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THE ANOREXIC SELF VS. THE AUTHENTIC SELF: A SYSTEMATIC AND
INTEGRATIVE GUIDE IN THE ADULT TREATMENT OF ANOREXIA NERVOSA

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Abstract

Anorexia nervosa is a serious and persistent mental health disorder that has the highest mortality risk and suicide rate of any psychiatric illness in the Western world. Anorexia nervosa presents a challenge to understand on almost every level. Treatment outcomes for anorexia nervosa are often not optimistic, and treatment efficacy has been under-researched. Informed by an extensive literature review, a systematic and integrative guide addressing the anorexic self in anorexia nervosa was designed specifically for adult women currently struggling with the disease. Cognitive behavioural, interpersonal, and narrative therapeutic techniques attempt to uncover the nature of the anorexic identity and the extent to which it takes over a client's sense of self. A therapeutic guide targeting the commonalities and uniqueness of anorexic clients provides a treatment alternative for clients who continually struggle with the anorexic identity. By initially treating the anorexic identity, clients may be able to identify cognitive distortions and recognize the control that the anorexic identity has over psychological, social, and behavioural wellbeing. The hope in designing and implementing an alternative approach for treating anorexia nervosa is that we will gain the ability to identify the core issues of the anorexic thought process and provide a unique healing experience for those involved in treatment.

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A Systematic and Integrative Guide in the Adult Treatment of Anorexia Nervosa

The purpose of this project is to define and develop a treatment guide for women suffering from anorexia nervosa. Anorexia nervosa remains, for most patients who fall ill, a treatment-resistant, chronic illness with significant morbidity and mortality (American Psychological Association, 2000). Clients with anorexia often hide behind their emaciated physique to mask their uncertainty about who they should be. This is one of the common threads that tie together many clients with anorexia.

Current treatment recommendations for anorexia nervosa involve a multidisciplinary approach that includes motivation for recovery, weight restoration, psychosocial functioning, or compulsory treatment. The current standard approach in treating anorexia nervosa relies on weight restoration and psychotherapy to address the physical and behavioural symptoms of the disease. This guide provides an alternative approach to treating anorexia nervosa that targets the anorexic identity through cognitive behavioural therapy (CBT), narrative, and interpersonal therapy (IPT).

Treatment outcomes for anorexia nervosa are often not optimistic and treatment efficacy has been under-researched (Steinhausen, 2002; Steinhausen, Boyadjieva, Griogotoiu-Serbanescu, & Neumarker, 2003; Treasure & Schmidt, 2002). Anorexia is considered a complex illness to treat, in part because there is no known single effective treatment for eating disorders (American Psychiatric Association Work Group on Eating Disorders, 2000). Treatment resistance, although a clinical feature of anorexia, may be a result of ineffective treatment. In a review of women who have recovered from anorexia nervosa, self-development, self-understanding, and self-discovery were documented as

essential components of therapy to promote recovery (Beresin, Gordon, & Hertzog, 1999; Garrett, 1997; Hsu, Crisp, & Callender, 1992; Maine, 1985).

Rationale

Treatment programs that are behavioural in nature (Agras, Barlow, & Chapin, 1974) do not always address the original issues that led to the eating disorder (Zerbe, 1996). Before and after a healthy weight is restored, clients with anorexia typically struggle with identity issues and related issues of autonomy, dependence, powerlessness, and perfectionism. Clients who struggle with identity, ineptness, and a lack of personal power find solace in their new-found anorexic identity. Their facade is an emaciated form that disguises feelings of ineptness.

Maintaining the facade becomes the foremost concern of clients with anorexia. As their former selves recede, they seek to preserve their new identity, masking deep-rooted concerns about their inadequacies and ability to excel (Malson, 1998a). In psychotherapy, Bruch (2002) emphasized the need to focus on the anorexic's feelings of inner self-doubt and loss of self-identity rather than on weight and dieting.

Method

Several important steps, outlined by Merton (2000), were involved in the development of this manual. A comprehensive review of the literature on anorexia nervosa in the last 10 years guided the process. A focus on self and identity in relation to anorexia nervosa highlights the second stage in developing the treatment guide. The third stage is a review of recommended psychotherapies for treating adult clients with anorexia nervosa, including cognitive behavioural, interpersonal, narrative therapy, feminist therapy, motivational enhancement therapy, and solution- focused therapy. The fourth

stage is a combination of theoretical, psychotherapeutic, and recent research regarding the self and identity and the proposed intervention strategies that best address and manage adult clients with anorexia nervosa.

A Practical Guide: Developing a Systematic and Integrative Approach in the Adult Treatment of Anorexia Nervosa

The goal in the development of this practical guide is to offer clinicians in private practice, eating disorder clinics, and hospitals a systematic and integrative approach in the adult treatment of women with anorexia nervosa. Challenged by clinical findings and necessity, therapists proceed on a lifelong professional journey of exploring, deleting, adding, and integrating various theoretical and technical paradigms to find effective alternatives in treating anorexia nervosa. The process of changing, challenging, and undoing the negative mindset of anorexia nervosa to reduce the characteristic nagging self-doubt is part of the application of cognitive therapy (Garner & Bemis, 1982). Recovery is a conscious process involving rediscovery of the self and deliberate reprogramming of thought processes (Garrett, 1997; Hardin, 2003; Hsu et al., 1992; Noordenbos, 1989). The foundation for the practical guide emphasizes the retention of valuable early tenets and the addition of new theoretical and technical concepts in the treatment of anorexia.

The guide is designed in two sections. Part A: The Anorexic Self versus The Authentic Self provides an educational focus on the nature of anorexia nervosa, the loss of self-identity, and the development of the anorexic identity. The literature exploring the nature of self in relation to anorexia nervosa informs the educational aspect of the guide (Bruch, 2002; Hepworth, 1999; Lamoureux & Bottorff, 2005; Malson, 1998a, Rusca,

2003; Surgenor, Plumridge, & Horn, 2003). A literature review of existing CBT, narrative, and IPT treatment for anorexia nervosa provides the background for designing an alternative approach to treatment.

Part B: *Beyond Anorexia Nervosa: Rediscovering Self* involves an integration of the material highlighting anorexic cognitive distortion, overvaluing of thoughts, deficits in self-esteem, and loss of self-identity. The combination of therapeutic interventions aims to identify the relationship of anorexic cognitive distortion and loss of self-identity in the maintenance of anorexia nervosa. The treatment guide contains eight components of therapy. Treatment is aimed at treating long-term adult female sufferers of anorexia nervosa in understanding and managing their disease.

The Program

The program is guided by the Canadian Psychological Association (2000) and the CCA (2001) standards of ethical practice. In light of the physical complications due to anorexia nervosa, participants are required to sign an informed consent that information regarding their physical health will be shared between the therapist and physician in an open communication of the client's present and ongoing health status.

An introduction to the guide outlines the ethical considerations in treating adult sufferers of anorexia nervosa, the importance of having physicians monitor their physical health, and the limits of confidentiality. The guide begins with an overview of the eight components of treatment. The first component reviews the nature of anorexia nervosa, the symptomatology, and the effect of the disease on individual identity. The second component focuses on anorexia nervosa and self identity, identity development, individuation, and separation as they pertain to each individual and her experiences. The

third component highlights a recent approach to treatment in understanding the anorexic identity and the extent to which the patient's identity has been compromised by the disease. The work of Bruch (2000), Lamoureux and Bottorff (2005), Maisel, Epston, and Borden (2004), and Vitousek (2005) supports the notion of encouraging clients to develop strategies to challenge the anorexic mindset and recognize the benefit in changing their view of self. The fifth, sixth, and seventh components of the guide are devoted to the therapeutic techniques of CBT, IPT, and narrative therapy in dealing with the anorexic thought process and the amelioration of the former self. The fifth component focuses on cognitive behavioural therapy and CBT therapeutic techniques in treating the anorexic identity. This component highlights the value of cognitive mapping, journaling, reauthoring of lives, role evaluation, reconstruction, and externalization of the anorexic self in hopes of providing a foundation for change. The sixth component of the guide focuses on interpersonal therapy and IPT therapeutic techniques in treating the anorexic identity. The seventh component of the treatment guide outlines social constructionism and narrative therapeutic techniques in treating the anorexic identity. The eighth and final component of therapy reviews the concept of self in relation to anorexia nervosa and concludes with follow-up at three and six months post-treatment.

Implications. The practical guide offers a systematic and organized approach, focusing less on symptomatology and more on the underlying issues of the maintenance of anorexia. The project may provide clinicians involved in treating the adult anorexic population with an alternative approach for therapy. A therapeutic model targeting the commonalities and uniqueness of anorexic clients provides a treatment alternative for clients who continually struggle with the anorexic identity. By initially treating the

anorexic identity, clients may be able to identify cognitive distortions and recognize the control that the anorexic identity has over psychological, social, and behavioural well-being. The hope in designing and implementing an alternative approach in treating anorexia nervosa is to identify the core issues of the anorexic thought process and provide a unique healing experience for those involved in treatment.

Part A: The Anorexic Self Versus the Authentic Self

Current Conceptualization of Anorexia Nervosa

Eating disorders are of great interest to the public, a perplexity to researchers, and a challenge to clinicians. They are featured prominently in the media, often attracting sensational coverage. Their cause is elusive. Social, psychological, and biological processes all play a role in the development and manifestation of the disease. They are difficult to treat, and some clients actively resist help (Bruch, 2000; Charpentier, 2000; Fairburn & Cooper, 1990; NICE, 2003; Vitousek, Watson, & Wilson, 1998). Patients with anorexia nervosa overvalue their shape and weight and judge their self-worth largely, or even exclusively, in terms of their shape and weight and their ability to control them (Fairburn, 2004).

Anorexia nervosa is a serious illness that has a profound impact on the lives of many individuals and their families. It arises in adolescence, with peak onset at 18 years, and affects as many as 2% of young women and 1% of males (Hoek & vanHoeken, 2003; Lucas, Beard, O'Fallon, & Kurland, 1991; Woodside, Walfish, & Kaplan, 2001). First described more than 125 years ago, anorexia is primarily characterized by a persistent determination to refrain from eating in order to achieve a low weight, often to the point of severe malnutrition. The persistent dieting and concomitant weight loss usually lead to amenorrhea (in females) and are accompanied by a specific psychopathology that includes a morbid fear of fatness (APA, 2000).

In anorexia nervosa, the pursuit of weight loss is successful in that a very low weight is achieved. Weight loss is primarily the result of a selective and severe restriction of food intake. Many patients engage in obligatory exercise that promotes and maintains

weight loss. In addition to food restriction and exercise, other extreme forms of weight loss are practiced by a few individuals (Beaumont, 2002). Self-induced vomiting and the misuse of laxatives or diuretics contribute to the achievement of a very low body weight.

Engaging in self-starvation, obligatory exercise, and other extreme forms of weight control behaviour gives the anorexic a false sense of self-control. Symptoms of depression and anxiety disorders, irritability, lability of mood, impaired concentration, loss of sexual appetite, and obsessional features are frequent psychological accompaniments of anorexia nervosa (Fairburn, 2004). These features typically become worse as weight is lost, but improve with weight gain. As clients become more invested in the pursuit of thinness, they also become more depressed, irritable, and obsessive around the limitation of food and extreme forms of weight control.

Interest in the outside world declines as patients become preoccupied with weight loss, resulting in social withdrawal and isolation. This may explain the investment clients begin to make in creating and maintaining an anorexic self. The all-consuming lifestyle of diet and exercise isolates one from the outside world and from underlying emotional struggles that some choose to hide from. Following a rigid diet and exercise plan may also allow clients to become preoccupied, not with themselves, but with a new-found identity that operates solely on weight and shape.

Diet and weight concerns are not uncommon in adolescent and adult women, but what is uncommon is why some women embark on a life-threatening course towards thinness while others are satisfied with average weight loss. This is consistent with the belief that the overvaluation of shape and weight are not the only factors that contribute to the development of an eating disorder. In recognizing the presence and influence that

underlying problems with identity may have in manifesting an alternative self, therapists can strive to address these issues when treating clients with anorexia nervosa.

Main Risk Factors in Developing Anorexia Nervosa

Clients with anorexia nervosa maintain weight loss through a variety of restrictive and excessive behaviours in an all-consuming pursuit of thinness. The main risk factors in developing anorexia nervosa appear to be influenced by a genetic predisposition to perfectionist and obsessive personality traits. Psychological factors of low self-esteem, alexithymia, and perfectionism also tend to contribute to and perpetuate the cycle of starvation. Ninety percent of those diagnosed with an eating disorder are women, which may explain the influence of social and cultural standards in what some theorists describe as a culture-bound syndrome (Maisel, Epston, & Borden, 2004;; Freedman & Combs, 1990; Reed, 2002).

Genetics. There is a clear and possibly substantial genetic contribution to the development of anorexia nervosa. Eating disorders run in families (Fairburn & Wilson, 1993). There is evidence of familial coaggregation of anorexia nervosa and obsessional and perfectionist traits (Lilenfield, Kaye, & Strober, 1997). Treasure and Schmidt (2002) showed a concordance for anorexia nervosa in 55% of monozygotic twins and 5% in dizygotic twins, suggesting a significant heritability factor for the disease. What is uncertain is the extent to which heredity influences the development of anorexia nervosa given the range of individual and environmental factors that may not lead one to develop an eating disorder (Klump, Miller, Keel, McGue, & Iancano, 2001; Kortegaard, Hoerder, Joergensen, Gillberg, & Kyvik, 2001; Wade, Bulik, Neale, & Kendler, 2000). Polivy and Herman (2002) suggest a role for genetics in the regulation of physiological parameters

that may contribute to an eating disorder. However, it is difficult to understand how a genetic predisposition to perfectionism and obsessiveness develops into an eating disorder for some women and not for others.

Gender. Research has consistently demonstrated that women are more likely than men to suffer from eating disorders (Hall & Hay, 1991). Over 90% of those diagnosed with an eating disorder are women (American Psychiatric Association, 2000). As compared to studies that suggest eating disorders affect as many as 2% of young women and 1% of males (Hoek & vanHoeken, 2003; Lucas, Beard, O'Fallon, & Kurland, 1991; Woodside, Walfish, & Kaplan, 2001) women may also be more likely diagnosed with an eating disorder than men given the cultural idealization of slimness and emphasis on body image in Western society for women rather than for men. In addition, studies have converged on the finding that girls and women are more likely than boys and men to experience dissatisfaction with their bodies, with most girls and women reporting that they would like to be thinner than they believe themselves to be (Joiner & Kashubeck, 1996; Koff, Reardan, & Stubbs, 1990). The idealization of slimness and derogation of fatness in cultures of abundance is more intense for females than for males (Striegel-Moore, 1997).

This sex-linked evaluation of thinness is usually invoked to account for the fact that eating disorders are 10 times more prevalent in females than in males (Striegel-Moore, 1997). Why do males not develop eating disorders as often as females do? Do males not express dissatisfaction with their bodies? Are males satisfied with their bodies? This seems unrealistic given the extent to which men engage in diet and exercise behaviours. Body dissatisfaction may in fact be regarded as an essential precursor (and continuing accompaniment) to eating disorders. The more intense this dissatisfaction, the

more likely it is that one will undertake attempts to lose weight. When combined with the genetic risk factors of perfectionism and obsessiveness, individuals with intense dissatisfaction with their body may develop anorexia nervosa.

Psychological Factors in Developing Anorexia Nervosa

Anorexia nervosa appears to be influenced by a genetic predisposition to the personality trait of perfectionism. The heritability component of perfectionism alone does not necessarily lead one to develop an eating disorder without the presence and influence of other psychological factors; namely, low self-esteem, alexithymia, and self-identity (Bastiani, Rao, Weltzin, & Kaye, 1995; Fairburn, 2004, 2003; Klump et al., 2000).

Perfectionism derives from the desire to hide imperfections and is motivated by feelings of inadequacy and a desire to avoid interpersonal rejection. Feelings of personal inadequacy are connected to low self-esteem, which is another psychological factor present in anorexia nervosa. Self-esteem or self-worth includes a person's subjective appraisal of himself or herself as intrinsically positive or negative to some degree (Tangney, 2002). In clients with anorexia nervosa, a negative and imperfect view of self contributes to and exacerbates perfectionist standards as a means of concealing perceived imperfections. Perfectionism, in anorexia nervosa, may provide a new-found identity that masks problems with self and self-worth.

In addition to perfectionism and low self-esteem, alexithymia, or the inability to identify or express emotions, may connect the difficulty anorexics have in expressing their dissatisfaction with self and their bodies. In trying to mask their sense of personal inadequacy through attaining and portraying a perfect exterior, clients strive to diminish their distress over who they are and who they are not.

Perfectionism. In pursuing perfection, clients with anorexia nervosa are often subjected to standards of beauty imposed by others as well as themselves. Perfectionism, as defined by Hewitt and colleagues (2004), is the belief that one must strive to be perfect. It is argued by Hewitt et. al, that perfectionism can contribute to eating disorders by making normal shortcomings more traumatic or by making a normal body a sign of imperfection. Bruch (2000) and Crocker & Wolfe (2001) also alluded to the role perfectionism plays in the development of anorexia nervosa. What is interesting is whether perfectionist standards increase as weight is lost thereby perpetuating the cycle of starvation. Why do clients with anorexia nervosa create an unattainable standard of thinness for themselves that goes beyond perfection?

