manipulated, he is helpless in stopping the sacrifice
from happening, and says, “Tis useless, for circumstances compel me to carry out the murderous sacrifice of my daughter.”  

Menelaus asks, “How so? Who will compel thee to slay thine own child?”  

To which Agamemnon replies, “The whole Achaean army here assembled.”  

This is gut wrenchingly painful for Agamemnon, but he does not turn back. Sending his men off to war takes precedence. In the end, Iphigenia is sacrificed to the Gods, the winds cooperate at last, and the army sails off to Troy. Although the Greeks end up victorious, it is only through extreme sacrifice that they do so.

Sullivan has noted in regards to war that “in order to undertake this masculine task of making war,” it is done by “completely severing [oneself] from any feminine connection.”  

What this myth offers is a way to look at the struggle with anorexia imaginally. Anorexia demands extreme sacrifice. The myth shows how the anorexic must cut herself off from her own feminine essence as Kate did. The anorexic can no longer connect with the depth of her experience, or the relationship with her intuitive self. Instead, she becomes overtaken by an unrelenting drive to achieve. She becomes linear and rational in her thoughts, and progress becomes her central goal. With Kate, as with other anorexics, there was no longer an understanding of her interdependence with the living world. Instead, a false pride and arrogance brought her to believing she could do it all herself, which separated her from the rest of life.  

The anorexic can no longer justify play as she would have done as a child. Solitude, like play, is forbidden to her. These are nothing but seemingly unproductive time wasters. Nothing apparent to her could be produced from these. Disregarding these feminine inclinations means that the anorexic has to sever herself from her experience. Using her mind to make war with her body, she successfully amputates the feminine, just like Agamemnon. Then, the obsession to
control how she looks becomes all consuming. Lelwica would say it becomes her new “false God.”

Turning to the story of Iphigenia, if Agamemnon was at all connected to the depth of his feeling for his daughter, he could never have allowed her to be sacrificed. He had to cut himself off from his feelings, just as the anorexic has to be cut off from her feelings in order to march ahead with an ego driven plan and goal to stay thin. Like Agamemnon, the anorexic must cut off and push away vulnerability and tap into the part that is strident, forceful, arrogant, and aggressive with regard to holding to the plan. For Agamemnon, it was about getting to Troy and winning the war at all costs. For the anorexic, it is about being thinner and looking better and being more attractive than anyone else, at all costs.

In the Wonderful Wizard of Oz, the Wizard represents the split in the culture between the masculine and the feminine. This Wizard lives behind the fortress of his palace walls insulated from others. He appears to be the master of his environment. With a façade in place of the all-knowing, the Wizard maintains an illusion of authority. When he says, “Pay no attention to that man behind the curtain!” as his secret is being revealed, he deceptively continues trying to protect his vulnerability anyway. He does not want his image of power to be shattered. Similarly, when the culture continues to live behind the pretense that strength translates to aggression, and believe that vulnerability is weakness, the façade continues to be carried on through time. The feminine then remains devalued. Women are controlled by the message that beauty is all that really matters and being thin the almighty goal. Behind this buttressed façade of strength, the feminine remains cut off. It becomes difficult to relate to one another openly and honestly. The
truth remains buried behind the cultures fortified walls of deception. The anorexic, and the majority of women in general, remain at war with their bodies.

In eating disorders, the false self includes a requirement for perfection. However, the Wizard who tried to be an all-knowing, perfect being, shows us that such ways of being are anything but human. His façade kept him from being able to respond from the heart. Finally, when he was exposed, it was quickly apparent that he was warm and kind and funny. He brings humor and delightfulness below the false self. He admitted, “Times being what they were, I accepted the job [as wizard].”  

When the anorexic is disconnected from her real self, she takes on the eating disorder as her life. It is all she thinks about, all power, energy, insight, intelligence all go toward feeding and being with the eating disorder. Yet, like the Wizard, when the anorexic begins to explore beneath the false self, there is a real person to be discovered with vulnerabilities and realness of being that can delight the world with the truth of who she really is.

