What are eating disorders really about? a therapist's case study of self and the experience of bulimia

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In qualitative research the case study is used when the researcher believes there is something in a case that is worthy of study. How valuable is it for the therapist to be the subject in their own case study? As therapists we invest much energy in scrutiny of the lives and struggles of our clients. What of our own lives and struggles? Much controversy surrounds the use of the therapist's personal struggles. Should the therapist be a removed, objective 'expert' with all personal psychological distress well-managed and at no time evident to clients or peers? Or could the therapist's story not only be just as informative as that of their clients, but is it possible that the therapist's clinical experience and knowledge will illuminate important themes and issues that valuably inform our work with clients who share the same psychological struggles? AVIGAIL ABARBANEL, as a therapist with an interest in eating disorders, writes of her experiences as a former sufferer of bulimia. Recent events caused old bulimic thought and feeling patterns to resurface. This paper presents her own story as a case study that offers an opportunity to discuss and illuminate aspects of the struggle with bulimia and, perhaps, with other eating disorders.

The brief literature review offered here covers some of the recent research in the area of eating disorders with a focus on studies that explore the most researched approaches to treatment: cognitive behaviour therapy and family therapy (Wilson, Grilo & Vitousek, 2007). The rich literature on psychoanalytic or feminist interpretations of eating disorders, and other valuable personal narratives in this area, have not been covered here, although many are available.

Studies with a focus on individual factors explore the intra-psychic mechanisms that lead to, and sustain an eating disorder with the hope that this will inform practice. Duemm, Adams and Keating (2003) propose a *'dual pathway model'* of bulimia and suggest that *'internalised societal pressures lead to self-perceived body dissatisfaction'* that in turn leads to the development of bulimia (p. 281). The authors expand this model by highlighting the role of the need for approval and fear of social rejection—*'sociotropy'*.

Fairburn et al. (2003) identified *'five predictors of persistent binge eating: duration of disturbed eating, greater overevaluation of shape and weight, a history of childhood obesity, poorer social adjustment, and persistent compensatory behaviour'* (p. 107).

Another recent study by Fischer, Anderson and Smith (2004) identified *'trait urgency'*, a form of impulsivity defined as *'the tendency to act rashly in the face of distress'*, to be a major factor in both eating disorders and alcohol use (p. 269). Bulimic behaviour is seen as a way of trying to cope with distress, and this study suggests that people with bulimia, or those at risk of developing bulimia, have this type of impulsivity. Negative mood changes are considered to be antecedents to disordered eating behaviours. *'Mood and stress in daily life are related to binge eating and vomiting'* in women with bulimia and bulimic events are *'…more likely to occur on dysphoric days'* (Smyth et al., 2007, p. 637).

From a family systems perspective a bulimic daughter may be a crucial point in a triangle in families with *'at least one triadic imbalance'* (Lewis, 1987, p. 640). Bulimia is seen as arising from a difficulty in separating from a rigid family structure. Other factors considered are family isolation, the special meaning the family attaches to food and eating, and the family's preoccupation with appearance and image. Lewis (1987) also argues that bulimic daughters may be trying to

communicate important messages to their siblings and that if these messages can be identified and communicated more openly this can help the young women to let go of their disorder.

Tantillo (2006) found that psychoeducational multifamily therapy group (PMFTG) combined with cognitive-behaviour therapy produced promising results. Tantillo views eating disorders as '*diseases of disconnection*' and believes that the main therapeutic factor in this model lies in the social connections formed between people in the group. The Maudsley model of family therapy, a manualised family-based treatment model for adolescent girls with anorexia, is based on parents initially taking control of the daughter's eating and weight management. It had excellent results with this population, but proved ineffective when tested with adults (Wilson, Grilo & Vitousek, 2007).

A recent study by Ranson, McGue & Iacono (2003) considered the application of the addiction model to eating disorders, but found that the data supported a familial link more than an addiction model.

Bulimia is also seen as a possible result of insecure attachment in families where there are negative cycles of hostile control (Johnson, Maddeaux & Blouin, 1998; Ratti, Humphrey & Lyons, 1996). Emotionally Focused Family Therapy (EFFT) has been proposed as a way to help families by identifying the attachment patterns and the negative cycles in the family (Johnson, Maddeaux & Blouin, 1998).

Methodology

In the case study approach to qualitative research the case is chosen because there is something in it that the researcher believes is worth studying (Creswell, 1998). Yin (1994) argues that case studies are more than merely an exploratory tool and can be useful for description and explanation.