Perfectionism is considered a trait characteristic that, according to Hewitt and Flett (2003), involves unrealistic demands for the self or others to be perfect or the perception that others have unrealistic demands for them. This view attempts to explain the all-consuming pursuit of thinness and the unrealistic demands anorexics put upon their body in an effort to gain self-acceptance through the rigors of anorexia nervosa. It is a willful rejection of self and an acceptance of an anorexic identity that is reinforced by the media and a culture that views thinness as perfection (Hepworth, 1999; Surgenor; Surgenor, Plumridge, & Horn, 2002). Interestingly, perfectionist self-presentation, a concept involving the interpersonal expression of perfection, is a valid and reliable construct and a consistent factor in the personal psychological distress evident in anorexia nervosa (Hewitt & Flett, 2004). It is argued that the need to promote one's perfection or the desire to conceal one's imperfection involves self-esteem regulation.

It is important to address the nature and presence of psychological factors in anorexia nervosa that foster the development of the anorexic self. The relationship between psychological factors of perfectionism, low self-esteem, and alexithymia and the formulation of the anorexic identity may serve to protect a negative view of self and feelings of inadequacy through the external expression of an anorexic façade that may serve to protect anorexics from their own despised self.

In creating a perfect self, clients with anorexia nervosa begin to measure their self-worth in terms of their achievements in becoming and remaining anorexic. This may contribute to difficulty in treating anorexia nervosa, as clients are fearful of losing the only way they have learned to cope with feelings of inadequacy and lack of self-worth. The question remains, who are clients trying to please, themselves or others? Does self-imposed perfectionism on its own contribute to the development of eating disorders? Or, are anorexics struggling to achieve an external standard of perfection? If so, why, after weight is gained, are there remaining indices of perfectionism that do not contribute to and reinforce the desire to remain thin or in this case perfect? It seems plausible to assume that the lower the anorexics' sense of self-worth, the higher the degree of perfectionist standards they set for themselves in order to appear to themselves and others as adequate.

It could also indicate a desire to create an alternative self that is not subjected to the criteria of acceptance set by others, as well as themselves. The anorexic can find solace in becoming and being anorexic. In this sense, anorexia nervosa is not something a client despises, but glorifies as an expression of achievement in weight loss and an illusion of self-acceptance. In struggling to achieve perfection, anorexic clients mask their

uncertainty of what they should be versus who they want to be. Clients who suffer from an already low opinion of themselves create a false sense of self in achieving a thin ideal. What is reinforced is an empty shell that focuses on weight and not on one's self.

Alexithymia. The role that perfectionism and low self-esteem play in the development and manifestation of anorexia nervosa may be somewhat explained by alexithymia, which may point to the emotional challenges faced by clients with anorexia nervosa in identifying and expressing emotion. Alexithymia is described as the inability to identify or express emotions and literally means "to have no words for emotions" (Johnsson, 2001; Smith & Amner, 1997). But why can't clients with anorexia verbalize their feelings? If clients are not able to identify and express their emotions, do their feelings become somatized over time?

Alexithymia in anorexia may explain difficulties in recovery even after a client has physically regained weight but continues to struggle with emotional and identity issues (Hsu, Crisp, & Callender, 1992; Smith & Amner, 1997).

Low self-esteem. In trying to please themselves or others, anorexics only set an unattainable standard of perfection and may also set up a perpetuating cycle of self-hatred. Deficits in self-esteem may leave people with eating disorders unprepared for the developmental tasks of separation and individuation that are thought to influence a positive view of self. Cognitive theorists discuss self-esteem deficits in clients with anorexia nervosa as partially related to a cognitive belief that they are ineffective, incompetent, and vulnerable to external control (Garner & Bemis, 1982). The inability to form a healthy sense of self creates psychological distress for clients and the perceived

notion that they are inadequate. This view is consistent with the notion that anorexia nervosa is an expression of a self that is not otherwise known.

Madigan (1987) also discusses how clients can identify with their wasted body and declare the condition a form of self-realization and self expression. This could explain the concept of alexithymia and the possibility that clients who struggle with emotions may begin to somatize feelings they cannot identify or express. By prescribing to a new-found identity, one of perfection, clients promote their anorexic self to proclaim and display their perfection in being anorexic while avoiding and concealing their feelings of imperfection and inadequacy.

The relentless pursuit of thinness to achieve a body of perfection sets the stage for susceptibility to an eating disorder. The mediating effects of body dissatisfaction also play a role in the cycle of starvation and negative body image. Individual specific characteristics of perfectionism, low self-esteem, and alexithymia contribute to a negative view of self that only finds solace in the restriction of food and eventual weight loss. Profound emaciation is also associated with regressive behaviours and ironically as an erosion of the former self (Bruch, 1978). The erosion of the former self is also a psychological effect of starvation and, according to Malson (1998a), is a disassociated state. The disassociation invades and affects one's sense of self. The disassociated state maintains a separation from the authentic self and, as pounds dwindle away, simultaneous disassociation from the environment can occur. Finding solace in profound emaciation erodes one's sense of self as well as one's sense of reality. The disassociation from reality promotes denial of the disease and the effects of starvation on individuals, their environment, and the reinforcement of their negative view of self.

Environmental Risk Factors

Individual specific characteristics of perfectionism, alexithymia, and low self-esteem seem to contribute to the cycle of starvation in anorexia nervosa. The erosion of self may take place in response to rapid weight loss that results in disassociation from both oneself and from reality. The environment plays an important role in influencing and mediating images of idealized slim physics that in turn tend to reinforce a women's negative view of her self and her body. Eating disorders have become more prevalent in cultures that have an abundance of food and idealize slimness. Women who live in a culture that promotes beauty and the thin ideal are more susceptible to being dissatisfied with their bodies and internalizing body dissatisfaction as a reflection of a bad self, and are therefore more vulnerable to developing an eating disorder.

Cultural and media influence. Initially, it was believed that the idealization of slimness and the subsequent tendency towards anorexia nervosa was concentrated in the upper socioeconomic class (Garner & Garfinkel, 1979). As our culture has become increasingly homogenized, with media images of a thin ideal physique now permeating every corner of society, eating disorders have become correspondingly more democratic (Garner & Bemis, 1985; Striegel-Moore, 1997); the incidence and prevalence of eating disorders no longer affects only a higher socioeconomic class (Striegel-Moore, Silverstein, & Rodin, 1985). The sociocultural model of eating disorders attempts to explain the influence of culture on women and their bodies.

Not surprisingly, the media are often blamed for increasing the incidence of eating disorders on the grounds that media images of idealized (slim) physiques motivate or even force people to attempt to achieve slimness themselves. The media are accused of

distorting reality; the models and celebrities portrayed in the media are either naturally thin or unnaturally thin through exceptional means of achieving and maintaining a slim physique. As with the culture of abundance, idealized media images are at best a background cause of eating disorders. Exposure to the media is so widespread that if such exposure were the cause of eating disorders, it would be difficult to explain why anyone would not be eating disordered (Tiggemann & Pickering, 1996). For those who develop anorexia nervosa, it is difficult to understand how the media and Western culture influence eating disordered behaviours that go beyond the thin ideal to the pursuit of life-threatening emaciation that no longer is defined by society as beautiful but as an illness.

It is difficult to understand how the media and Western culture influence the development of an eating disorder without including personality traits of perfectionism, low self-esteem, and body dissatisfaction. Initially, Garner and Garfinkel (1987) reviewed personality traits and cognitive abnormalities that exist and predispose one to develop anorexia nervosa. Body dissatisfaction has recently been found to be influenced by the media (Stormer & Thompson, 1996). Thus, media influence is thought to precipitate anorexia nervosa by making women feel dissatisfied with their appearance. What is interesting is how the media influences women to confined body weight ideals that are not global expressions of beauty. Why do some cultures express female beauty in terms of a voluptuous body while others express beauty in the form of a thin physique?

It would appear that eating disorders do not occur uniformly in all cultures at all times. An obsession with slimness is a core feature of anorexia nervosa and is concentrated in cultures where food is abundant. In cultures of scarcity, the ideal body shape is much more likely to be rotund, suggesting that the idealization of weight leans

toward what is most difficult to achieve according to the food abundance in that culture (Stark-Wroblewski, Yanico, & Lupe, 2005). This would explain why, in Western culture where food is abundant, the idealization of thinness is unachievable for most women. In this sense, a culture of caloric abundance may be considered a risk factor for developing anorexia nervosa.

It is important to note from the outset, however, that this risk factor is not specific. Growing up in a culture of abundance, while perhaps increasing the chances of developing anorexia nervosa, does not make it likely that a person will develop an eating disorder. The question then is whether a particular individual takes this valuation of thinness to a pathological extreme depends on additional factors including personality traits, the internalization of appearance standards, a drive for thinness, and underlying problems with identity.

There is variation in the extent to which people internalize our culture's valuation of slimness, and the extent of such internalization predicts body dissatisfaction, drive for thinness, and certain anorexic characteristics (Stice, 2001; Stormer & Thompson, 1996). What factors determine the extent to which the value of thinness is internalized? The connection between perfectionism, low self-esteem, body dissatisfaction and societal standards of beauty (Wolf, 1990) must be taken into consideration when determining the multifactorial contributions in developing anorexia nervosa. In contrast, among clinical and nonclinical samples, both men and women who perceive themselves as physically unattractive or who report negative or dysphoric attitudes toward their physical appearance (i.e., a negative body image) have typically been found to have poor self-esteem, social anxieties and inhibitions, sexual difficulties, and a vulnerability to

depression (Cash, 1990; Cash, Ancis, & Strachan, 1997; Cash & Labarge, 1996; Cooper, Taylor, Cooper, Fairburn, C. G., 1987). Moreover, persons who exhibit disordered eating behaviours often have dysfunctional perceptions of their physical appearance (Garfinkel & Kaplan, 2000).

The problem of body image dissatisfaction is quite prevalent in the general population. A large-sample national survey (Cash, Ancis, & Strachan, 1997) of adolescents and adults indicated that 31% of female respondents and 24% of male respondents reported negative attitudes about their physical appearance. This survey also found that a negative body image was clearly associated with lower levels of self-reported psychosocial well-being. Why do women take dieting to a pathological extreme given that both men and women report negative body image and perceive their bodies as unattractive? This may be a result of the cultural obsession with appearance standards that promote the thin ideal for women whereas the male ideal is muscular and physically fit.

Western worldview of beauty. In keeping with the view that the development of anorexia nervosa is a result of multifactorial contributions, a sociocultural model of eating disorders (Streigal-Moore, Silverstein, & Rodin, 1986) attempts to explain gender differences in the prevalence rates of eating disorders by proposing that eating disorders have developed in response to increasing pressures for women in our society to achieve a thin body ideal. Sociocultural factors that contribute to the development of disordered eating include a significance of appearance in the female gender role, the importance of appearance for women's success in society, and the thin ideal promoted for women, particularly in the mass media. The model also acknowledges that sociocultural factors

may interact with other variables such as genetic, family characteristics, and developmental processes (Stice, 1994). This view highlights the significant differences between male and female body image and the social expectations of what feminine and masculine beauty represent.

Body dissatisfaction, according to Polivy and Herman (2002), is probably a necessary factor in the emergence of eating disorders, although it does not sufficiently explain why men and women who are dissatisfied with their bodies do not embark in the behavioural and psychological confines of anorexia nervosa. After all, it is possible to be dissatisfied with one's body and yet not do anything about it. Why is it that, of two dissatisfied people, one throws herself/himself into (usually futile) attempts to achieve a satisfactory body, whereas the other remains dissatisfied but does not diet/starve, binge, or purge?

Anorexia nervosa usually develops in adolescent and young women. It is the third most common chronic illness in teenage girls and is seen only rarely in males (Beaumont, Beardwood, & Russell, 1977) The determining factor may be whether or not the individual seizes upon weight and shape as the answer to the problems of identity and control. In anorexia nervosa, some young women become invested in achieving a perfect body as an existential project (i.e., as a way of giving their lives meaning, coherence, and emotional fulfillment that are otherwise lacking). Some become invested in achieving complete control over their eating, weight, and shape, believing that control in these domains is possible even though such control is not possible elsewhere in their lives. Vitousek, Watson, & Wilson (1998) describe the investment dividends of anorexia

nervosa as a maladaptive solution to suffering, confusion, and sense of inadequacy by identifying with weight and not self.

The inability to express emotion, perfectionism, and low self-esteem creates anxiety in anorexic patients. Negative affect and negative feelings about the self may be channeled into negative feelings about the body or body dissatisfaction (Stice, 2001). Dieting has been posited to precipitate bingeing (Polivy & Herman, 2002) and eating disorders in general (Polivy & Herman, 2002; Stice, 1994, 2001) and it is body dissatisfaction that may presumably cause dieting. Weight concerns and dieting may help predict the emergence of an eating disorder (Joiner & Kashubeck, 1996; Steiger, Leung, Puentes-Neuman, & Sottheil, 1996; Stice, Hayward, Camerson, Killen, & Taylor, 1998). Weight concern and negative feelings about one's body are also predictors of increased body dissatisfaction as a mediating effect in the perpetuation of anorexia nervosa.

Conversely, satisfaction with one's weight acts as a protective factor in adolescent girls who are otherwise at high risk for developing anorexia nervosa (Chandy, Harris, Blum, & Resinick, 1995). In addition, a drive for thinness in anorexia nervosa patients may reflect a drive for food restriction as a compensatory mechanism for increased anxiety (Vervaet, van Heeringen, & Audenaert, 2004) and may be particularly reactive and susceptible to societal messages referring to the ideology of slenderness (Gendall, Joyce, Sullivan, & Bulik, 1998). Essentially, girls are taught to be attractive, not active, and thus parts of a whole self are fragmented and excluded from their identity (Malson, 1989). Culture gives girls and women ambivalent messages about the female body; namely, that personal worth is measured exclusively by the appearance of the body and that the female body is shameful.

It is not surprising that some women, and not men, develop eating disorders in a society that glorifies images of bodies that are unattainable and unrealistic for most women to achieve. The internalization of idealized standards of thinness creates a drive for thinness that is relentless. The investment in anorexia nervosa is a maladaptive solution to suffering, unexpressed emotion, and a sense of inadequacy by identifying with weight and not self.

Attachment Theory and the Development of Anorexia Nervosa

Internalizing idealized standards of thinness perpetuates the cycle of body dissatisfaction, a drive for thinness, and a sense of personal inadequacy. The cultural component in developing anorexia nervosa is strengthened by considerable evidence that exposure to attractive, thin female models increases depression, guilt, shame, anger, and body dissatisfaction in women at risk for eating disorders (Henderson-King & Stewart, 1997; Stark-Wroblewski, Yanico, & Lupe, 2005). From the perspective of attachment theory, eating disorders are conceptualized not as a reflection of sociocultural standard of female beauty, but as externalizing behaviours enacted to allow the diversion of attention away from attachment-related concerns and toward the external and more attainable goal of body change (Joiner & Kashubeck, 1996).

Based on this model, persons with eating disorders are expected to have a higher frequency of adverse early experiences with their attachment figures and a higher prevalence of insecure attachment (Dozier & Kobak, 1992). Both of these predictions have been repeatedly confirmed by studies of clinical and non-clinical populations. The insecure attachment style has been also considered a risk factor for the development of an eating disorder.

Autonomy and separation difficulties in anorexia nervosa. Autonomy disturbances and separation difficulties have been consistently postulated as an important factor in the etiology of eating disorders, especially anorexia nervosa (Garner & Garfinkel, 1979). Clinicians have put forward the idea that women with anorexia nervosa have problems achieving independence and adulthood by way of the developmental task of separation-individuation (Bruch, 1978; Minuchin, Rosman, & Baker, 1978; Sours, 1980). However, mature development requires more than separation. Another facet of adult functioning is relationships, a concept that is often ignored in the theoretical literature (Armstrong & Roth, 1989). Only recently has research indicated the importance of the evolution of relationships in identity formation (Ainsworth, 1989; Miller, 1986). If women with anorexia nervosa have a history of attachment difficulties and problems with separation, it seems possible that they may also struggle with underlying problems with identity. If the developmental task of separation-individuation does not occur within the developmental process, then young women may come to rely on anorexia nervosa as source of being different or, in this case, individual.

The struggle for autonomy and struggle for self. The importance of combining the roles that autonomy and relationships play in the development of anorexia nervosa has been further documented (Minuchin, Rosman, & Baker, 1978; Selvini-Palozzi, 1978; Viaro, 1990). A relationship between the search for autonomy and the development of self has also been studied (Case, 1991). Bruch (1978) characterized anorexia nervosa as a maladaptive search for autonomy and self-mastery. Sours (1980), Selvini-Palazzoli (1978), and Masterson (1977) have each presented views of autonomy disturbances in patients with anorexia nervosa. A central concept for these theorists is that the

development of autonomy is dependent on successful differentiation of the self-representation from object-representations. Resolutions of conflict in each stage of development prepare the way for an adequate self to develop, as well as for autonomy and independence in relationships.

In family systems theory, Minuchin et al. (1978) described the development of anorexia nervosa as resulting from family characteristics that are incompatible with the development of autonomy. Selvini-Palozzi (1978) discusses family communication patterns in which the daughter with anorexia nervosa serves a homeostatic function in the family that prevents interpersonal problems from emerging directly. This view is consistent with the presence of alexithymia in anorexia nervosa. The combination of the inability to express emotion as an individual as well as within a family creates an interpersonal struggle to be heard and to be understood. It is therefore possible that the struggles for self, for independence, and for autonomy are thereby manifested in a new-found self, the anorexic self. Although there are commonalties of these themes in the clinical literature, there is little empirical confirmation of disturbances in autonomy development in studies of patients with anorexia nervosa (Hsu, Crisp, & Callender, 1992, Orbach, 1995).