The guardian of the gates to the great city of Oz, (in the movie, interestingly played by the same actor as plays the Wizard) at first shuts Oz off to Dorothy and her companions, and then, only begrudgingly allows them to enter. By doing so, he shut Oz away from what Dorothy and the others had to bring, which was warmth and expressiveness for life in all its vulnerabilities and with all its longings and curiosity for heart, courage, brain, and home. Similarly, gatekeeping limits the anorexic, cutting her off from vulnerability and life; gatekeeping limits culture from relating to the true warmth and expressiveness of the feminine nature.

These two myths both point to the distinct cut-off inherent in the condition of anorexia and the reality that there is a need for reintegration with the mind and heart,
body and brain, masculine and feminine parts of oneself. There is also the need for there to be transformational process that allows a person to descend through the complications that otherwise keep her from knowing her inner world. This is an inner world that guides and can ultimately take one to a place of greater self-acceptance and ability to be with one’s experience.

**Significance of the Learnings**

Bringing some attention to counter-dependency in relation to this field of study is a significant contribution. It plants a seed for future research and inquiry, which I discuss further under the sub-heading Areas for Future Research. Very little is written in general about the concept of counter-dependency. In the field of eating disorders, and specifically anorexia, I was unable to come across any mention of it at all. As well, nowhere was I able to find the mention of Imaginal Psychology in relation to the study of eating disorders, specifically anorexia. This will be further discussed under the sub-heading Bridging Imaginal Psychology.

The learnings of this Clinical Case Study gave me the opportunity to probe deeply into Kate’s psyche. When clinicians explore such depths with anorexic clients, it is likely that anorexic clients will be held with more compassion, caring, and understanding, and an ability to hold their experience in a bigger picture. The clinician might thus avoid a rigid agenda to extricate bad or evil things or destroy the symptom, and instead work with what resides deep down underneath all that. Instead of seeing the perfection or the false façade as something bad, they can be seen as part of a big picture with some problematic aspects that are still part of a whole. The goal then is not about trying to get rid of them
but to transform them. Such an approach can be more humane, personal, and holistic, and allows the clinician to work with the client rather than against them. It also allows the freeing of the client’s self-sabotaging energy and makes it life-affirming.

Another significant consideration worth mentioning here is related to anger, such as that which Kate experienced. There is a great deal of ignored and denied anger in an anorexic client. Because anorexic clients are masters at manipulation, this intense energy often times causes the clinician to unknowingly become overwhelmed, defensive, and/or lost. The client’s air of niceness, politeness, and sweetness means that often the clinician does not quite comprehend that the anger is there. The lovability is more appealing to be with. The clinician colludes with the client’s denial and falls for their unconscious or subconscious smoke screen. Clients act like they are fine, and the clinicians go along with it. Here, again, is the façade. However, the extreme of pleasantness points to the reality that the untapped opposite lies sleeping within. This disequilibrium directs the observant clinician. The fact that clinicians working with anorexics say that such clients are impossible to work with points to the clinicians’ failing to tap into what needs to happen in the therapy. Instead, they are letting themselves be manipulated.

Another manipulation trap is how logical and rational an anorexic can be at first sight. As is typical of many anorexics, Kate was unusually bright. She would often want to engage in a tug of war about what things meant, when in actuality, she is pulling to be understood. The anorexic wants her experience to be validated. This points to the fact that clinicians may also be fooled by the intellectualism, get stuck, and not know how to dig deep.
The Application of Imaginal Psychology to Psychotherapy

In reflecting upon my work with Kate, several considerations come to mind regarding applying Imaginal Psychology to psychotherapy. Initially, it is very important that the clinician not come up with the answers for the client, but rather, ask questions and bring in a curiosity. The focus must not be about the story, but about her, the client. How things affect her becomes the focal point in the therapy. It is best to help the client track what her experience is in the moment. An imaginal practitioner would be more likely to follow their inner inclinations and be receptive to guiding imagery. A clinician can be more effective when they can be aware of their inner experience, and also hold enough space for the client’s experience to come forward. Tracking the experience of their own inner process, the experience of how the client relates to herself, and the connection between those two relationships is at the heart of the work. It is up to the clinician to hold receptivity and to be conscious enough to recognize when the clinician is trying to push experience away. The clinician needs to be open to hearing the pieces of the client’s story as metaphor and as relative to what is happening between client and clinician in the therapy room itself. An imaginal approach requires more space and silence. It also requires trusting that this twosome can walk through the messes together without knowing where they are going, and without an agenda of where they are supposed to end up.