Ideally researchers would formulate a research question before they choose an approach. In this paper, the data preceded the question. The data is in the form of a personal narrative, which contains a recollection of memories and a description of my meaning-making process. The narrative emerged as a spontaneous response to a troubling experience that surfaced during an attempt to write a university paper. I decided to use it as a case study because I believe that it illuminates possible pathways to understanding and treatment of eating disorders.

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To achieve rigour in case study research, researchers have to *'work hard to report all evidence fairly without changing anything'* (Yin, 1994, p. 10). In this case the narrative has been compressed to meet the practicalities of the word limit. Yin (1994) points out that *'case studies, like experiments, are generalisable to theoretical propositions and not to populations or universes'* (p. 10). On this basis the analysis of the data contains ideas and thoughts that need consideration and further exploration, but does not contain causalities or certainties. Clearly, my experience of bulimia is not universal. However, in every personal story there is a kernel of universality. *'From the individual descriptions general or universal meanings are derived, in other words, the essences or structures of the experience'* (Moustakas, 1994, p. 13).

Silverman (2006) argues that in a qualitative study text must not be used only as a resource to support the process of establishing facts, but must be analysed carefully in its own right because the text itself is a part of the phenomenon being studied and not merely something that describes it. Unfortunately, the scope of this paper does not allow for a deep textual analysis so the text is mostly used as a resource.

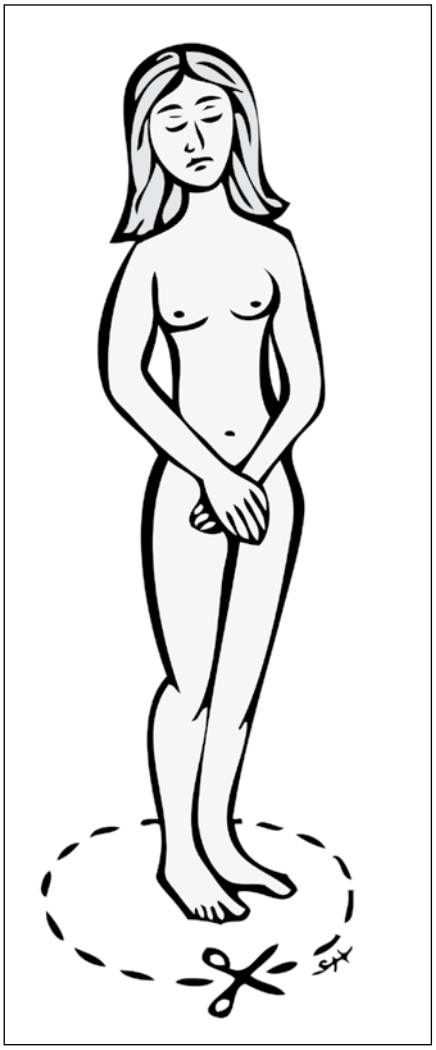

Illustration: Savina Hopkins

Bulimia revisited

When I started my own therapy in my twenties, I did not tell my therapist about my bulimia. I worried that if I told my psychologist that I had bulimia, she would focus on it, and I did not want that. I felt that the bulimia was only a symptom of what I thought at the time was some kind of general unhappiness. I preferred to take a risk and believed that the bulimia would take care of itself if I dealt with my 'real' issues. After a few months of weekly and sometimes twice-weekly sessions (of what I know now was client-centred therapy) I started to feel less anxious and troubled, the bingeing-vomiting cycle stopped and the preoccupation with my weight and appearance diminished substantially, but did not disappear completely. As my anxiety gradually lessened, I was able to concentrate on the things that mattered to me.

My latest flare-up of bulimic-style thoughts and feelings took me

by surprise. I was trying to engage with my latest university assignment when I started to feel nervous and uneasy. I started to think about food and experienced a familiar 'hunger'. I heard myself think, *'I feel restless. I need to get up. I want something, I need to eat something'*. I noticed that at the same time I was also starting to think that I was too fat, and that I had to lose weight—and there it was: the bulimic thinking and feeling patterns were all there as if they never left! Although I set aside a few days just to work on that assignment, I was almost completely unproductive. Unlike in my past however, I was much more aware of what was happening to me. I knew that it was important to take it seriously and engage with it rather than escape or avoid the experience.

Engagement and background

My starting point was the fear and unease I felt when I sat down to work on my assignment. I first asked myself if there was any problem with the material I was covering. Was it perhaps too difficult for me? Was I anxious about my course? I concluded that this wasn't the problem.