Despite their differences in emphasis, difficulties with attachment in early infant-mother relationships, the demands for autonomy at adolescence, and the obsessional pursuit of thinness seems to appear in the overcontrolling maintenance of a prepubescent body, which is the core phenomenon of the pathology of anorexia nervosa. While theorizing about the nature of impaired developmental processes in bulimia is more recent, it too emphasizes inappropriate parental involvement and the resultant failure to

adequately separate both physically and cognitively from the maternal object (Sugarman & Kurash, 1982). Drawing on the theorizing and observations of mother-infant interactions by Mahler, Pine, and Bergman (1975), Sugarman and Kurash (1982) suggest that the process for the development of body differentiation may be interrupted by an inaccurate responsiveness to an infant in the separation individuation. This lack of responsiveness may lead to a hostile or at best ambivalent connection between the infant and her own bodily functions as well as an incomplete or tenuous disconnection from the mother. The flood of bodily changes at adolescence, together with the demands for greater physical and psychological autonomy, results in the return of these hostile-ambivalent feelings and beliefs that have been internalized. This type of action-object cognition, described by Grothaus (1998), is consistent with some developmental models of the origin of the child's sense of self (Case, 1991).

The prediction from attachment theory is that such infants would show patterns representing insecure attachments when the attachment system is threatened. However, it is difficult to be more precise in predicting the type of insecure attachment involved in anorexia, as the pathological pursuit of thinness and the exclusive reliance on weight and shape for self-evaluation and self-esteem may be interpreted as reflecting either insecure-avoidant or insecure-resistant attachments. It could be argued that the anorexic's preoccupation with her body enables her to dismiss the importance of family and peer relationships and avoid the anxiety involved in separating from family and establishing peer attachments, and indeed to avoid the necessity of these changes. Alternatively, the emphasis on body shape, weight, and appearance could be seen as a type of hypervigilance to the judgments of others and to the possibility of criticism, rejection, and

abandonment (Leon, Keel, Klump, & Flukerson, 1997). In either case, the symptoms of anorexia may function to regulate and ensure predictability in the young women's proximity to parents and peers.

Attachment theory proposes to introduce the concept of autonomy, attachment, and related difficulties with self in the developmental process. Attachment theory seeks to understand the nature of anorexia nervosa through parent-child relationships that are formed early in life. It seems likely that an insecure attachment in childhood creates an insecure view of self. The developmental process of individuation may appear traumatic to an anorexic client who has come to rely on patterns of emotional neglect, abandonment, and rejection in parental relationships and otherwise. This view may highlight how the influence of an insecure attachment in early years affects the quality of both a relationship with one's self and others in the adolescent phase of separation and individuation. Attachment theory may help explain the difficulties of some young women who have experienced attachment difficulties at an early age as they continue to experience difficulties with the development of self and self-identity.

However, attachment theory alone cannot address why those with similar attachment difficulties in childhood do not develop eating disorders. Insecure attachment in childhood may create an insecure individual who does not engage in conscious starvation and who satisfies feelings of ineptness and inadequacy in ways that do not involve eating. In order to develop a deeper understanding of how and why clients with anorexia nervosa begin to develop an anorexic mindset, it is important to view anorexia nervosa through a varied theoretical lens.

Postmodern Conceptualization of Anorexia Nervosa

In attempting to understand anorexia nervosa through a variety of theoretical concepts it is important to ask the question: Do we really know what anorexia is or do we propose theories about it? It may appear that poor outcomes in anorexia nervosa treatment are a result of a misunderstanding what the disease is and what it is understood to be. Recent postmodernist studies of anorexia nervosa, including social constructionism and existentialism, challenge current clinical understandings and therapies for the disease by illuminating not what anorexia is but what it is known to be by clinicians. This modern view helps deconstruct the disorder and therapy for it (Surgenor, Plumridge, & Horn, 2002). Postmodernist approaches point to the need for social reconstruction of lay and community understandings of anorexia nervosa. They also have implications at the level of individual therapy and could be deployed with patients to establish individual but authentic bases for therapy. Postmodern approaches deconstruct the socioeconomic, cultural, and political underpinnings of anorexia to uncover a reality of the disease from the perspective of the individual.

A Social Constructivist Understanding of Anorexia Nervosa

Social constructionist theory is an example of a postmodern view of psychology that attempts to deconstruct preconceived notions of anorexia nervosa that are based on socioeconomic, cultural, and political influence. Behavioural and cognitive theories of psychology are objective in that they assume the external world is real and humans acquire responses and knowledge in accordance with what exists in the world. In contrast, constructivism assumes that subjectivity is critical because learners take in information from the external world and cognitively process it in ways that reflect their needs,

dispositions, attitudes, beliefs, and feelings. Constructivist theory builds on the assumption that learners construct knowledge as they attempt to make sense of their experiences (Freedman & Combs, 1990). Learners are not empty organisms waiting to be filled, but rather active organisms seeking meaning. Learners form, elaborate, and test mental structures until a satisfactory one emerges, creating meaning from experience. This process depends on the interaction between the learner and the environment and must occur in the context in which the interaction occurs.

How might clients with anorexia nervosa construct knowledge about themselves and attempt to make sense of their own personal experience with the disease? It seems possible that an active search for meaning and identity may leave some women with a false illusion of what society has constructed for them. That is, in an attempt to make sense of what it is to be a woman, those with anorexia nervosa take in information from the external world that does not reflect their own subjective experiences and beliefs about who they are. If clients view themselves as inadequate and unacceptable and struggles with self-identity, it may be that anorexic clients begin to collect information that only serves to reinforce their negative view of self. Clients with anorexia nervosa may begin to test the effect starvation has on whether dieting meets their needs, attitudes, and beliefs. Initially, it may appear that dieting improves one's subjective self-evaluation; however, as the pounds dwindle, dramatic weight loss may also reflect a client actively collecting information that feeds the needs of not one's self, but of the anorexic self. The needs, attitudes, and beliefs of the anorexic self may actively collect information from the external world that may reinforce feelings of incompetence and self-hatred, thereby perpetuating the cycle of starvation and fostering the development of an anorexic identity.

Feelings of incompetence and self-hatred are channeled into negative feelings about weight and shape that serve to mediate both the cycle of starvation and the annihilation of one's former self. Thinness, in this sense, is an expression of an individual's self-loathing. By losing weight, clients may feel they are losing a part of themselves they have grown to despise.

Adopting a postmodern, narrative, social constructionist worldview offers useful ideas about how power, knowledge, and truth are negotiated in families and larger cultural aggregations (Anderson, 1990). In this view, realities are socially constructed, constituted through language, organized and maintained through narrative, and there are no essential truths. Gone is the faith in an objectively knowable universe. Gone too, is the modern notion of an essentialized self, an individual ego who is the locus of choice, action, and rational self-appraisal. In their place is a variety of perspectives cutting across the human sciences and humanities.

The basic tenet of constructivism acknowledges multiple realities that are socially constituted and historically situated and defy adequate comprehension in objectivist terms (Neimeyer, 1993). Language, in this view, actually constitutes the structures of social reality, requiring the cultivation of new approaches (hermeneutic, narrative, deconstructionist, rhetorical, and discursive) appropriate to analyzing the text of human experience in social context. In relation to anorexia nervosa, the postmodern view attempts to uncover the individual within the eating disorder. Anorexia nervosa is therefore an action of choice to eliminate the authentic individual through an irrational self-appraisal that leads to the development of an apparently more acceptable self.

Bottorff and Lamoureaux (2005) describe three factors that contribute to women's vulnerability and make it difficult to inch away from anorexia: the sense of control and power that anorexia seems to offer, the way their sense of identity is linked with anorexia, and their perception of themselves as not good enough. This view highlights the negative control of disease on the possibility of recovery for clients who identify not with themselves but with their success in becoming and being anorexic.

Postmodernism and the Anorexic Self

Postmodern approaches attempt to reconstruct the understanding of anorexia nervosa through the deconstruction of the complex, socioeconomic, cultural, and political dynamics of contemporary Western societies that have defined anorexia nervosa (Malson, 1998b). How might anorexia nervosa be theorized as an expression of a wider postmodern cultural condition? The construction of the anorexic body as a disappearing body and as a signifier of female/feminine identity under erasure may be theorized as a peculiarly intense and distressing expression of a wider postmodern cultural condition (Surgenor, Plumridge, & Horn, 2002). Self without anorexia and the emaciated body would be an empty shell and devoid of identity according to Malson (1998b). This view may explain the construction of the anorexic self in order to provide an otherwise absent identity. This view may also explain how anorexic clients find solace from self-hatred and self loathing in an escape from both their authentic self and from reality.

Emaciation, however, is only a temporary relief. Anorexia nervosa has been described as a self-pathology (Geist, 1989) and as a pseudo-solution to intra and interpersonal difficulties of consolidating a sense of self as a separate and autonomous individual (Bruch, 1982). Located within a postmodern context, however, such

difficulties can be seen not as psychopathology originating within the individual but as constituted within and by the complex socioeconomic, cultural, and political dynamics of contemporary Western societies (Malson, 1998b). This may explain the difficulties clients with anorexia nervosa pose to therapy. Recent postmodern discursive approaches to understanding anorexia nervosa take issue with the phenomenon of self-starvation. Hepworth (1999) argues that anorexia is socially constructed in the sense that it is known or understood through disciplines like psychology and psychiatry that are themselves discourses that systematize and discover realities. A postmodern view is a departure from what is known about anorexia to what anorexia is (Hepworth, 1990, 1999).

But what is anorexia nervosa? It is important to note that the phenomenon of clinical anorexia nervosa has no empirical reality or existence, at least in terms of the postmodern sense of the unknowable outside of the disciplinary discourses that construct it. In reconstructing the current understanding of anorexia nervosa, social constructionism attempts to inform and challenge individual therapy in order to begin to address intra and interpersonal difficulties that are inherent in both the nature of the disease and identity formation. This view is consistent with the work of Bruch (2000); Epston, Maisel, and Borden (2004); Malson (1998b); Rusca (2003); and Lamoureux and Botorff (2005). It seems plausible that society influences a woman's sense of self in developing a feminine ideal that proposes a set of beauty standards that bare no prejudice. The standard of beauty is seen as an achievement and an attainable goal that, if attained, would result in the formation of an acceptable self. What is questionable is whether that newly formed self is an answer to an individual's struggle with identity and an authentic sense of self or an answer to a socioeconomic and cultural persuasion of what it means to be female.

Western society promotes the perfecting of one's image to meet a prescribed image of beauty through dieting, self denial, and an ascetic approach to self-acceptance. Therein lies the impression that women who follow the notion that appearance standards set the stage for self-acceptance are often left feeling inept and devoid of authenticity long after the weight is lost.

The Existential Approach and Understanding Anorexia Nervosa

In a postmodern context, anorexic psychopathology is understood as a complex socioeconomic, cultural, and political interplay of Western society that is internalized by women as a means of identity formation and identity reformulation. Existential psychotherapy follows a similar theoretical foundation whereby existentialism arose from dissatisfaction with the prevailing efforts of psychotherapy to gain scientific understanding in psychiatry (Binswanger, 1958). Existential therapists believed that drives in Freudian psychology, conditioning in behaviourism, and archetypes in Jungianism all had their own significance. But where was the actual, immediate person to whom these things were happening? Are we seeing clients as they really are, or are we simply seeing a projection of our theories about them (May & Yalom, 1980)?

Existential therapy attempts to understand the social and cultural interaction of human experience. Existentialists have devised methods of therapy that fall into the common error of distorting human beings in the very effort to help them. How does an existential approach relate to the treatment of anorexia nervosa? Have we devised methods of therapy that distort the nature of anorexia nervosa and the individuals who suffer from the disease? Do we see clients with an eating disorder for who they are or as a reflection of a socio, economic, and cultural problem? How does therapy address the intra

and interpersonal struggles clients present? If we relate to clients as eating disordered and not as individuals, therapists may reinforce an already present struggle for identity and authenticity by addressing not what an individual sees their disease as but what society has constructed it to be.

Existentialism and the anorexic self. In order to develop an understanding of anorexia nervosa using an existential framework, the concept of self should be explored. Is anorexia nervosa understood through a projection of theories about them or through the experience of clients who define themselves by external acceptance rather than self-acceptance? Rusca (2003) suggested that the concept of self, according to a Kierkegaardian view, includes the concepts of conscience and will, without which the self is poorly defined. A combination of chance and necessity, according to Rusca (2002), sets the foundation for self-development. Necessity, in this case, can be defined in biological terms as the genetically determined component of self. Chance is the totality of external factors that influence the development of self in a mutual relationship between an individual and will. The complex interaction among chance, necessity, and will leaves the individual in search of an identity trying to answer the basic question: What is my real self?

A willful rejection of self. In the quest to discover one's true self, an individual realizes that identity is not established on its own and is left with three alternatives: accepting oneself, simply not wanting to be oneself, or refusing to devise another self (Rusca, 2002). The third alternative is chosen by anorexics and ultimately leads to despair. The process of a willful rejection of self leads individuals in pursuit of a new self. This, according to Rusca (2003), allows control over the development of this new

self and the development of one's body. This view may explain the emergence of an alternative self, the anorexic self, as a result of a willful rejection of an authentic self. Anorexia nervosa then becomes a willful attempt at emaciation in order to gain acceptance from and for a new-found identity.

Anorexia nervosa can be explained as a process of individuation. From an existential point of view, one might consider that somehow in adolescence the umbilical cord is severed and the individual is left alone with a given body, gender, and sexuality to deal with, to accept, or to reject, and a mind able to reflect on itself. The emergence of the anorexic self is reinforced and perpetuated by the presence of perfectionist standards to which many anorexic clients subscribe. If one views one's self as unacceptable, the new anorexic identity may falsely present as acceptable to others as well as to themselves. Acceptable, in this context, is a thin body and a false sense of self-esteem derived from the achievements associated with extreme weight loss and adherence to a physical and psychological mindset in the all-consuming pursuit of thinness.

Existentialists (Rusca, 2002) view anorexia nervosa as a rejection of self in the process of individuation. In addition to the intrinsic struggles of an anorexic, social and cultural implications in the development of the disease are evident. Anorexia nervosa is commonly regarded as a culture-bound syndrome that is consistent with a social constructivist and feminist conceptualization of the disorder (Maisel, Epston, & Borden, 2004; Freedman & Coombs, 1990; Rusca, 2003). In the development of the new self, an anorexic is incorporeal and totally controlled. The controlling part is at times perceived as a separate "it" controlling the mind. The new self, which so much wanted to be in control, is out of control by being under the orders of the "it". The anorexic self has found a new

identity in weight loss and self-hatred (Rusca, 2003). The search for identity in clients with anorexia nervosa becomes a willful rejection of an authentic self and an acceptance of the anorexic self.

Existentialism questions therapy that distorts human beings in the very effort to help them. The postmodern approach deconstructs what is known about the disease and attempts to reconstruct an authentic understanding of the disease. This view is consistent with the existential belief that human beings are subject to the dehumanization of modern culture (Binswanger, 1958). This basic tenet of existentialism may explain the sociocultural influence that the idealization of thinness has, not only on women's bodies, but on their ability to be authentic. Anorexia nervosa may be understood as a reflection of a modern culture that rejects a woman's authenticity in favour of an unattainable beauty standard that begins to dehumanize women's bodies and to dehumanize women themselves. It is possible to view anorexia nervosa as a reflection of a feminine identity under erasure (Malson, 1998b). If women are subjected to images of what it means to be female, then the developmental process of adolescence takes on a different meaning than just separation and individuation. If women are to truly separate and mature as individuals, it seems likely that society may impede this process with images of idealized bodies and idealized female roles that tend to inhibit women from being and becoming anything other than authentic. Beyond authenticity and acceptance, all women are exposed to a culture that glorifies a particular appearance, yet some do not develop eating disorders. However, glorified images of women that appear to be perfect in every way may set the groundwork for an interpersonal struggle for women to be authentic and true to one's self despite a societal message that says otherwise.

Current Treatment Recommendations for Anorexia Nervosa

The etiology of anorexia nervosa is an enigma involving a complex combination of psychological, biological, and social stresses. Several treatment methods have been recommended for anorexia. In principle, there are four aspects to treatment management: individual motivation for recovery, weight restoration, psychosocial functioning, and compulsory treatment.

Difficulties in Treating Anorexia Nervosa

It is no surprise that anorexia is a highly difficult condition to treat and that it has a moderately high relapse rate. No single theory prevails in explaining why anorexics are convinced that life would be perfect if they were thinner.

Treatment methods. Several treatment methods have been recommended for anorexia. Recommendations of current international services for eating disorders have been drawn from a number of published guidelines (Eating Disorders Association, 1994; Kreipe et al., 1995; Locke, Le Grange, Agras, & Dare, 2001; NICE, 2003; Royal College of Psychiatrists, 2000). Treatment programs that are behavioural in nature do not always address the original issues that led to the eating disorder (Ratnasuriya, Eisler, Szmukler, & Russell, 1991; Zerbe, 1996). Over the past 50 years, little progress has been made in developing new, effective treatments for anorexia nervosa (Kaplan, 2002). Eating disorders remain difficult to treat, have high rates of relapse, and may persist throughout the life of the client (Kaplan & Garfinkel, 2000).

The four aspects of treatment management. Mainstream opinion of the treatment management of anorexia nervosa can be summarized in four principles. The first is to help patients see that they need help and to maintain their motivation thereafter. This aim is crucial, given their reluctance to change (Fairburn, 2004; Peplau; 1991; NICE, 2003).

The second is weight restoration. This goal is needed to reverse malnutrition and of itself usually leads to substantial improvement in the patient's overall state. Weight restoration can be achieved on an outpatient, day patient, or in-patient basis, the relative merits of these being the subject of debate (Gowers, Weetman, Shore, Hossain, & Elvins, 2000; Meads, Gold, & Buris, 2001; Zipfel, Reas, & Thornton, 2002). Indications for admission to hospital include risk of suicide, severe interpersonal problems at home, and failure of less intensive methods. Physical indications include a very low weight, rapid weight loss, and the presence of medical complications, such as pronounced edema, severe electrolyte disturbance, hypoglycemia, or infection. Under such circumstances, admission should be to a general medical ward or a psychiatric unit with good access to general medical help. In either instance, staff experienced in the management of the disorder is a great advantage. Admission should always be viewed as a preliminary to subsequent outpatient treatment.