Another important contribution is related to taking in experience. The clinician uses his own body as an instrument, a deep well. This means that the clinician notices where in their own body they are being affected and where things get stuck, as well as how to make space in the body. Often times I noticed that I felt where the client was
affected in their body before they knew, because I was affected in my body in that place first. Tracking experience in this way, might allow the clinician to ask what the client might be feeling in their body. Rather than working strictly from the cognitive or intellectual, working with somatic responses is important to the imaginal practitioner. For example, I would often notice anxiety building inside me and then notice that the client was kicking their foot intensely. What the client is putting out into the room is no different for the clinician than ingesting a food. I experience its flavor, its texture, its temperature. I allow it to be a felt sensation experienced fully; not only chewing, but putting my teeth into it to get more out of it. Such a process allows it to be taken in wholly, and allows the body to do the work that only the body knows how to do. Rather than impeding digestion by contracting, defending, or resisting, digestion does what it knows how to do. Then what the client offers the clinician comes out of the clinician and the therapy differently than it came in. Conscious awareness brought into this process helps to metabolize the pathology.

The imaginal clinician is also less likely to follow the client’s story line merely for what it is, but recognizes instead, how it continues to point to what lies beneath. For example, when discussing her unexpected pregnancy, it was the look of despair on Kate’s face that was needed to be tended to, rather than the components of the story that she was relating. The clinician recognizes the look and inquires into it by following the thread from the client’s look of despair and grief. Attention is paid to what gets in the way from her being fully present with her despair such as gatekeeping voices, imaginal structures, and her personal history. In following my experience as the clinician, it is also about what tries to take me off track from being able to be fully present, and aware of the guiding
images surfacing in me that might inform the work. It is about being fully aware of the
gatekeeping that is trying to distance me from the experience in the room as well as my
own imaginal structures.

In applying the Imaginal Approach to psychotherapy requires the recognition and
consistent application of using ritual to help contain and hold the process that is at work.
Like the Wizard, the gatekeeping voices might want the clinician to believe their
presence with the client is enough. But to safely allow the depth of the transformational
process to occur, the clinician must allow themselves to be held by something greater.
This is accessed by ritualizing the experience. In my own work, I do this by simply
lighting a candle and sitting quietly in meditation before meeting with clients.

Conceptualizing the Imaginal Approach in the treatment of Anorexia Nervosa can
be complicated and difficult, and yet so essential for the treating therapist. The quest to
help the client discover her own inner life, with its tangled feelings, secret expressions,
and hidden inclinations, is the bridge to her process of recovery. Without this approach,
the client is left bereft of any hope for real change to occur. This journey into the
unknown realms involves trust, inclusion, patience, courage, fierceness, and the
willingness to be with things that are messy; everything the anorexic has yet to allow or
accept into her life. Rather than analyzing the tangibles, the clinician works in the realm
of the symbolic, listening to what is said as metaphor rather than concrete. It is through
the clinician’s willingness to be with the relationship with their client as a way of being
with soul, which allows for the transformational process to occur.
Bridging Imaginal Psychology

Bridging Imaginal Psychology to mainstream settings and clients always goes better with humor. At one time, I tended to be so serious about this bridging process. However, experience has taught me that being defensive about Imaginal Psychology has the opposite of what is intended. Rather, it is only by living and modeling the approach that this can occur. Applying it not only to the face-to-face work with clients, but also to who one is in the world, within a circle of colleagues, friends, and family, that bridging to Imaginal Psychology takes place. Through keeping daily practices that convey seriousness, respect, and appreciation for and about this approach, and by applying the approach to day to day life, a bridge builds. This process of bridge building is not exclusive to the therapy room, which would make it hypocritical. Rather, it is about holding to a personal practice, meaning ritualizing in one’s own daily life. If one does not practice an imaginal approach to life, it just becomes something rigid that a clinician is supposed to do when sitting with the client; another should, contrary to the approach of Imaginal Psychology. By bringing the imaginal process into one’s own life, and only by doing so, can it be brought into the lives of others.