Then I asked myself if I remember feeling like this in the past, the result was a flood of memories. I realised suddenly that I have always felt like this every time I studied, and in particular when I was excited about what I was doing and when I was being intellectually creative. In fact, it was that very excitement that seemed to trigger the feelings of fear and uneasiness.

When I was in high school, I used to do my homework after everyone else had gone to bed. I would often start around 11 p.m. I saw this as a personal failure and believed that I was disorganised or slack. I remember feeling I had to spend time with my parents, usually watching TV. When I was studying it often felt as if I was doing something wrong, something against them, or as if I was taking something away from them.

I was always a smart kid and liked my school work. When I was very small, my parents seemed proud to show me off to friends and family. But later around the age of 12 (year 7) after I received the results of IQ tests we all went through at school, I felt that something changed and my parents no longer approved of me being smart.

Around the same time when I would mention with excitement something I had learned at school to my father, (which previously I did quite often), he started to respond aggressively with, *'What, do you think you are better than us?'* My mother too, would act strangely if I tried to tell her something I learned. This came as a shock. I was confused and felt I had done something wrong and that I was hurting my parents. I then concluded that I couldn't talk to my parents about school any more. I remember sometimes bringing home a piece of work I did at school that got high praise and telling my parents all the good feedback I received. Their response was, *'Yes, we know the teachers think you are great. But we know who you really are'*. This left me not only feeling confused and hurt, but also filthy. I started to feel as if I was a bad person and as if I was doing bad things, only I wasn't sure exactly what they were.

Another thing I concluded from this was that my parents were smarter than the teachers. So if the teachers thought that I was good or smart, they must be really stupid and wrong about me. I began to feel split and fake. There was the 'me' that others saw, and another 'me' at home that my parents knew.

Over the years I realised that my parents had serious issues with their intellect. They both had a profound fear of study and a deep sense of intellectual inadequacy. They also tried to hide this, pretending that they were smarter than others. I colluded with them by praising and supporting them and hiding my real thoughts. My mother was taken out of school at age fifteen because her father did not think that women needed education. My father, who comes from a very disadvantaged background, never finished Year Seven.

Both my parents had opportunities to go through professional development courses in their workplaces and I remember those times as troubled and disturbing. My parents seemed frightened of study and said that they couldn't do it. My mother in particular suffered dark depressed moods when she tried to study. Because I was so motivated I couldn't understand their difficulty.

The making of an eating disorder

From around the age of twelve years I started to feel that I was disappointing my mother. I noticed her watch my body and heard her make many unhappy comments about it. Going shopping for clothes with her was a nightmare. She often told me that *'you have to suffer to be beautiful'* and made sure I did. Whenever we got ready to go to a family wedding or an occasion that required dressing up she was brutal. When she hurt me while doing my hair and I complained, she would beat me up *'so that I had something to cry about'*. Examining my face closely, my mother often told me, *'You can always have a nose-job when you are older, you know'*. I didn't understand what a nose-job was but it scared me. I remember deciding defiantly that I would never have one, no matter what.

I suppose many adolescent girls spend time in front of the mirror, fascinated by the changes in their bodies. When I started to look at myself in the mirror, I saw a deformed person, an ugly, fat girl whose shape was not right and who I hated. My father's comments about my appearance started when I was quite young. I remember a frightening and odd incident when I was about five years old. My father called me into the kitchen with a voice that meant I was in trouble for something. My

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mother was sitting there with him. As I stood there he started yelling at me that I was making the dimple line in my chin deliberately to embarrass him, and that I should stop doing it. I was so frightened that I wet my pants. This tended to happen when I was frightened by my parents. It was humiliating.

Relatives and friends of the family also commented freely on my body and shape. It was a part of our culture. I was often called 'stout' or 'solid', particularly by my father, which I remember as humiliating and frustrating. For many years, even when I was already a young adult, he would try to touch my bottom whenever I passed near him. He always pretended it was a joke. I hated it but at the same time thought that I was making a big deal out of nothing.

My mother was very interested in beauty pageants, and was a great admirer (and a harsh critic) of the women who participated in them. In 1976 (when I was 12) Rina Mor, an Israeli, won the 'Miss Universe' contest. My mother was overjoyed. As a woman, you couldn't have a higher achievement in life. My achievements at school paled by comparison, and I felt like a complete failure.