The third aspect of management is addressing patients' overevaluation of shape and weight, their eating habits, and their general psychosocial functioning. There is no single way to achieve this aim. One approach that has some research support is a family-based treatment, which seems to be of most help to younger patients (Russell, Szmukler, Dare, & Eisler, 1987) and is mainly used with adolescents. There are various forms of family therapy, but the approach that is most effective remains unclear (Dare & Eisler,

1997). Cognitive behaviour therapy is a logical alternative for older patients. Both forms of treatment require training to implement them, and both are best offered on an outpatient basis.

The fourth aspect of management, use of compulsory treatment, is only relevant to a few cases. Reconciling respect for patients' wishes and their right to receive good treatment can be difficult. Compulsory treatment, though legally permissible, should never be undertaken lightly (Goldner, Birmingham, & Smye, 1997; Russell, 2001). Sesan (1994) described how hospitalization for treatment engendered frightening images of disempowerment for the client. Such settings may perpetuate a pattern of oppression by rigidly controlling women's behaviours and actions and inadvertently silencing them. Sesan suggested that our attempts to control the symptoms of eating disorders may well have prevented women from expressing themselves in the only way they know how. This view highlights the importance of recognizing the level of control the disease has over clients' abilities to see themselves as anything other than anorexic. Silencing and controlling a client by way of forced feeding may only serve to infuriate the anorexic and ignore the authenticity of the client.

Drug treatment does not have an established place in the management of anorexia nervosa. No drug has been shown to have clinical value in promoting weight regain (Mitchell, 2001; Treasure & Schmidt, 2002), although preliminary findings suggest that fluoxetine might reduce the risk of relapse in patients whose weight has recently been restored (Kaye, Nagata, & Welzin, 2001). Medication has been proffered as a magic wand. A recent open clinical trial of the novel antipsychotic agent olanzepine (a benzodiazepine with multiple receptor affinities including selective binding to

mesolimbic dopaminergic neurons) gave cause for optimism, with demonstrated enhancement of weight gain and a lack of extrapyramidal side effects. Selective serotonin reuptake inhibitors have been proposed to prevent relapse and are useful in reducing depressive and obsessive-compulsive symptoms. However, recent genetic studies that showed an association with polymorphism in the novel norepinephrine transporter gene promoter polymorphic region in restricting anorexia nervosa lend support to early use of the antidepressants reboxetine, a selective norepinephrine reuptake inhibitor, and venlafaxine, which inhibits both serotonin and norepinephrine reuptake (Unwin, Bennetts, Wilckne, Beumont, Russel, & Nunn, 2003).

Psychotherapeutic Approaches in the Treatment of Anorexia Nervosa

In following the four aspects in treatment management, psychotherapeutic intervention addresses the myriad of psychological deficits that clients experience with an eating disorder. The primary target of psychotherapeutic treatment is the modification of clients' negative thinking and dysfunctional assumptions about eating, body shape, and weight. Anorexia nervosa is often described as a treatment-resistant condition. Treatment resistance may also be a result of psychotherapeutic treatment that is based on what is known about the disease versus what the disease actually is. This view is consistent with the notion that anorexia nervosa is an interpersonal struggle that develops into an alternative self. In addition to interpersonal struggles, anorexic clients may also experience intrapersonal difficulties, particularly within families of sufferers. Viaro (1990) describes the difficulties that exist in family dynamics that serve to reinforce a client's feelings of inadequacy, personal failure, and personal responsibility.

Therapy that addresses the anorexic self may find clients challenging a part of themselves they have forgotten and rediscovering an authentic base for recovery. In addition, clients are able to gain insight in their intrapersonal struggles with family and friends and how that directly affects their feelings of self-worth and personal inadequacy. In an effort to understand the present approach to the recommended treatment for anorexia nervosa, Cognitive Behavioral, Interpersonal, and Motivational Enhancement therapy need to be explored.

Cognitive Behavioural Therapy

In an effort to utilize evidence-based psychological treatment for anorexia nervosa, Fairburn, Shafran, & Cooper (1999) (1988) described the use of cognitive therapy for anorexia nervosa. This approach is derived from Beck, Rush, Shaw, and Emery's (1979) cognitive therapy approach for depression. The primary target of this treatment is modification of a client's negative thinking and dysfunctional assumptions about eating, body shape, and weight. Current applications of CBT in the treatment of anorexia have been strongly influenced by this cognitive approach (Garner, Vitousek, & Pike, 1997). Nonetheless, no widely accepted treatment intervention for anorexia nervosa exists. Cognitive behavioural therapy attempts to address and modify the core psychological deficits of low self-esteem, all-or-none thinking, cognitive distortions, and dysfunctional concerns over weight, shape, and self-control. Deficits in self-esteem and self-regulation may leave people with eating disorders unprepared for the developmental tasks of separation and individuation.

Generally, people with eating disorders are extremely dependent on external phenomena for the maintenance of their self-esteem. Performance and achievement are

tied to pleasing others rather than oneself. This makes patients with anorexia and bulimia nervosa particularly vulnerable to the influences of cultural, family, and peer groups.

What may also be at work is the presence of an alternative self, the anorexic self, which completely controls the client. Performance and achievement could then be tied to pleasing only the anorexic self and nothing else. Clients are under the orders of the “it”, as described by Rusca (2003), and are extremely dependant and vulnerable to the demands of what it takes to become and remain perfectly anorexic.

Cognitively, clients with anorexia nervosa have various abnormalities (Garner & Bemis, 1982). Of particular importance is a dichotomous or all-or-none thinking style. Although some of the characteristic features of eating disorders have their roots in the individual and in early relationships, these impinge on issues such as self-worth and attractiveness, which have been closely associated with culturally mediated influences in Western society. Perhaps anorexia nervosa could be characterized as a separate identity that comes to shape and form an individual’s sense of self and feelings of self-worth and attractiveness. The difficulty in treating the characteristic features of eating disorders may be the influence these characteristics have over a client’s ability to function in any way other than what the eating disorder dictates. Cognitive therapy that addresses the level of control the anorexic identity has over a client’s authentic sense of self, feelings of worth, and attractiveness may begin to explore a client’s inability to be authentic and their resistance to change.

In keeping with such a multidimensional view, most clinicians would recognize the value of a treatment approach that also addresses the physical and psychosocial nature of a client’s clinical presentation. Most recognize the need to address the extreme

distortion in clinical state produced by starvation, as well as the psychosocial issues that are important in the evolution and maintenance of the disorder.

Fairburn & Wilson (1993) proposed a modified cognitive-behavioural model of what maintains anorexia nervosa and described its implications for treatment. The model postulates that the defining feature of anorexia nervosa is an extreme need to control eating. Fairburn and Wilson recognized the importance of dysfunctional concerns with shape and weight, but relegated them to a less central role, suggesting that existing cognitive-behavioural accounts of anorexia might be overinclusive. They proposed a focal treatment aimed at sense of self-control and suggested that the features that need to be addressed are the use of eating, shape, and weight as indices of self-control and self-worth; the disturbed eating itself; and low body weight. In contrast, they suggested that cognitive behavioural therapy problems and family difficulties are targets of the leading cognitive-behavioural approach (Garner, Vitousek, & Pike, 1997) and do not need to be tackled unless they prevent change.

The CBT model may be a useful heuristic, however remains unproven in treatment efficacy, and does not appear to address the interpersonal struggle with identity nor the controlling aspect of the anorexic self. In fact, the anorexic self may be treatment-resistant as clients both idealize and adore their new-found identity as a refuge from their reality. Treatment resistance in clients with anorexia nervosa may be a result of therapies that only address the cognitive and behavioral function of anorexia nervosa and not the cognitive and behavioural function of the anorexic self that reinforces and protects a client from the possibility of recovery.

Interpersonal Therapy

Interpersonal psychotherapy (IPT) is a brief and highly structured manual-based psychotherapy that addresses interpersonal issues in depression to the exclusion of all other foci of clinical attention. This approach has allowed modification of the original treatment manual for depression to a variety of illnesses. Originally developed by Klerman, Weismann, & Rounsaville (1984) for the treatment of depression, IPT was subsequently adapted for eating disorders (Fairburn, 2004; Fairburn, Jones, Peveler, Hope, & O'Conner, 1993). IPT is an active but nondirective treatment that focuses on the interpersonal difficulties in the client's life. Although therapists initially draw a connection between the patient's interpersonal difficulties and symptoms of anorexia nervosa, this connection is only implied thereafter.

Like CBT, IPT is composed of three phases. In phase one, an interpersonal model of therapy is presented and the patient is introduced to the four main realms of interpersonal difficulty: role disputes, role transitions, interpersonal deficits, and unresolved grief. The client's eating disorder is placed within this interpersonal framework (e.g., a specific role dispute as a trigger for starvation). In phase two, the therapist maintains a nondirective stance in working with clients to implement adaptive interpersonal change in their lives. Phase three focuses on feelings about termination, a review of treatment gains, and strategies for coping with future interpersonal distress.

Specific attention to eating patterns, compensatory behaviour, or attitudes toward body shape and weight are not prescribed in IPT. Moreover, this therapy involves neither self-monitoring nor specific behavioural instruction. Attachment theorists view the experience of loss and, to a lesser degree, disordered attachment as underlying much of

human psychopathology. IPT can be seen as indirectly addressing these issues within the therapeutic frame. IPT has been adapted for treating anorexia nervosa and related problems involving restrictive eating and weight loss. Many of the factors that have been identified as important in the development of anorexia nervosa are readily conceptualized within the four IPT problem areas of grief, interpersonal disputes, interpersonal deficits, and role transitions (Weissman, Pursoff, & DiMassio, 2001).

In relating IPT therapy to the development and maintenance of the anorexic self, it seems plausible that therapy may address interpersonal disputes, interpersonal deficits, and role transitions as part of a therapeutic approach that conceptualizes the disorder as a loss of self. In developing an alternative self, clients begin to identify with the role of being anorexic. By incorporating the basic tenets of IPT in a blend of CBT, IPT, and narrative therapy, clients may begin to understand their interpersonal struggle with self-acceptance and the control the anorexic self has over their ability to recover.

Motivational Enhancement Therapy

In considering new and innovative approaches to the treatment of anorexia nervosa, it is useful to reconceptualize the primary symptom to target in treatment. Traditionally, the symptoms that have been targeted are the behavioural components of an anorexic's drive for thinness. However, a major difficulty encountered in treatment is the sufferer's denial of the illness and resistance to changing any of these weight loss facilitating behaviours.

The Trans-Theoretical Model of Change

Recently, there has been considerable interest in the importance of motivational interventions in the engagement and treatment of people with anorexia nervosa (Geller,

Cockell, & Drab, 2001; Treasure & Ward, 1997; Vitousek, Watson, & Wilson, 1998) based on the trans-theoretical model of change (Prochaska & DiClemente, 1998).

Motivational interviewing is a potentially useful technique that aims to move clients to a position in which they are more prepared to contemplate change. The model describes a series of stages that individuals pass through while attempting to change such behaviours. These stages are precontemplation, contemplation, preparation, action, and maintenance.

Precontemplation. Precontemplation is the stage at which there is no intention to change behaviour in the foreseeable future. Individuals in precontemplation can wish for change, but are not seriously considering change (usually defined as within six months). As far as anorexia nervosa is concerned, the truth is that most patients with anorexia, with the possible exception of those who have been chronically ill for many years and have suffered its many negative effects, are in precontemplation and are not truly invested in changing behaviours that serve their drive for thinness.

Contemplation. Contemplation is the stage in which people are aware that a problem exists but have not made a commitment to any action to eliminate the problem. This phase is characterized by extreme ambivalence about treatment and by recognizing the need for some kind of treatment but being unable or unwilling to commit to actually doing it. It is quite common for individuals with anorexia to seek treatment on their own during this stage, usually because they have begun to experience some of the negative consequences of their behaviours and, as a result, their resistance and denial have begun to break down. Individuals with anorexia nervosa can stay stuck in the contemplation stage for years (Fairburn, 1999).

Preparation. Preparation is the stage that is characterized by a combination of intention and behavioural change. In addition to intending to take significant action in the near future, individuals in the preparation stage have also made some small behavioural change but usually not enough to be considered as effective action (Prochaska & DiClemente, 1998). Patients with anorexia nervosa can be in preparation for many months. They may take small steps during this stage, such as increasing their food intake or reducing their purging or exercise.

Action. Action is the stage in which individuals actually modify problematic behaviours. During this phase, symptom levels are usually high, with the individual working diligently and spending a significant amount of time and energy engaged in treatment and working with caregivers. For individuals with anorexia nervosa, this is the stage at which concrete change such as weight gain occurs.

Maintenance. Maintenance is the stage in which individuals work to prevent relapse and consolidate gains made during the action stage. For most individuals, it is more difficult to maintain change over time than to produce initial change. This is certainly true for patients with anorexia nervosa. The relapse rate for anorexia nervosa is notoriously high; in some follow-up studies, two thirds of weight-restored patients relapse over time (Hertzog, Doter, Keel, & Selwyn, et. al. 1999). It is expected that individuals will go through the various stages more than once before definitive change occurs and is maintained. This is certainly true of people with anorexia nervosa, where relapse is the norm rather than the exception. Motivational interviewing complements the trans-theoretical model and is especially useful for individuals in the earlier stages of change when ambivalence and resistance are prevalent.

There have been several recent studies using MET in treating patients with eating disorders (Woodside, Walfish, & Kaplan, 2001; Geller & Drab, 1999; Treasure & Schmidt 2002; Ward, Troop, & Todd 1996). Treasure and Schmidt (2002) adapted MET for eating disorders and produced a therapist's manual for use in treating these conditions. It appears that MET increases motivation to change, but still unanswered is whether this increased motivation actually leads to a better treatment outcome in clients. There are no randomized controlled trials evaluating the efficacy of MET alone or in combination with other therapies.

What also appears to be left unanswered is why clients remain in the precontemplation stage for years, with or without motivational therapy. It seems plausible that treatment resistance is a factor in a client's lack of motivation to change their maladaptive behaviours. However, in an effort to motivate clients, therapists may miss the ability to reconceptualize what an individual brings to therapy and what lies beneath their resistance to change. MET might also point to the control of the anorexic identity and why some clients remain in precontemplation for years. The precontemplation stage in anorexia nervosa is rather like asking a person to become something that they are not. The individual identifies only with the side of them that is anorexic. Therapy that promotes change must also reconceptualize a client's anorexic self and promote a reclaiming of self.

Several treatment methods have been recommended for anorexia. The consensus, based on existing studies, is that cognitive and interpersonal therapies are the most beneficial (American Psychiatric Association Work Group on Eating Disorders, 2000; Steiger, 1989). Zerbe (1996) supported this view, noting that with the addition of

psychotherapy 75% of clients with eating disorders improve significantly over time. Bruch (1978) allowed that insight-oriented psychotherapy may be useful, but only after starvation has been treated successfully. During psychotherapy, Beaumont (2002) suggested encouraging clients to appraise their strengths and weaknesses realistically. Such an approach helps clients cope with separation and individuation issues and establishes a secure relationship that promotes independent development.

Conclusions Regarding the Psychotherapeutic Approach

At this point, in the absence of empirical evidence, the psychotherapeutic approach to anorexia nervosa needs to be informed by good clinical practice. Based more on consensus and prevailing practice than on empirical evidence, psychotherapy remains the cornerstone of treatment for anorexia nervosa. The evidence for the efficacy of psychological treatments comes primarily from case reports and the few studies that have been conducted. This evidence is far from definitive (Kaplan, 2002; NICE, 2003). There is agreement among experts that creating a close therapeutic relationship through a unique approach like Madigan's (1997) is beneficial with anorexic clients. Chassler (1994) underscored the need to develop a treatment alliance, which she admitted takes a substantial amount of time before interpretive work can begin. Bruch (1978) highlighted identity renewal as a major theme of treatment, stating that the objective of psychotherapy "is to help a patient in her search for autonomy and self-directed identity by evoking an awareness of impulses, feelings, and needs that originate within her" (p. 135).

Anorexia is a complicated and chronic disease, requiring intensive and individualized treatment. Despite differences among clients, all share the condition of

self-induced starvation, which they prize highly. Clients with anorexia hide behind their emaciated physique to mask their uncertainty about who they should be. This is the common thread that binds together all clients with anorexia, and this is the core issue that needs to be addressed in therapy.

Part B: Beyond Anorexia Nervosa – Rediscovering Self

The Anorexic Identity

Over the past 50 years, little progress has been made in developing new and effective treatments for clients with anorexia nervosa. The last two decades have seen the development of a better understanding of the importance of the starvation state in perpetuating the disorder (Garfinkel & Kaplan, 1985) and the absolute necessity for nutritional rehabilitation in a multidimensional approach to treatment. However, the topic of effective treatment for anorexia nervosa is still the subject of much debate, and research into effective management that truly impacts on long term outcome is lacking (Fairburn, 2004; Treasure, Todd, Brolly, Tiuller, Nehmed, & Dedman, 1995).

These studies indicate that when a person presents with the symptoms of anorexia nervosa the disease is quite likely to become chronic as a result of the limited and ineffective treatment options for effectively treating the disease. Although a multidisciplinary approach to treating the disorder has proven to be heuristic, the underlying problem with identity remains elusive in some treatment modalities, and the concentration on nutritional rehabilitation and weight gain often perpetuates the cycle of starvation once clients are released from in-patient treatment programs. Eating disorders are often a matter of learning to live with the problem and trying to help ensure that the person experiences the best possible quality of life given the limitations associated with the disorder (Kaplan & Garfinkel, 1999). At a wider and perhaps more informed level, it is important to gain a better understanding of the experience of the sufferer. How do clients view the disorder, how does it affect their lives, and what is their experience with treatment and treatment resistance?