Areas for Future Research

Review of the literature made it apparent that there is little explicit discussion of counter-dependency in relation to eating disorders, including anorexia. However, my work with Kate, which is corroborated by my work with other clients, makes me aware that counter-dependence is a significant issue for anorexics. Frankly, I was shocked that I did not come across any articles or books that addressed this topic, as counter-dependent
tendencies are inherent in anorexia. Though many authors such as Orbach and Eichenbaum speak to the dynamics of co-dependence, counter-dependence is not sufficiently addressed. While co-dependence plays a significant role in the dynamics of anorexia, there is a significant gap related to the lack of specific consideration of counter-dependence. To be sure, the two are related, like two sides of a coin. It might be that the co-dependent tendencies are more prevalent in the bulimic or compulsive overeater while counter-dependent traits are more prevalent in the anorexic.

Many elements of the anorexics’ personality are drawn to counter-dependent behaviors. These are things such as having to look good all the time, how she expects perfection in herself and others, her strong need to be right, the difficulty she has in getting close to others, her trouble being able to relax, and how she seldom appears vulnerable, all discussed by Weinhold and Weinhold. Given the anorexic’s proclivity for counter-dependency, further the study of anorexia in relation to counter-dependency would be a significant contribution. It is amazing to me that there is not a book somewhere entitled, *The Counter-dependent Anorexic*. The title is all inclusive and speaks for itself.

It seems appropriate to end this work with consideration about future research that might integrate Imaginal Psychology and clinical work with Anorexia Nervosa. The persistent challenges of working with anorexic clients and the high rates of recidivism are indications that more is needed. Imaginal Psychology draws upon a unique approach and lens through which the client might be observed, understood, and assisted. Since Imaginal Psychology is new, there are many possibilities for the directions that such research could take. If I were to design a next research project, it would involve more
individual experiential processes that might help clients through role play, meditative exercises, and cultivating more relationship to the Friend.
APPENDIX
APPENDIX 1

INFORMED CONSENT FORM

To Kate:

You are invited to be the subject of a Clinical Case Study about the complications of dealing with anorexia in one’s life. The study’s purpose is to better understand how therapists can more quickly recognize the subtleties of this eating disorder, and what relevant interventions to use when treating their clients with anorexia.

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 in published material, any and all information that could serve to identify you will 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 therapists who work with clients with eating disorders, specifically anorexia nervosa.

The Clinical Case Study does not directly require your involvement. However, it is possible that simply knowing you are the subject of the study could affect you in ways, which could potentially distract you from your primary focus in the therapy. If at any time you develop concerns or questions, 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 being 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 Clinical Case Study Coordinator at the Institute of Imaginal Studies, 47 Sixth Street, Petaluma, CA., 94952, telephone: (707) 765-1836.

I, ________________________________, understand and consent to be the subject of, or to be referred to in, the Clinical Case Study written by Barbara Murphy, on the topic of the complications and interventions of treating anorexia. 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 Barbara Murphy. Any questions of mine about this Clinical Case Study have been answered, and I have received a copy of this 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 Barbara Murphy will not disclose my name or the names of any persons involved with me, in this Clinical Case Study.

I hereby unconditionally forever release Barbara Murphy 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 of the mention, 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 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 and provisions of this consent shall be construed and interpreted pursuant to the laws of the State of California.

Signed this _____ day of ______________, 20__, at ______________________, California.

By: ______________________________________________________________
    Client’s signature

____________________________________________________
Print client’s name legibly and clearly on this line.
NOTES

Chapter 1


6. Carol Normandi, and Laurelee Roark, *Over It* (Novato, CA: New World Library, 2001), 45. Twenty-five years ago, these two women began “Beyond Hunger,” a non-profit organization that provides support groups for those with eating disorders. They have also written *It’s Not About Food* (New York, NY: Penguin Putnam Inc, 199).