My family's relationship with food was peculiar and intense. My father comes from a poor background and my mother is a daughter of Holocaust survivors. From early childhood I heard stories of how they never had enough to eat as children. My parents said they were determined that my brother and I would never suffer that kind of deprivation, and so there was always an abundance of food at home. My mother cooked and baked regularly and I had free access to baked goods and sweets. If any limits were imposed, they were feeble.

I learned to eat for comfort from my mother. She always served us too much food but my brother and I were forbidden from leaving the table until we finished all of it. I remember always leaving the table feeling too full and heavy. It was very confusing at the same time to hear comments about being too fat. My mother always complained that she too was fat. I never thought she was. Even when I was small my mother asked me for advice on what to wear and I used to watch when she put on her make-up and did her hair. It was like a ritual. When I was older I became her hairdresser although I didn't always want to, and we spent many hours discussing appearance, clothes and hair.

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The worries about being fat (I wasn't even overweight) were already in place as well as the tendency to eat for comfort. But my bulimia started at age seventeen. I learned about purging from a TV program about eating disorders that my mother and I watched together. It seemed like the perfect solution. I could eat as much as I wanted, and still stay thin! I remember even saying that to my mother right there and then. She said nothing in response. I later found out that my mother was already bingeing and purging.

Back to the present

When I became aware of my fear and uneasiness about my studies, I decided to write a dialogue between my 'mother' and me as a way of working through what I was feeling. I sometimes think of it as doing psychodrama in writing. Through this dialogue I arrived at an important discovery about the dynamic behind my bulimic thought patterns.

I wrote angrily to my mother and then allowed 'her' to respond. The dialogue was a way to air things that I believe my mother thought, or things she said to me directly and indirectly throughout my upbringing. My dialogue mother said I was too fat, that I wasn't looking after my appearance and let myself go, that I was a disappointment to her and that going to the gym and developing muscles was not appropriate for a woman.

My discovery came at a point in the dialogue when I asked, *'Why are you doing this?'* The response was, *'Because I don't want to be alone. Why should you be happy when I am not? What gives you the right to be happier than the rest of us? You abandoned me and you had no right to do that. This is not what I had children for.'* It was at that point that I realised that my bulimia was not about appearance, beauty or thinness or about a relationship with food. These are the building blocks that created the mechanism of my disorder, but they were not the real cause of it. The real 'engine' behind my bulimia was my mother's need for me to be troubled. Making sure I was preoccupied with something that took me away from what was making me happy and fulfilled, was my mother's way of trying to help herself feel less alone in her own suffering.

Being interested and excited about intellectual things is an immediate reminder that I am a disappointment to my mother. When I study I am what my mother did not want me to be (smart instead of beautiful, interested in ideas rather than superficial things and escapism) and this is the trigger for the bulimic process. Being bulimic has been an attempt to be close to my mother and get her approval by engaging in aspects of life she could relate to, like the worry about weight and appearance, and being troubled and unhappy. It is a continuation of the split existence that I began to develop as a child. I want and try to be what I feel I am, but I am driven to be what I feel my mother wants me to be. It is clear that deep down there is still a part of me that craves my mother's approval (although she has not been a part of my life for years).

Discussion and implications for practice

During the years of my recovery I had to overcome a lot more than bulimia. I suffered from trauma and many associated symptoms such as chronic anxiety and severe panic attacks, fears and nightmares. I was dependent, deeply insecure and immature, had poor resilience, did not cope well with life and had a poor sense of self. Bulimia was a part of this cluster of problems.

Not every client with an eating disorder suffers from trauma, but an eating disorder is highly unlikely to be an isolated symptom in the person's life. This case study puts the 'spotlight' on bulimia, but does not suggest that bulimia should be viewed or treated in isolation. What is valuable about this case study, and the reason it was worth noting, is that the bulimic symptoms re-appeared without the wider context of anxiety or other symptoms. This offered an opportunity to focus on the ways I dealt with it, and what I learned from it in the hope that this will encourage further discussion about this disorder and about treatment options.

The idea that I played a role for my mother and, in particular, that I was not meant to be happy or fulfilled was not new to me. I realised this years ago and made a conscious (and painful) choice to abandon that role gradually, and walk on my own path. (Had I not made that choice it would not have been possible for me to acquire an independent profession, open a private practice or speak publicly about issues that concern me.) However, prior to the events described in this case study I did not connect this with my bulimia. Neither did I see the connection between bulimia and my intellectual work and study. I believe my case study demonstrates the interdependence between understanding or insight, and acceptance of one's emotions.