Alternative Psychotherapeutic Approaches in Treating the Anorexic Identity

Several innovative approaches to treating anorexia nervosa have recently surfaced that take issue with the phenomenon of anorexia nervosa and attempt to reconstruct the clinical understanding of the disease and therapy for it. It may be that treatment resistance in anorexia nervosa is not about the sufferer but about the treatment itself. Social constructionism, narrative, and feminist therapy offer an alternative conceptualization and approach in treating adult anorexia nervosa and the anorexic identity.

Social Constructionism and Narrative Therapy

New and innovative approaches in understanding the nature of anorexia nervosa provide professionals in the field of eating disorder treatment with an alternative in conceptualizing and treating the disease. It is important to gain an understanding from a variety of perspectives in how anorexics view the disorder and its effect on the lives of individuals. As noted earlier, the construction of anorexia and the anorexic body are a postmodern view of the complex, socioeconomic, cultural, and political dynamics of Western societies. Social constructivism examines the nature of constructed stories that are based on internal and external stimuli. The reconstruction of what we know anorexia nervosa to be is a major contribution of narrative therapy in understanding the sufferer. Another major contribution of narrative approaches is the examination of the problem-saturated stories that are authored for and created by anorexics and their families. Narrative therapy attempts to locate these stories, not simply as internal to the family of anorexics, but as drawn from the pool of culturally shared beliefs. Locke, Epston, and Maisel (2004) suggested that, at the outset of treatment, every individual experience of anorexia needs to be recognized as unique and every individual will experience the

disorder differently. Although the authors emphasize the expectation that similar themes are common, they assert that it is crucial to tease out these individual stories in order to create a counter-narrative that may have the ability to overcome the treatment resistance of clients that is enmeshed in their anorexic story.

For example, particularly in Western societies, there may be seen to be a dominant narrative that distressed states or experiences are a result of inherent personality flaws, organic deficits, or biologically inherited tendencies. Family members and others may come to describe the person with anorexia nervosa in terms of pathologizing and totalizing language, such as that seen when clients with eating disorders are referred to as anorexics. Such terms may become internalized and over time come to shape and eventually consume the whole of a person's identity to the point where aspects of the person's life, other than that related to problems of food, become marginalized. How might a dominant narrative of anorexia nervosa affect an individual's authentic sense of self?

Epston and White (2004) document how our culture's dominant discourses and some treatment providers assert that "the patient has anorexia" or "the patient is anorexic." "Patients" also have a grasp on this way of constructing their world: "I have anorexia" and "I am anorexic." Levenkron (1983) goes as far as to say that "anorexia has captured this person" (p. 241). This view may describe the all-controlling "it" that Rusca (2002) alluded to, or the struggle with identity that appears to be a common factor in clients with eating disorders (Bruch, 2002; Hepworth, 1999; Lamoureux & Borttorff, 2005; Malson, 1998b). What if therapy shifts to a narrative that does not construct the view of what the anorexic is but what lies beneath? This may be a way of contesting

anorexia so that the narrative becomes one of an individual sense of self and not a narrative of the anorexic self.

Problem-saturated stories. In families, some of the processes whereby problems occur have been described as problem-saturated conversations in social constructionism and narrative therapy (Anderson et al., 1986). As a difficulty starts to develop, the focus of the family conversation may move toward a pathway to pathology in which the talk shifts to an identification of problems to the exclusion of any talk which may recognize exceptions and competencies (Dallos & Hamilton-Brown, 2000; Eron & Lund, 1993). Anderson (1990) and his colleagues documented how realities are socially constructed, realities are constituted through language, realities are organized and maintained through narrative, and that there are no essential truths. Gone is the faith in an objectively knowable universe. Gone too is the modern notion of an essentialized self, an individual ego who is the locus of choice, action, and rational self-appraisal. In their place is a variety of perspectives cutting across the human sciences and humanities. This view may highlight the anorexic's struggle with identity given the lack of choice, action, and rational self-appraisal that is evident by society constructing essentialized views of self. What if women were not subjected to a social prescription of what they should be, but were instead encouraged to be authentic?

In developing an alternative identity, clients with anorexia nervosa create an illusion for themselves and for others. As the anorexic identity begins to form, clients and their families begin to relate only to the problem-saturated story of what it means to live with anorexia nervosa. It may then appear that the person with anorexia is nothing other than anorexic. The focus may then serve to perpetuate a client's feelings of personal

inadequacy and personal failure that are not a reflection of the person, but a reflection of the control the disease has over the individual. This view highlights the importance of externalizing the problem of anorexia nervosa away from the individual in order to gain some understanding of the extent to which the disease is in control of the individual.

Narrative therapy identifies the modern notions of an essentialized self that appears to be an essential component in developing an anorexic identity. That is, anorexia nervosa may be seen as a separate identity that controls the person's rational self-appraisal and locus of choice through the demands of what it means to look and be anorexic.

Deconstructing the story of anorexia nervosa. In narrative therapy, clients identify their own problems and resolutions. The anorexic identity and the problem-saturated story of anorexia nervosa affect individuals and families dealing with the disease (Wylie & Pare, 2001). By influencing the client's view of reality through therapy, the client's anorexic identity is changed in an active, imaginative endeavor between the therapist and the client. Clients are given more control in the creation of their own stories and their own identities and, consequently, more control over their lives (Wylie & Pare, 2001).

Feminist Theory

Overall, the goal of constructivist counselling is to help anorexics win freedom from the dominant problem narrative and achieve genuine authorship of their authentic lives. Feminist therapy addresses the dominant narrative of client's lives in regards to power, oppression, privilege, and the concept of gendering that is shaped or defined by society's structures and assumptions about gender (Reed & Garvin, 1996). This perspective is similar to the social constructivist view of cognition as a proactive,

anticipatory phenomenon with clients actively, collectively recording, and refining their understanding of the experiential world (Anderson, 1990).

To practice feminist therapy means understanding a broader theoretical perspective. Key to feminist practice is the concept of gendering and the exploration of the dynamics of how class, race, ethnicity, sexual orientation, and other factors linked to societal inequities intersect with and change our understanding of gender-based inequities and gender processes. In feminist therapy, this translates to consciousness-raising regarding relations of power, oppression, and privilege. Discussion focuses on societal and political biases related to gender, age, race, class, ethnicity, and the impact on clients' sense of self and their lived experience. A feminist therapist assists clients in understanding personal changes from the perspective of society, culture, and context (Lazerson, 1992). Feminist therapy facilitates understanding the effects of power and ways to utilize relations of power positively in one's life (Bender & Ewashen, 2000). The power of language is explored in terms of using more liberating and empowering language. In feminist practice, there is a constant effort to connect, validate, and integrate rather than to polarize different experiences. The multitude of ways individuals learn and understand their experiences is valued.

Feminist theory and understanding the anorexic self. Understanding the power of individual experience in shaping one's concept of self facilitates the understanding of anorexia nervosa as a form of disempowerment and erosion of self. Sesan (1994), in reviewing feminist literature on eating disorders, described how hospitalization for treatment engendered frightening images of disempowerment for clients with anorexia nervosa. Such settings may perpetuate a pattern of oppression by rigidly controlling

women's behaviours and actions and inadvertently silencing them. This view is consistent with the sociocultural emphasis on beauty and a thin ideal in that the female body is controlled by media images that depict what women should aspire to be. Sesan suggested that our attempts to control the symptoms of eating disorders may well have prevented women from expressing themselves in the only way they know how. Self-expression, in this view, is consistent with the belief that clients with anorexia nervosa develop an identity based on eating disordered thoughts and beliefs. Clients are controlled by this new-found identity and are disempowered to believe they are acceptable only in achieving the socially constructed image of female beauty.

This view may also emphasize the role perfectionism plays in the manifestation and maintenance of anorexia nervosa and the individuals who suffer from the disease. The personality trait of perfectionism may set the groundwork for individuals who become silenced by the rigors of becoming and remaining anorexic. Perfectionism may then be a part of the anorexic identity that strives to be perfect in the eyes of the anorexic. Perfect, in this sense, is an emaciated body that is under the orders of the "it." Anorexia nervosa disempowers clients through disempowering their authenticity and challenging their views of self in a problem-saturated story of personal inadequacy and lack of self-worth.

Evaluation of Current Approaches Addressing the Anorexic Self

Therapeutic intervention that attempts to deconstruct the current clinical understanding of anorexia nervosa is a way to reconceptualize the disorder so that treatment may address the underlying problem of identity, self-worth, perfectionism, and the controlling aspect of the anorexic self. CBT, IPT, social constructionism,

existentialism, and feminist theory offer a complex analysis of what it means to be anorexic.

CBT is a relevant and useful therapeutic intervention in targeting the anorexic mindset. Cognition is seen as proactive and anticipatory. The anorexic self in this context is proactive in maintaining the self-loathing that perpetuates personal feelings of inadequacy and not being good enough. Clients operating on the controlling “it” of the anorexic identity anticipate therapy and recovery as a means of destroying the only thing they have learned to identify with (Levenkron, 1983; Rusca, 2002). IPT addresses the interpersonal dispute between the role of the individual and the role the anorexic identity plays in the life of the client. This approach identifies the extent to which the anorexic identity has taken over the actual person. IPT begins to unravel the interpersonal struggles of the individual within the confines of a newly defined anorexic self (Mann, 1992, Bruch, 2000). Role confusion, role disputes, and problems with identity may be seen as the actions of the anorexic self and not of the individual. Social constructionism suggests that the problem-saturated story of anorexia nervosa becomes internalized over time and both the family and the so-called anorexic become enmeshed in the symptoms of the disease (Maisel, Epston, & Borden, 2004; Vitousek, 2005). Clients begin to associate themselves with being the anorexic or proclaim that they are anorexic. This view emphasizes the level of identification to which clients and families dealing with anorexia nervosa begin to subscribe.

Similarly, existentialism offers clinicians the ability to understand the nature of this so-called anorexic self and explains how the controlling “it” becomes somatized over time. This concept appears to highlight the necessary elements that maintain the

disease and the treatment resistance of the anorexic identity and not the clients themselves. Feminist theory also alludes to the disempowering effect of therapeutic approaches that appear to silence the person within the disease. This view attempts to explain that while the anorexic is under the control of the rigors of the disease, the authentic self is lost and ultimately silenced.

In order to develop a treatment approach that targets the realities of the disease, an integration of cognitive behavioural, interpersonal, and social constructionism seems applicable in determining therapeutic intervention that addresses cognitive distortion, perfectionism, self-worth, feelings of personal inadequacy, and struggles with identity. This approach is a therapeutic departure from current treatment options in that it recognizes the controlling aspect of a separate identity at work. At work is the anorexic identity, a powerful voice behind treatment resistance, chronic suffering, and the inability to recognize the individual inside the disease.

Controlled, randomized research that compares long-term psychodynamic psychotherapy with another approach is very rare, almost absent, in clinical literature at large (Gowers & Waugh, 2004). Yet, psychodynamic psychoanalytic therapies are the most widely used among clinicians (Russell, Szmukler, Dare, & Eisler, 1987) and these therapies have fertilized the development of other approaches. In the specific field of eating disorders, Pike (1998) estimated that in private practice the vast majority of clinicians are using psychodynamic techniques. In general practice, not related specifically to eating disorders, Jensen and Bergin (2005) found that among therapists who defined themselves as eclectics, 70% said that the psychoanalytic psychodynamic approach laid the foundation for their work. These findings may support the long-held

psychoanalytic assumption that solving underlying problems can reduce overt behavioural symptoms, even if the latter are not directly focused on in the session. This belief may support the notion that anorexia nervosa is a maladaptive attempt to mask an individual's underlying problems with identity, loss, and relationship difficulties. The overt behaviours in becoming and remaining anorexic may in fact be examples of an individual's difficulties in resolving these problems. An eclectic approach in the re-conceptualization of anorexia nervosa may create an alternative to treatment.

Insights and changes. Young and Ensing (1999) suggested that anorexia nervosa is unique in providing a perceived sense of power and control to the affected individual, and thus the process of recovery may be different. A few researchers have attempted to describe patient experiences of recovery from anorexia nervosa (Beresin, Gordon, & Hertzog, 1989; Garrett, 1997; Hardin, 2003; Hsu et al., 1992; Maine, 1985; Noordenbos, 1989). These researchers offer important insights and have identified some themes that describe the recovery process. Gaps remain, however, in our understanding of the intricate processes that underlie recovery from anorexia nervosa. What may explain these gaps is recognizing the presence of an identity that is reliant on the symptomatology of anorexia nervosa in order to function. The anorexic identity is therefore reinforced through the rigors of starvation and the perfectionist standards to which clients subscribe.

Recognizing the Recovered Anorexic

Interestingly, Lamoureux and Bottorff (2005) described the necessary elements in the recovery process as perceived by recovered anorexics themselves. The participants in the study described the components of the recovery process as “becoming the real me.” The components of the recovery process consisted of: (a) seeing the dangers, (b) inching

away from anorexia, (c) tolerating exposure without anorexia, (d) gaining perspective by changing the anorexia mindset, and (e) discovering and reclaiming self as “good enough” (Lamoureux & Botorff, 2005). The study described recovery as a process in which women slowly rediscovered and redefined themselves as individuals without anorexia nervosa.

It would appear that the process of recovery may be seen differently through the eyes of those suffering with anorexia nervosa. By recognizing the views of recovered anorexics, the ability to understand the unique presence of a separate identity allows clinicians to see the power of the anorexic identity in maintaining the disease and provide an authentic base for therapy.

The nine females participating in this study had clear ideas regarding the kind of approach they believed would provide insight and understanding (Lamoureux & Botorff, 2005). The participants questioned treatment that focused on symptoms of weight loss (such as food diaries, nutritional advice, and weighing) that tended to reinforce starvation as a coping strategy and not a deeper understanding of what causes anorexia nervosa. Treatment may therefore operate to consolidate anorexia nervosa as a coping strategy by focusing on the symptoms of the disorder. It is not being argued that the focus on the symptoms is always a bad strategy, but rather that this strategy may be more relevant at particular times within treatment, such as when self-starvation reaches a point where it becomes life-threatening.

It would seem plausible to apply the principles of recovery and the necessary therapeutic approaches that target both the issue of weight and the underlying problem with identity (Mann, 1990). Stober (1997) acknowledged that anorexia nervosa is used to

shield the self from underlying fears that loved ones will fail to appreciate their inner struggle of unmet needs or emotions, thereby protecting the self from exposure to potentially unbearable disappointments. It could then be argued that, at some points in therapy, focusing on weight may be irrelevant and possibly damaging for the patient and may only serve to isolate the individual.

Particularly in the early stages of engagement in treatment, it may be important for therapists to seek a shared understanding of the meaning of the disorder with the sufferer, such as seeing it as a survival technique, rather than a death wish. By identifying with the shield that anorexia nervosa creates, therapists may have the ability to slowly unmask the fears and disappointments of the client rather than reinforcing the shield by focusing on weight and weight-restoring measures. Understanding the complex relationship that clients with anorexia nervosa have with the disease, it is evident that the relationship serves to empower, reinforce, and perpetuate a client's feelings of personal inadequacy, personal failure, and interpersonal and intrapersonal struggles with identity. On the other hand, the disease is a protective barrier from clients' self-hatred in that it creates an alternative identity that appears to be acceptable.

In the quest to attain perfection, clients with anorexia nervosa subscribe to a rigid and controlling schedule that is ritualistic, all-consuming, and, above all, a pursuit of denial and self-persecution (Fairburn, 2004; Garner & Bemis, 1985). Anorexia nervosa may then be seen as a lifestyle that is adhered to at all costs. The more chronic the disease, the more developed the anorexic lifestyle becomes. This may also point to the difficulty in treating long-term sufferers of the disease, as it is not only an identity that they have come to develop and rely on, but also a way of life that serves to eliminate their

feelings of ineptness and inadequacy. Clients fail to see their true selves and relate only to attaining and glorifying their success at being and remaining anorexic.

The Formulation of the Anorexic Identity

In order to understand the process of developing anorexia nervosa, one must also conceptualize the formulation of the anorexic identity. The development of the anorexic identity corresponds with the extent to which a client subscribes to a weight loss regime that at some point becomes all-consuming. It is difficult to understand why some women who begin a weight loss program develop anorexia nervosa while others are able to achieve and accept a healthy weight loss. This is an important distinction to make between normal weight loss and anorexia nervosa. The distinction may lie in an individual's perception of self. The disease may be precipitated by the interpersonal and intrapersonal struggles of identity that Bruch (2000), Madigan (1997), Maine (1985), Malson (1998a), Russell (2002), and Surgenor, Plumridge, and Horn (2002) describe as necessary factors in the development and maintenance of the disease. What is difficult to assess is whether a loss of self precipitates the onset of anorexia nervosa or whether it is a gradual process in which the more invested a client becomes in the rigors of the disease the more developed the anorexic identity becomes.

In the Beginning

By establishing therapy that addresses the extent to which clients are under the control of a separate identity, it is important to understand how the anorexic identity begins to form as a client embarks on a quest to become perfect. In the beginning, when weight loss first occurs, clients with anorexia are typically thrilled about their accomplishment. As weight loss is sustained, maintaining the weight or losing additional

weight becomes a major preoccupation. Although clients may continue to excel at work or school, inevitably the effects of chronic malnourishment take a toll on functioning. Activities that were previously enjoyed are ultimately abandoned, friends may become estranged, and once-valued achievements become distant and irrelevant. Instead, clients with anorexia relentlessly define themselves by their new form, identifying with their wasting body as a source of self-realization (Beumont, Russell, & Touyz, 1993). Anorexics have an uncanny ability to survive on the smallest amounts of food. Clients with anorexia often grow increasingly withdrawn and isolated. Initially, they may inspire admiration and awe among friends, who compliment them on their slim figures. Eventually, this admiration from friends turns to bewilderment and frustration as clients with anorexia become devoted to their new endeavor.