11. Ibid., 9.


16. Ibid.


19. Aftab Omer, Definition was taken from Meridian University *ITP Definitions* handout, 2007.

20. Ibid.

21. Ibid.

22. Ibid.

**Chapter 2**


3. Ibid., 13.

4. Ibid., 21-25, 239-254.


9. Ibid.


17. Franko and Erb, “Managed Care or Mangled Care?: Treating Eating Disorders in the Current Healthcare Climate,” 45.


24. Ibid., 78.

25. Ibid., 79.


29. Ibid., 123.


33. Sours, Starving to Death, 367.

34. Gura, Lying in Weight, 261.


39. Ibid.


44. Ibid.

45. Ibid.


48. Information gathered by author during a three day tour of Remuda Ranch in Wickenburg, AZ during October, 2001 and numerous Center for Discovery seminars and meetings with staff.

49. Ibid.

50. Sours, Starving to Death, 366.


52. Ibid.


54. Ibid. Author also attended all day seminar given by Lock, et al. about integrating the Maudsley Method with clients, 2007.


58. Ibid, 11.

59. Ibid., 4, 194.

60. Ibid., 91.


62. Fairburn, Cognitive Behavior Therapy and Eating Disorders.


64. Ibid.


67. Ibid., 106.


69. Ibid.


76. Ibid.


80. Ibid.

81. Ibid.

82. Ibid.


84. Ibid.

85. Ibid., 321.

86. Ibid., 322.


88. Ibid, 74.


91. Ibid., 75-80.
92. Ibid., 78.
94. Ibid., 127-128.
95. Ibid., 129-135.
96. Ibid., 136-137.
99. Ibid., 56.
100. Ibid., 54-71.
101. Ibid., 63, 80-86.
102. Ibid., 151.
104. Ibid.
106. Ibid.
109. Marya Hornbacher, this idea was presented by the speaker at an eating disorders conference, “Fat & Thin: Healing the Split,” held by John F. Kennedy University and The Eating Disorders Institute at John Muir/Mt. Diablo Medical Pavilion titled, May 6, 2000.
114. Ibid., 39-46.
115. Ibid., 39-46.
116. Ibid., 39-46.
118. Ibid.
121. Ibid.
122. Ibid., 249.
127. Ibid.
135. Ibid., 326.
136. Ibid.
137. Omer, *ITP Definitions*. 
138. Ibid.

139. Aftab Omer, *Psychologists as Community Makers* course at the Institute of Imaginal Studies, author’s notes, July 14, 1998.


144. Ibid.


146. Ibid.


151. Ibid.


157. Ibid.


162. Ibid.

163. Ibid.

164. Weaver, *The Old Wise Woman*, 72.

165. Ibid., 3-4.

166. Weaver, *The Old Wise Woman*, 4, 72.


170. Ibid., 79.

171. Ibid., 79-91.


**Chapter 4**

1. Omer, “ITP Definitions.”

2. Ibid.

3. Ibid.


6. Ibid.
7. Kalsched, The Inner World of Trauma, 45.


10. Sours, Starving to Death, 321-330.


14. Normandi and Roark, It’s Not About Food: Change Your Mind, Change Your Life, End Your Obsession with Food and Weight, 7-10.

15. Lyrics from Ding-Dong! The Witch is Dead! Soundtrack from the 1939 film, “The Wizard of Oz”. Lyrics written by E. Yip Harburg and music by Harold Arlen.

16. About 12 years ago I read the book The Wisdom of Oz by Gita Dorothy Morena, the granddaughter of L. Frank Baum who wrote The Wonderful Wizard of Oz. Without doubt, the insights I gained from reading that book have stayed with me and influenced my writing of the primary myth in the Learnings Chapter. Gita Dorothy Morena, The Wisdom of Oz: Reflections of a Jungian Sandplay Therapist (Berkeley: Frog, Ltd., 1998).


18. Ibid. This is Sullivan’s basic premise in working with clientele.

19. This metaphor was first introduced to me by my first supervisor, Erin Riley, in 2001.

Chapter 5


2. Depicted in the 1977 Greek movie, Iphigenia, directed by Mihalis Kakogiannis.


4. Ibid.

5. Ibid.


7. Ibid., 20.

9. “Pay no attention to that man behind the curtain!” is a line recited from the Wizard in the 1939 MGM film, *The Wizard of Oz*.

10. “Times being what they were, I accepted the job!” is a line from the Wizard in the 1939 MGM film, *The Wizard of Oz*.

REFERENCES