In the more distant past, my bulimic cycle happened very fast. I had no awareness of what I was really feeling. I just felt a drive to eat and then purge and did it. In this sense I displayed the quality of *'urgency'* described by Fischer et al. (2004). The crucial difference this time was my ability to stay with what I was feeling and not act on it. Rather than fight with my feelings and worry about them, I 'listened' to them. The memories that helped me make sense of my experience surfaced as a result of that. Writing the dialogue with my mother was a way of staying with my feelings. I learned that I (or some part of me) still wanted my mother's approval and that to achieve it I must be unhappy. My bulimic behaviour in the past was a way of soothing or avoiding the feelings of fear and tension generated by doing what my mother did not approve of. These feelings were so intolerable that I 'had to do something'. This supports the view that intra-psychically, bulimic behaviours are an attempt to cope with difficult emotions (Fischer, Anderson & Smith 2004; Smyth et al. 2007).

My experiences lead me to consider that therapists who focus on their clients' symptoms, and treat these as an 'enemy' to defeat or destroy, might inadvertently move their clients away from their actual experience and the opportunity to discover useful meanings within these. An exclusive focus on cognitions might also have the same effect. If, for example, therapists are to help their clients overcome the trait of urgency, it may be useful to help them 'befriend' their feelings.

What I learned was that therapy can help clients realise that their feelings are a potential source of insight and that acting on them (through the bulimic cycle) can take that opportunity away. Learning to 'sit with' feelings and accept them can also decrease the need to engage with the bulimic cycle in the short term. Through my recovery I learned not only to listen to the part of me that suffers, but also to soothe and 'take care' of it. This led to more autonomy, inner peace and much less reliance on outside reassurance. I believe it also healed my chronic anxiety. I suggest that once clients learn to sit with their emotions, they also need to learn to soothe the part of them that suffers. This might require therapists to teach such skills.

My case study supports a family systems approach to eating disorders. My family dynamic seems typical of families of women with bulimia that includes rigidity and negative attachment patterns. As an adult I needed to understand my role in the family, in particular in relation to my mother, and be able to disentangle myself from it. In order to heal, clients might need help to differentiate from their role in the family. (Kerr & Bowen, 1988).

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It seems to me that there is something superficial in the preoccupation with food and eating, and the shape and weight of one's body. My mother modelled to me what she believed was a more appropriate area for a female to engage in than intellectual work. She also modelled a life of inner-turmoil and unhappiness, and this indeed interfered with my attempts to engage with intellectual work that interested me. This is both a feminist and an existential issue.

It might be necessary to help female clients consider what they would occupy themselves with if they did not obsess about food and body image. It might be important also to explore whether they believe they have a right to fulfil themselves as human beings, and what fulfilment and being a woman means to them. Existential and transpersonal approaches to therapy as well as a feminist orientation could be useful in helping female clients consider the real purpose or meaning in their life. When the client discovers a more significant purpose, she can then decide consciously whether she wants to engage with it or not. She also has to consider what price she is prepared to pay for her choices. Viewed from this perspective the client will

not merely work on healing her eating disorder in therapy, but on her entire life and identity.

If a client from a rigid family decides to engage with her true purpose, this could have a negative affect on her family relationships. I paid a price for my desire to heal and engage with what mattered to me. The better I got, the more a relationship with my parents became impossible. The choice between myself and my own purpose, and a relationship with my parents was painful. I made it as an adult when I was ready to deal with the pain it brought. But I could not face that choice when I was still an adolescent and believed that I needed my parents in order to survive in the world. The rigidity of family relationships and the nature of family attachment are significant factors in the capacity of clients to differentiate. An existential approach to therapy can expose these dilemmas and help the client become more conscious of her choices. It is important that therapists be mindful of the special challenges that adolescents face as a result of their attachment to their family.

According to Johnson et al. (1998) *'the most relevant question is not, which treatment is generally superior, but when and for whom is a particular treatment modality most appropriate? Bulimia is also a multidimensional and multi-determined problem, and different treatments may be necessary to address different aspects of the disorder'* (p.245).

Based on my case I propose a combination of existential, feminist and family systems perspectives to work with eating disorders in females, as well as modalities that teach acceptance of emotions and ways to self-soothe. I also suggest that too much of a focus on the mechanics of the disorder can be counterproductive. Bulimia, albeit a serious problem, is likely to be a symptom of a deep and multifaceted problem that must be addressed in order for the client to recover.

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