The bewilderment of family and friends and the isolating nature of the disease are described most aptly by Chassler (1994) in her discussion of psychoanalytic theories of anorexia. She related a story by Kazantzakis in which a starving adolescent lies listlessly on the ground, stretched out beneath the hot sun. He is admonished by an onlooker who encourages him to get up, eat, and get to work. The adolescent replies, "In hunger, I am king," as if to imply that the state of hunger is a kingdom unto itself and that by remaining hungry he is omnipotent and untouchable (Chassler, 1994, p. 397). This sense of omnipotence is paradoxically intertwined with the stark, restrictive lifestyle required to maintain this kingly identity.

This view may also describe the development of the anorexic identity that is perpetuated and strengthened by the numbers on the scale. The reinforcing factor of emaciation and a drive for thinness becomes internalized over time and clients often

begin to seek self-approval, self-acceptance, and self-esteem from their success at being anorexic. It is also important to note that the formulation of the anorexic identity begins to override all forms of reality for clients with anorexia nervosa. Clients' distorted images of self are for them a reality. Distorted is the belief that they are the anorexic. Clients are often unable to see themselves as separate entities and often describe themselves in terms of the anorexic mindset to which Levenkon (1983), Maisel, Epston, and Borden (2004), and Rusca (2002) alluded. Anorexics see themselves not as emaciated but as living their lives according to who they believe they have become, the anorexic. In this sense, anorexics admire their ability and adherence to the rigors of being anorexic and that have become their lifestyle.

Underlying anorexic symptomatology is the belief that they are never good enough, never thin enough, and inadequate in every way. Recovery may then be seen as an effort to silence them once again and an attempt to deny their self-expression.

The metaphor of the king is not unlike that of the anorexic sparrow described by Bruch (1978) in *The Golden Cage: The Enigma of Anorexia Nervosa*. A recovering client describes the cage as "an artificial pattern I had created a cage studded with jewels ...because I wanted to make an impression" (Bruch, 1978, p. 150). Inside the cage, the client with anorexia alludes to feeling like a sparrow, "too plain and simple" for a luxurious home, yet also deprived of the freedom to do what she truly wanted to (Bruch, 1978, p. 23). The images of the starving king and the sparrow inside a beautiful cage suggest a sense of despair and helplessness inside an elegant facade. The façade is the sense of contentedness and omnipotence that clients with anorexia nervosa create in order to hide from the realities of self-hatred and never feeling good enough. Recovery, in

many ways, may expose anorexics to feelings of emptiness and loneliness long before the anorexic identity developed.

The Four Stages in Developing the Anorexic Identity

The anorexic façade may also be interpreted as a separate identity (Levenkron, 1983). Levenkron describes four stages in the development of anorexia nervosa and a pseudo identity, the anorexic identity. The four stages are the achievement stage; the security compulsive stage; the assertive stage; and the pseudo-identity stage. The stages in developing the anorexic identity serve to explain the similarities clients share in a simultaneous disassociation from reality and themselves.

The achievement stage. The first stage, according to Levenkron (1983) is the achievement stage. The achievement stage forms when a person decides to go on a diet to lose weight to somehow fulfill an underlying desire to be accepted by peers, as a way to fit in, and possibly to answer the pangs of low self-esteem. Simply wanting to diet is not considered pathological. Many normal people go on diets and many normal people go off diets. The anorexic starts out like a normal person with the concept of losing weight as a great accomplishment. However, the dieting is soon transformed from normal dieting to superdieting. This growing sense of achievement and praise from peers solidifies the anorexic's restrictive eating practices. The feelings of being virtuous and successful are far more important to the anorexic than mere feelings of hunger. This view is consistent with the perfectionist standards outlined by Hewitt and colleagues (2004) and with the anorexic's attempt to seek approval and acceptance from others. This may also point to underlying problems with identity and self-esteem that preclude weight loss and are

exacerbated as the disease progresses. Achievement, in terms of the anorexic mindset, is continued weight loss and the perception that they are closer to perfection.

The security compulsive stage. Once the anorexic attains achievement in becoming and being anorexic, the anorexic no longer has a goal weight and ironically begins to feel fatter and fatter. The anorexic will view others as thinner, whether they are or not. Levenkron (1983) says that body distortion is necessary to reinforce the anorexic's mission to keep dieting and to lose more weight. Levenkron's view may also be describing the presence of another identity at work that is manipulated through powerful anorexic rhetoric as described by Maisel, Borden, and Epston (2004). Body distortion, although an essential component in anorexia nervosa, does not explain a client's adherence to the rigors of the disease and the simultaneous disassociation from reality.

The anorexic will develop other compulsive activities that keep food to a minimum and/or burn more calories. Obsessional fears of fatness will begin to mount and weight loss behaviours must be repeated as a way for the anorexic to feel secure and in control and to quell those fears. This stage at which the anorexic loses touch with self and with reality, family, and friends. Emotions shut down and thoughts revolve solely around food and weight. This view is similar to, and consistent with, the presence of alexithymia in the symptomatology of anorexia nervosa. All energies are spent on fighting food, fighting fat, and being the anorexic.

The assertive stage. Losing touch with reality and oneself creates an illusion of omnipotence and a superficial sense of power for the anorexic. This illusion of power allows clients to become very protective of their weight loss and they begin to assert their power to maintain the anorexic behaviour. When concerned family and friends make

comments about the anorexic being too thin, the anorexic actually believes they are merely jealous and conspiring to make the anorexic get fat. Feeling empowered, the anorexic becomes even more tenacious in restrictive eating and calorie-burning behaviours. Taking charge and defending the anorexic behaviour further solidifies its importance in the anorexic's life.

The pseudo-identity stage. Family and friends are well aware of the advanced condition the anorexic has reached. They adapt and accept the too-obvious illness. This view may explain the nature of families and what social constructivists describe as living in the problem-saturated story of anorexia nervosa (Freedman & Combs, 1999). Families are often afraid, resentful, and angry at anorexics for the control they appear to exhibit over what was once a normal existence. Regardless, the anorexic now literally becomes "the anorexic." The anorexic adopts this new pseudo-identity and feels empowered and surreal. At this point, the disease becomes a valuable part of the anorexic's personality. To lose the anorexia would mean losing self-identity.

It is no surprise, then, that anorexia is a highly difficult condition to treat and that it has a moderately high relapse rate after treatment. The etiology of anorexia is an enigma; a complex combination of psychological, biological, and social stresses. Not one single theory prevails in explaining why anorexics are convinced that life would be perfect if only they were thinner. Given the nature and prevalence of anorexia nervosa, it is imperative for psychotherapeutic treatment to begin to focus on the pseudo-identity (Levenkron, 1983). Maisel, Epston, & Borden (2004), Malson (1998a), Lamoreux and Bortoff (2005) Bruch (2002), Hepworth (1999), and Rusca (2003), among others, described the separate identity of anorexia nervosa and the potential complications that

arise in trying to treat the disease but inadvertently ignoring the power of anorexic thoughts and behaviours. Although numerous researchers have alluded to anorexia nervosa as a disease of power and control, it does not appear that treatment recognizes the individual within the confines of an anorexic self. The anorexic identity seems to describe many facets of the disease that are treatment-resistant. The resistance may then be understood as an extreme reluctance in giving up what an individual prizes so highly. The anorexic may prize both the weight loss and the new-found identity that has provided an illusion of perfection, acceptance, achievement, and self-worth to an otherwise absent self.

A reconstruction of traditional therapies that do not attempt to treat the anorexic identity might offer an alternative to clients who would rather be anorexic than the empty shell that exists in their view of recovery. The empty shell is, at times, the golden cage that Bruch (2002) referred to in describing the encapsulating protection of anorexia nervosa. Clients feel safe within the disease. Recovery, as seen by the anorexic identity, may be far more terrifying than the disease itself.

Never good enough. For clients with anorexia, the facade is their emaciated form, which disguises feelings of ineptness and diverts attention to their amazing ability to survive and flourish with little nourishment. Maintaining the facade becomes the foremost concern of clients with anorexia. As their former selves recede, they seek to preserve their new-found identity. In doing so, clients with anorexia mask deep-rooted concerns about their personal inadequacies and their ability to excel. Self-scrutinizing and conscientious, they find reassurance in exceeding expectations, rather than merely doing

what is necessary. Their perfectionism, a key personality trait, becomes more apparent as they attempt to prove to themselves and others that they are good enough.

The struggle for perfection is a reflection of the anorexic's lack of self-esteem and belief that worth can only be measured in terms of accomplishments (Rumney, 1983). However, clients with anorexia believe that their performance is never really good enough, thereby reinforcing the notion that they have failed. Clients with anorexia are understandably reliant on the positive opinion of others to boost their self-esteem, yet they question the sincerity behind praise or compliments. This view is consistent with Hewitt and colleagues' (2004) view of perfectionism and self-imposed perfectionism. Clients with anorexia are in control of their own chastisement and they are their own harshest critics (Rumney, 1983). The new-found identity, the anorexic identity, is a sense of self that is comprised of the conflicts between autonomy and dependence, powerlessness and omnipotence, and perfectionism and self-effacement. Their precarious identity disintegrates as they assume the bizarre behaviours and obsessions characteristic of starving persons.

As noted in cases of starvation and chronic malnourishment (Keys, 1950), people with anorexia become obsessed with food. Hoarding food, pouring over recipes, and preparing food for others are typical behaviours. Food that is eaten is consumed slowly and carefully. Ritualistic behaviours surrounding food and exercise create a sense of control over one's environment and emotions. Child-like, clients with anorexia may play with food to avoid eating or prolong a meal. Profound emaciation is associated with regressive behaviours and, ironically, an erosion of the former self. Many of the more alarming symptoms, such as splitting of the ego, depersonalization, and severe ego

defects, are directly related to starvation (Bruch, 1978). Depersonalization may also describe the creation of an alternative identity that depersonalizes the individual within the disease. Anorexia nervosa, for the most part, is a persona and/or an identity that emerges in response to the starvation effect, self-denial, and self-hatred.

Severe consequences. The erosion of the former self is a psychological effect of starvation. Thought processes are compromised along with severe caloric restriction. The rituals surrounding food and exercise become a way of life and weight loss is sustained without conscious awareness. As pounds dwindle away, simultaneous dissociation from the environment can occur. Malson (1998a) discussed anorexia in terms of a dissociated state. The dissociation invades and affects the self and maintains a separation from the authentic self. In interviews with recovered clients, one woman concluded that she felt she was anorexia. The disease is all-consuming and becomes a new identity.

Recovery is not an isolated event that suddenly appears. It is a process that expresses itself in a wide range of subtle changes that occur during treatment. An essential part of recovery is a change in inner psychological orientation with better reality testing, more trust in being self-directed, and an ability to participate in life with a unified, not split, concept of self and body (Bruch, 2000). This view highlights the importance of recognizing the existence of a separate entity or identity at work. Clients are often suspicious of recovery because they fear giving up the only thing they have learned to identify with. This may also speak to the interpersonal and intrapersonal struggles clients experience within the confines of the disease. Social constructionism points to the problem-saturated story that is created within individuals and families with the disease. Families struggling with the individual and the disease begin to associate and

relate only to the “anorexic.” The family story then is one of suspicion, threats, worry, and doubt. This behaviour serves to reinforce the client’s inner struggle with personal inadequacy, feelings of not being good enough, and personal failure that tend to force the anorexic to retreat farther into the confines of weight loss and self-denial.

Pro-Anorexic Rhetoric

Anorexia nervosa provides an illusion of perfection, acceptance, achievement, and self-worth to individuals who feel they do not have these things otherwise. It is often difficult to understand the extent to which anorexia nervosa takes control over every aspect of a client’s life. The controlling aspect of the disease is an essential aspect in maintaining the anorexic façade. Another key component in the identity crisis that an anorexic client manifests is the powerful yet hidden pro-anorexic rhetoric. Maisel, Epston, and Borden (2004) demonstrated the ways in which anorexia is caused and maintained by powerful but hidden pro-anorexic rhetoric. By carefully listening to hundreds of patients, the authors discovered that after anorexia insinuates itself into people's lives through the weight-obsessed lingo of the media, it goes on to generate an endless supply of pro-anorexic rhetoric that mutates into sophisticated new forms whenever it confronts anti-anorexia resistance. This is similar to the problem-saturated story to which social constructivists Freedman and Combs (1999) related.

Pro-anorexic rhetoric is the anorexic identity’s voice. The voice is one that operates solely on the rigors of the disease and is the voice that Rusca (2002) defined as the anorexic being under the “orders of the it” (p. 365). It is often difficult for therapists, families, and friends of clients with anorexia nervosa to differentiate between the anorexic and the real person. Although it may appear that the individual is defensive and

resistant to change, it is also important to acknowledge and externalize the power and presence of the anorexic identity. This may serve to positively reinforce a client's authenticity and begin to unravel the power within the individual and not the disease.

Pro-anorexic rhetoric and the anorexic identity. Pro-anorexic rhetoric is the voice of the anorexic identity. The anorexic voice is a separate entity that is founded upon the existence and toxicity of anorexia nervosa. For example, anorexic rhetoric instantly offers a myriad of convincing reasons why recovery and the professionals who point out the harmfulness of self-starvation, are not to be trusted. The sufferer experiences toxic pro-anorexic thoughts not as alien or unwanted but as reality. This view is similar to Malson's (1998b) disassociated state that clients with anorexia nervosa begin to exhibit. In this context, a client simultaneously disassociates from reality while associating with the power of the anorexic voice. The inability of clients to discern between the anorexic voice and the real voice is the initiation stage of the disease. Anorexic thoughts proliferate and come to dominate a person's thinking and actions, leading clients to lose touch with their own values, their own identity, and their relationships. This is the anorexic identity.

The first priority of treatment, according to Levenkron (1983) is to distinguish the rhetoric of anorexia from the person's own values, hopes, and dreams. Externalizing anorexia in this way allows clinicians and family members to ally with the person against the anorexia. Once anorexia is seen as separate from the person, therapy can help the person see its true effects and turn against it. Vitousek (2005) related to the presence of an anorexic self and the positive effect of externalizing clients from the separate entity. Naming the externalized entity, for example, "anorexic voice," "negative mind," or

simply as “him or her” and contrasting that with the individual’s real self, true self, or healthy voice enables clients to distinguish between themselves and the disease.

Therapeutic Approaches in Treating the Anorexic Identity

The formulation of the anorexic identity is the beginning of a client’s disassociation from reality and association with pro-anorexic rhetoric that mimics and maintains anorexic symptomatology and mindset. In treating the anorexic identity, several therapeutic approaches offer alternatives for identifying the presence of an alternative identity and the control this identity has over a client’s ability to recover. Social constructionism, narrative therapy, IPT, and CBT therapeutic techniques attempt to uncover the extent to which clients with anorexia nervosa are under the orders of the “it” (Rusca, 2003).

Cognitive Behavioural Techniques

Neimeyer (1993) described constructivism as a philosophical context rather than a technique. It emphasizes the proactive, self-organizing features of human knowing and deals with decision-making processes (Anderson, 1990). Cognition is seen as a proactive anticipatory phenomenon with clients actively and collectively recording and refining their understanding of the experiential world. Anorexic clients, in this context, actively engage in, collect, and refine information that perpetuates their feelings of inadequacy and worthlessness. The resulting script is one of failure, inadequacy, and lack of control over their lives. Emaciation is the attempt to mask an anorexic’s self-hatred and create an alternative self. The resulting script may also explain the presence of an alternative self, the anorexic self that bombards clients with pro-anorexic rhetoric that emphasizes and reinforces a client’s sense of worthlessness and personal inadequacy. Cognitive mapping

encourages clients to record the nature and extent to which they engage in pro-anorexic thoughts and beliefs. Cognitive mapping explores the details of the anorexic thought process and allows both the therapist and client an overview of the negative and self-hating script that develops and is viewed as a reality. It is important to note that cognitive mapping is documentation of the thoughts surrounding the extent to which clients engage in pro-anorexic rhetoric. It is recommended that self-monitoring of eating or exercise behaviours not be part of the initial phase in treating anorexic clients, as concentration on the symptoms of the disease serves to isolate and reinforce the anorexic identity to continue to evaluate their success or failure at being anorexic. By changing the initial focus of therapy to the thoughts associated with the anorexic self, clients are able to monitor and understand the power behind the controlling “it” and engage in reality testing that offers insight into the presence of an alternative self that has encouraged clients to annihilate their authenticity in favour of emaciation and isolation. Cognitive mapping also encourages clients to begin to understand the evolution of both the disease and the anorexic identity.

By engaging in self-starvation, the new-found self finds accomplishment and self-worth in success at becoming anorexic. In actively engaging in creating a negative view of self, anorexics focus on their unattractiveness, worthlessness, feelings of failure, and not being good enough in order to perpetuate the cycle of starvation in an attempt to be a successful anorexic.

Individuals do things and have things done to them, we act and we react, and clearly we can learn from both types of experience (Reber, 1993). Anorexic clients make sense of their world in an idiosyncratic and personalized way. They view themselves as

responsible for the world around them. Personalizing and internalizing family dysfunction and personal struggles as personal inadequacies, anorexics begin to try to make sense of the world. The creation of this negative view of self, the anorexic identity, constructs a reality that depicts the constituted story that clients with anorexia nervosa tell by starving themselves and losing their self-hating identity. It would appear that reconstructing the narrative of anorexia nervosa enables clients to reauthor their negative views of self and return to an authentic and healthy sense of self.

Social Constructionism and Narrative Reconstruction

The constructivist approach to therapy is more reflective and elaborative with the therapist assisting the client to develop a personal construction of reality. Of particular relevance is the technique of narrative reconstruction (Epston & White, 1999). This provides an innovative literary perspective on psychological phenomena. An anorexic's story is a narrative construction of depression, worthlessness, unattractiveness, and failure as a result of experience with family dysfunction, inability to express emotions, and inappropriate internalization of negative life experiences.

Journaling and reauthoring of life stories. Overall, the goal of constructivist counselling is to help anorexics win freedom from the dominant problem narrative and achieve genuine authorship of their authentic lives. A long-term intervention is to advise clients to keep a personal journal in their quest to reauthor their life. In keeping a journal, the language of a new narrative is revealed over time. One is able to reflect on past beliefs, new-found beliefs, and future beliefs based on experiences, successes, and social interaction. This form of therapy addresses feelings of being stuck in the anorexic identity and offers documentation of emerging stories and an emerging sense of self.

Constructivist therapists see their work as collaborative with the client, involving a process in which personal narratives are recorded and refined to assist the client in understanding. This is a learning process that may use several narrative forms. Personal journals may be used (Mahoney, 1991) to facilitate both self-expression and self-exploration on the part of the client. Journaling may assist clients with anorexia nervosa in documenting beliefs about themselves that are considered part of the anorexic identity. The therapist and client can address the nature of the anorexic identity through the narrative that is revealed through the journaling process. The therapist may point to a narrative story that is built upon the presence of the anorexic mindset. At this point in therapy it is important to explore and distinguish beliefs that are reality-based from beliefs that are anorexic-based. Gaining perspective by changing the anorexic mindset relates to the misperceptions that food makes one fat, that gaining weight means becoming obese, and that being heavier somehow makes anorexics less worthy and less disciplined. Building on this information, the process of therapy may allow for a more realistic perspective for clients with anorexia nervosa. By becoming aware of and deconstructing distorted ideas, clients are able to understand how eating makes the anorexic feel like a bad person, how the anorexic does not deserve to eat, and about how being smaller means making smaller mistakes. Clients may begin to challenge their strongly held beliefs and misperceptions that anorexia is the only means of achieving a sense of control, identity, and self-worth. Acknowledging these as anorexic thoughts or wrong thinking helps clients develop a more accurate perspective of their lives and selves.

Reconstructing the self. The conception of personality as socially constructed also opens the possibility of more profoundly relational views of selfhood (Brumberg, 1988). The view of-self identity as constituted by the living web of connections we create and sustain with the people, projects, and places that give our lives meaning provides the basis for case conceptualization (Garner & Garfinkel, 1980). This more affirmative view of the social self sees individuals as manipulators of interpretive repertoires for constructing preferred versions of their motives and actions in relation to others (Wetherell, 1996). People are seen as choosing and implementing forms of representations appropriate to their immediate goals (Hall, 1996). Therapy with anorexics should focus on developing an understanding of how clients have constructed their view of personal inadequacy. The role of a therapist is to facilitate the experience of new stories and life narratives that are empowering, more satisfying, and give hope for a better future (Garner, 1997, Bruner, 1986). The focus of narrative therapy is an expansion and enrichment of meaning more than a change in behaviour.

Deconstructive listening. Narrative intentions lead us to listen to what people tell us as stories. Listening carefully to anorexics' stories and striving to understand their experience helps develop both trust and rapport and to have some ideas about the particular constraints their stories carry. Deconstructionists believe is fruitless to search for the real meaning of any text (Freedman & Combs, 1990). Listening to an anorexic's story begins with a not knowing attitude and therapists should provide an atmosphere of "what if the client feels this way or what if the client feels that way?" As clients engage in their storytelling, therapists can discern the constructions being made and new constructions that are emerging. In listening with this attitude, clients can view how their

stories are socially constructed and see that other stories may be created that suit the goal of recovery.

Developing new stories. Once problem-saturated stories are understood as social constructions, different, more fruitful constructions can be created. In negotiating between new and old stories, Freedman and Coombs (1994) suggested that therapists ask: How did you do that? What did you do that led you to feel this new feeling? In the case of anorexia nervosa, hallmark questions in developing a new life narrative include: "How did you feel about yourself prior to the disease? How did the disease start? Why do you feel inadequate? Why does anorexia make you feel better about yourself? Has the disease made you happy and content? Do you feel that anorexia has solved your feelings of self-hatred or has it made it worse?"

Developmental constructivism and the evolving self. In recognizing the power in reconstructing a negative view of self, it is also imperative for clients with anorexia nervosa to understand how the disease began and how it distorts reality. Guidano (1995) uses a movie-like technique to explore and reconcile discrepancies between the client's experience of a situation and explanation of it. For example, in working with anorexia nervosa, a therapist may move the client step by step through a slow motion replay of the battle with anorexia, panning across a series of scenes before zooming in on the one that has the greatest emotional significance. This could involve guiding the client through a careful exploration of the immediate feelings and perceptions registered in the moment (stiffening of the body, the partner's expression), and then shifting to the level of the client's explicit understandings of the starvation and self-hatred. According to Guidano, this reconstruction of the experience as both lived and interpreted promotes greater

emotional openness and reflective self-awareness, gradually modifying the client's usual view of self to make it more adequate to the experiential complexity of the experienced.

Interpersonal Therapeutic Techniques

In viewing anorexia nervosa as a problem-saturated story with an alternative self at work, it may also be helpful to view the role anorexia nervosa plays in the lives of clients. Kelly's (1991) original fixed role therapy required clients to enact a hypothetical identity in opposition to their prevailing identity. This may be an example of a short-term intervention for anorexia nervosa. Clients with anorexia view their true selves as worthless and inadequate failures. The anorexic identity creates a false sense of self in the relentless pursuit of thinness. Asking the client to play a role opposite to what she has constructed attempts to reauthor her negative view of self and enables her to see another side of her story.

Viewed from a social constructionist perspective, fixed role therapies of this kind could be expanded to acknowledge the multiple, often contradictory, roles we develop and sustain in response to the different contexts we inhabit. Combined with IPT techniques for resolving role disputes, relationship difficulties, and grief, this attempts to address the role of the anorexic identity in creating an alternative self that is not congruent with one's authenticity, one's family, or one's environment. The dispute is often the difficulty clients with anorexia nervosa have in maintaining the façade. The dispute is between reality and the orders of the "it." The anorexic role creates an ambiguous relationship with a client's authentic self. Clients no longer associate with their own abilities, strengths, and qualities that make them unique. Key to this process is the identification of personal weaknesses that clients have grown to despise and to

uncover their authentic qualities that are not subject to the rejection of an anorexic mindset. Externalizing the voice of anorexia is the next step in therapy that encourages clients to see themselves as separate from the disease and the anorexic identity.

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Appendix

BEYOND ANOREXIA NERVOSA: REDISCOVERING SELF



INTRODUCTION

Anorexia nervosa is a complex disease to understand and to treat. The disease is characterized by an all-consuming pursuit of thinness, low self-esteem, alexithymia, perfectionism, and feelings of worthlessness and personal inadequacy. Anorexia nervosa may also be characterized as a separate identity at work that is formulated in the early stages of the disease. As weight loss ensues, clients with anorexia nervosa begin to develop a separate identity that is founded upon the rigors of the disease. As the disease and weight loss continue, clients experience a simultaneous disassociation from themselves and their environment.

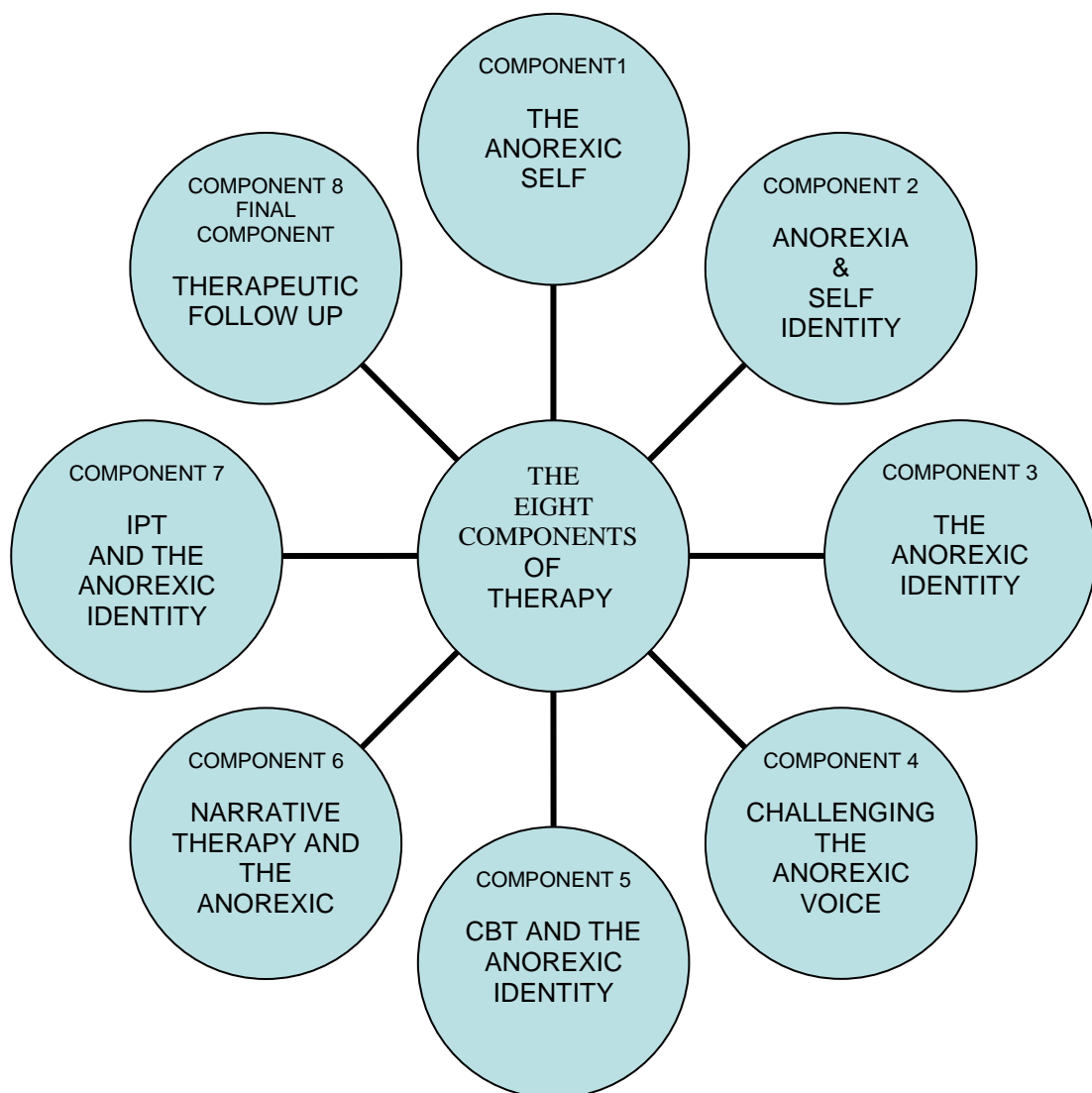
Beyond Anorexia Nervosa: Rediscovering Self involves an integration of the material that highlights anorexic cognitive distortion, overvaluing of thoughts, deficits in self-esteem, and loss of self-identity. The combination of therapeutic interventions aims to identify the relationship of anorexic cognitive distortion and loss of self-identity in the maintenance of anorexia nervosa. The treatment guide contains eight components of therapy. Treatment is aimed at treating long-term adult female sufferers of anorexia nervosa in understanding and managing their disease. The program is guided by the Canadian Psychological Association (CPA) (2001) and the CCA (1999) standards of ethical practice. In light of the physical complications due to anorexia nervosa, participants are required to sign an informed consent (enclosed) that information regarding their physical health will be shared between the therapist and physician in open communication of the client's present and ongoing health status.

ETHICAL CONSIDERATIONS IN TREATING CLIENTS WITH ANOREXIA NERVOSA

In treating clients with anorexia nervosa, it is important to adhere to the ethical standards of the CPA (2000) and the CCA (1999). Consent to treatment and the limits of confidentiality are important considerations when treating clients with anorexia nervosa. Informing clients of the nature of the therapeutic alliance and the limits of confidentiality when a client's physical and psychological health are compromised, or, at risk, given the nature of the physical and psychological effects of starvation in clients with anorexia nervosa. Therapists are required to report any concerns about the client's health and health-related concerns if and when the client's health and safety may be compromised. Therapists are required to have a Masters degree in Psychology and theoretical experience in cognitive behavioural, interpersonal, and narrative therapy.

OVERVIEW OF THE TREATMENT GUIDE

THE EIGHT COMPONENTS OF THERAPY



GUIDING PRINCIPLES IN THE THERAPEUTIC PROCESS

A. Diagnostic Criteria

Review DSM-IV-TR criteria for anorexia nervosa (American Psychiatric Association, 2000, p. 589).

B. Provide and/or coordinate care and collaborate with other clinicians.

Collaborate with providers of nutritional counseling and the client's physician to closely monitor physical health.

C. Establish and maintain a therapeutic alliance.

Build the alliance by acknowledging the patient's difficulties in recovery and treatment resistance. Acknowledge the presence of an alternative identity and explain the nature of the controlling aspect of the anorexic self.

D. Physical Monitoring of Client Physical Health

Throughout the formulation of a treatment plan and the subsequent course of treatment, the following principles of the Anorexic Self versus the Authentic Self require therapists to ensure that the client's general medical status is monitored by the client's physician. It is also imperative for therapists to monitor the client's psychological status and safety throughout the course of treatment.

COMPONENT 1

AN INTRODUCTION TO, AND AN UNDERSTANDING OF, THE ANOREXIC SELF

Beyond Anorexia Nervosa: Rediscovering Self is a departure from traditional methods of treatment for anorexia nervosa. Anorexia nervosa is characterized by an all-consuming and relentless pursuit of thinness. The underlying symptoms of the disease include perfectionism, low self-esteem, alexithymia, and feelings of personal inadequacy. Intrapersonal and Interpersonal difficulties also exist and create difficulties for clients in developing a healthy sense of self. First allowing clients to determine the extent to which they engage in negative self-appraisal may allow them to begin to interpret and understand how their ‘negative voice’ creates a negative view of themselves and reinforces eating disorder symptomatology.

Asking clients to complete the “When I look in the mirror” exercise creates an understanding between a negative view of self and how it may reinforce the anorexic voice.

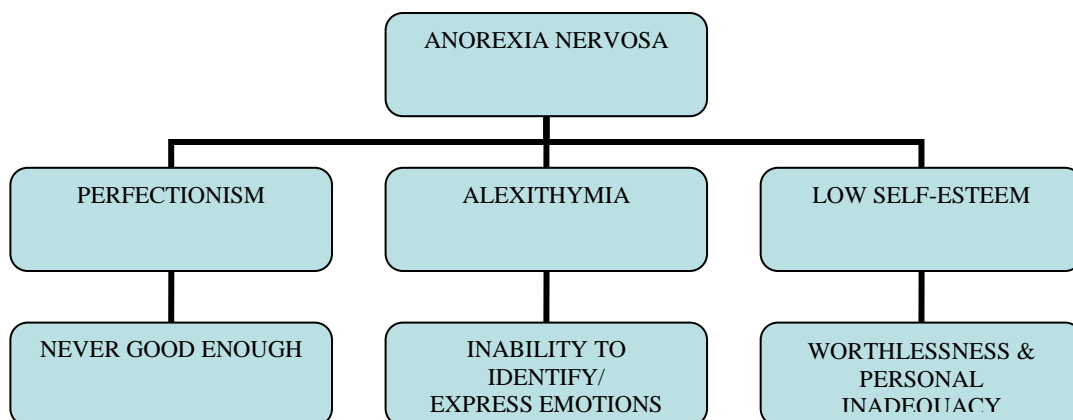
COMPONENT 2

THE NATURE OF ANOREXIA NERVOSA AND IT'S EFFECT ON SELF

IDENTITY

The second component of treatment reviews the nature of anorexia nervosa, the symptomatology, and the effect the disease has on individual identity. In assessing clients with anorexia nervosa, it is important to outline the various symptoms of the disease and the associated personality traits that contribute to the development of the disorder. The following diagram depicts the personality traits of perfectionism, alexithymia (inability to identify and/or express emotions), and low self-esteem.

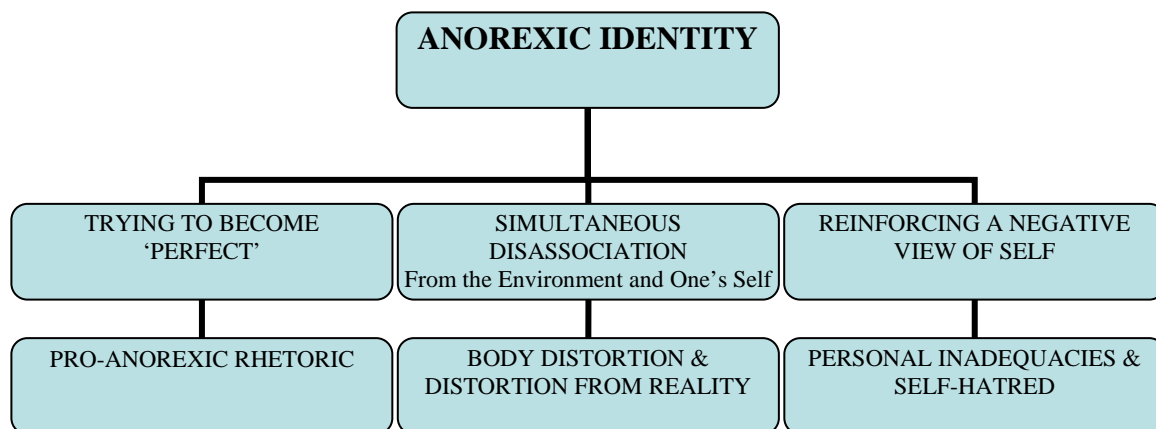
THE NATURE OF ANOREXIA NERVOSA



Highlighting relationships between perfectionism, never feeling good enough, alexithymia (the inability to express emotions), low self esteem, feelings of worthlessness and personal inadequacy helps clients see the effects that certain unattainable standards have on their ability to accept who and what they are.

THE FORMULATION OF THE ANOREXIC IDENTITY

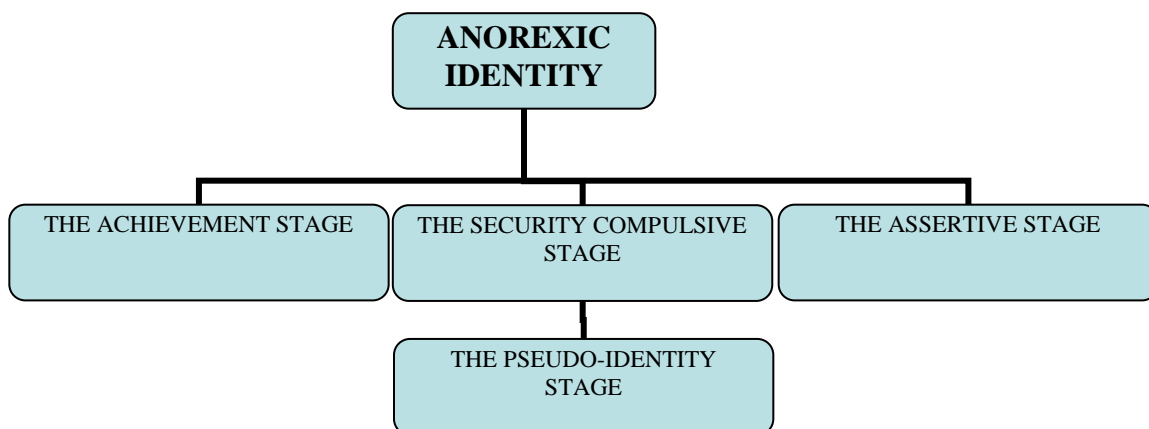
In treating clients with anorexia nervosa, it is important to recognize the presence of an alternative self at work. The anorexic identity may be externalized by way of naming the identity. Naming the identity (e.g., the anorexic voice, the anorexic self, or the negative voice) allows clients to see themselves as separate from the disease and separate from the self-defeating voice of pro-anorexic rhetoric.



COMPONENT 3
THE ANOREXIC IDENTITY, IDENTITY DEVELOPMENT, INDIVIDUATION,
AND SEPARATION

The Four Stages in Developing the Anorexic Identity

(Levenkron,1983)



The achievement stage forms when a person decides to go on a diet to lose weight to somehow fulfill an underlying desire to be accepted by peers, as a way to fit in, and possibly as an answer to the pangs of low self-esteem. The anorexic starts out like a normal person, with the concept of losing weight as a great accomplishment. However, dieting is soon transformed from normal dieting to superdieting. This growing sense of achievement and praise from peers solidifies the anorexic's restrictive eating practices.

The feelings of being virtuous and successful are far more important to the anorexic than mere feelings of hunger.

The security compulsive stage. Once the anorexic attains achievement in becoming and being anorexic, the anorexic no longer has a goal weight and ironically begins to feel fatter and fatter. The anorexic will view others as thinner, whether they are or not.

Levenkron (1983) says that body distortion is necessary to reinforce the anorexic's mission to keep dieting and to lose more weight. Levenkron's view may also be describing the presence of another identity at work that is manipulated through powerful anorexic rhetoric as described by Maisel, Borden, and Epston (2004). Body distortion, although an essential component in anorexia nervosa, does not explain a client's adherence to the rigors of the disease and the simultaneous disassociation from reality.

The anorexic will develop other compulsive activities that keep food to a minimum and/or burn more calories. Obsessional fears of fatness will begin to mount and weight loss behaviours must be repeated as a way for the anorexic to feel secure and in control and to quell those fears. This stage is the point at which the anorexic loses touch with self and with reality, family, and friends. Emotions shut down and thoughts revolve solely around food and weight. This view is similar to, and consistent with, the presence of alexithymia in the symptomatology of anorexia nervosa. All energies are spent on fighting food, fighting fat, and being the anorexic.

The assertive stage. Losing touch with reality and oneself creates an illusion of omnipotence and a superficial sense of power for the anorexic. This illusion of power allows clients to become very protective of their weight loss and they begin to assert their power to maintain the anorexic behaviour. When concerned family and friends make

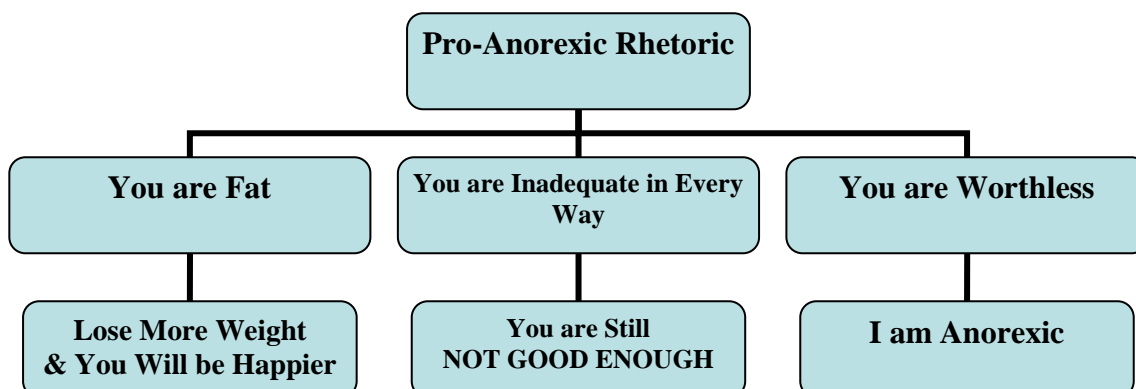
comments about the anorexic being too thin, the anorexic actually believes they are merely jealous and conspiring to make the anorexic get fat. Feeling empowered, the anorexic becomes even more tenacious in restrictive eating and calorie-burning behaviours. Taking charge and defending the anorexic behaviour further solidifies its importance in the anorexic's life.

The pseudo-identity stage. Family and friends are well aware of the advanced condition the anorexic has reached. They adapt and accept the too-obvious illness. This view may explain the nature of families and what social constructivists describe as living in the problem-saturated story of anorexia nervosa (Freedman & Combs, 1999). Families are often afraid, resentful, and angry at anorexics for the control they appear to exhibit over what was once a normal existence. Regardless, the anorexic now literally becomes "the anorexic." The anorexic adopts this new pseudo-identity and feels empowered and surreal. At this point, the disease becomes a valuable part of the anorexic's personality. To lose the anorexia would mean losing self-identity.

THE POWER OF THE ALL-CONTROLLING “IT”

Rusca (2003) alluded to the presence of an alternative self in anorexia nervosa.

Clients are under the orders of a separate entity that is all-controlling and begins to distort reality in favor of an anorexic mindset that continuously overrides all aspects an individual’s life. Maisel, Epston, & Borden (2004) discuss the social construction of anorexia nervosa and the construction of an alternative self. The voice of anorexia nervosa is seen as pro-anorexic rhetoric. Pro-anorexic rhetoric is a reinforcing factor in maintaining the disease. Clients often cannot distinguish between their own thoughts and the thoughts associated with the anorexic self.



It is important to note that clients are continuously and relentlessly engaged in anorexic thoughts. The client gains self esteem and a sense of self from the success at weight loss and success at being “anorexic”. Anorexia nervosa distorts a client’s body image, sense of reality, and sense of self. Therapists, using CBT, IPT, and narrative therapy, may address cognitive distortion, loss of self, and underlying problems with identity.

COMPONENT 4

CHALLENGING THE ANOREXIC VOICE



The fourth phase of treatment attempts to understand the extent to which the client's identity has been compromised by the disease. The nature and prevalence of anorexia nervosa make it imperative that psychotherapeutic treatment begin to focus on the pseudo-identity (Levenkron, 1983). Maisel, Epston, & Borden (2004) Lamoureux and Botttorff (2005), Bruch (2002), Hepworth (1998a), and Rusca (2002), among others, describe a separate identity of anorexia nervosa and potential

complications that arise in trying to treat the disease, however, inadvertently ignoring the power of anorexic thoughts and behaviours. Although numerous researchers alluded to anorexia nervosa as a disease of power and control, treatment does not appear to recognize the individual within the confines of an anorexic self.

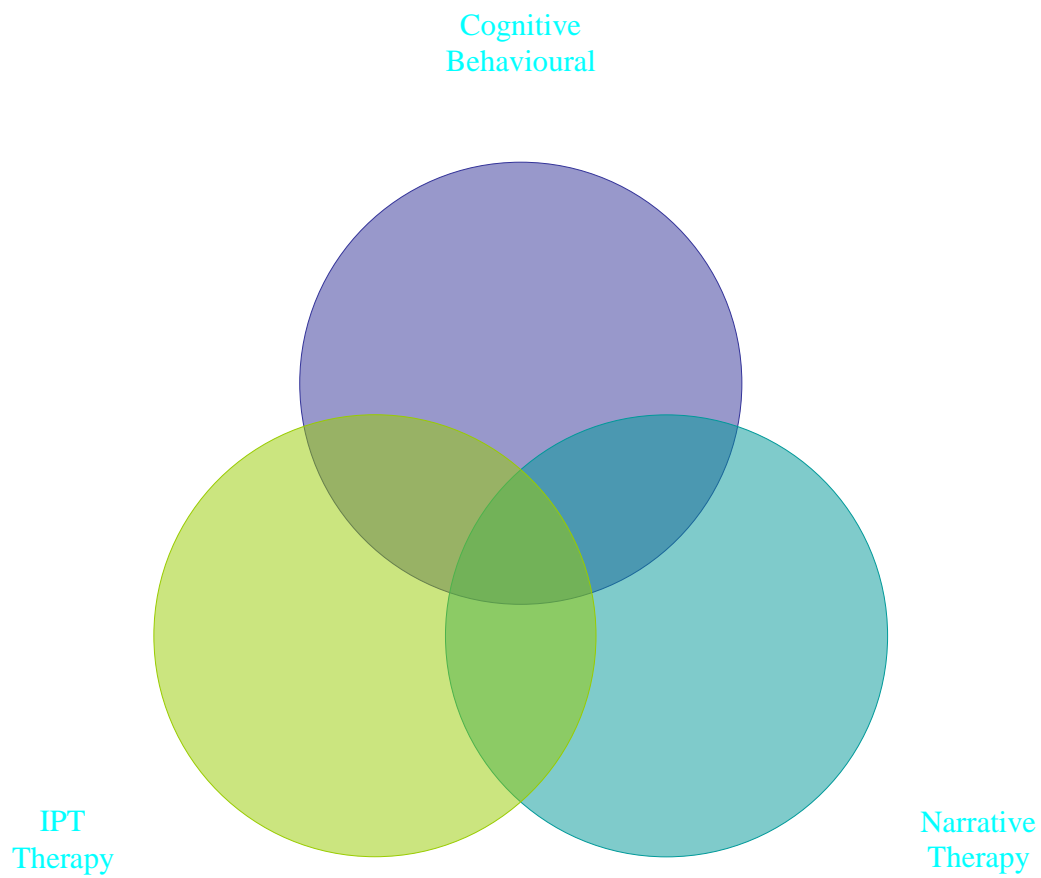
The anorexic identity seems to describe many facets of the disease that are treatment-resistant. The resistance may then be understood as extreme reluctance in giving up what an individual prizes so highly. In addition to weight loss, anorexics may also prize the new-found identity that has provided an illusion of perfection, acceptance, achievement, and self-worth to an otherwise absent self.

PRO-ANOREXIC RHETORIC AND SIMULTANEOUS DISASSOCIATION FROM REALITY

The anorexic experiences toxic pro-anorexic thoughts not as alien or unwanted, but as reality. This view is similar to Malson's (1998a) disassociated state that clients with anorexia nervosa begin to exhibit. In this context, a client simultaneously disassociates from reality and associates with the power of the anorexic voice.

COMPONENTS 5, 6, AND 7

THERAPEUTIC TECHNIQUES IN TREATING THE ANOREXIC IDENTITY



COMPONENT 5

COGNITIVE BEHAVIOURAL THERAPY AND TREATING THE ANOREXIC

IDENTITY

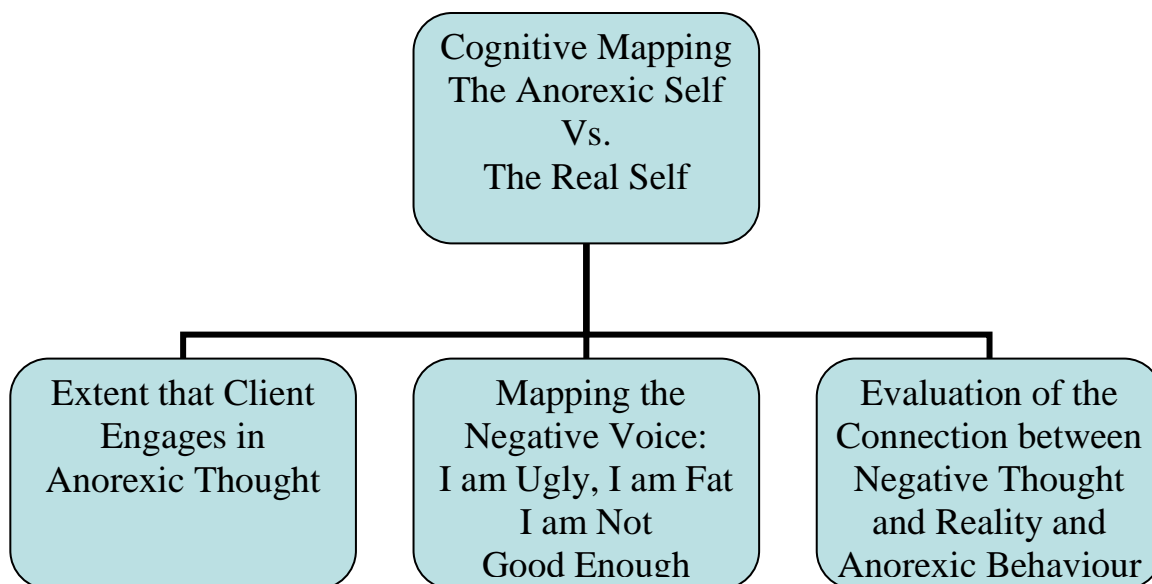
COGNITIVE BEHAVIOURAL THERAPY

The primary target of this treatment is the modification of client's negative thinking and dysfunctional assumptions about eating and body shape and weight. Current applications of CBT in the treatment of anorexia have been strongly influenced by this cognitive approach (Garner, Vitousek, & Pike, 1997).

Cognitive behavioural therapy attempts to address and modify the core psychological deficits of low self-esteem, all-or-none thinking, cognitive distortions, and dysfunctional concerns over weight, shape, and self-control. Deficits in self-esteem and self-regulation may leave people with eating disorders unprepared for the developmental tasks of separation and individuation. Generally, people with eating disorders are extremely dependent on external phenomena for the maintenance of their self-esteem. Performance and achievement are tied to pleasing others rather than oneself. This makes patients with anorexia and bulimia nervosa particularly vulnerable to the influences of cultural, family, and peer groups. Clients are under the orders of the "it," as described by Rusca (2003), and are extremely dependant and vulnerable to the demands of what it takes to become and remain perfectly anorexic.

CORE PSYCHOLOGICAL DEFICITS OF LOW SELF-ESTEEM, ALL OR NONE THINKING, COGNITIVE DISTORTION, DYSFUNCTIONAL CONCERNS OVER WEIGHT, SHAPE, AND SELF-ESTEEM

Cognitively, clients with anorexia nervosa have various abnormalities (Garner & Bemis, 1982). Of particular importance is a dichotomous or all-or-none thinking style. Although some of the characteristic features of eating disorders have their roots in the individual and in early relationships, these impinge on issues such as self-worth and attractiveness, which have been closely associated with culturally mediated influences in Western society. Perhaps anorexia nervosa could be characterized as a separate identity that comes to shape and form an individual's sense of self and feelings of self-worth and attractiveness. The difficulty in treating the characteristic features of eating disorders may be the influence that these characteristics have over a client's ability to function in any way other than what the eating disorder dictates. Cognitive therapy that addresses the level of control the anorexic identity has over a client's authentic sense of self, feelings of worth, and attractiveness may begin to explore a client's inability to be authentic and resistance to change.



In keeping with such a multidimensional view, most clinicians would recognize the value of a treatment approach that also addresses the physical and psychosocial nature of a client's clinical presentation. Most recognize the need to address the extreme distortion in clinical state produced by starvation, as well as the psychosocial issues that are important to the evolution and maintenance of the disorder.

Fairburn and Wilson (1993) proposed a modified cognitive behavioural model of what maintains anorexia nervosa and described its implications for treatment. The model postulates that the defining feature of anorexia nervosa is an extreme need to control eating. Fairburn and Wilson (1993) recognized the importance of dysfunctional concerns with shape and weight, but relegated them to a less central role suggesting that existing cognitive-behavioural accounts of anorexia might be over inclusive.

They proposed a focal treatment aimed at sense of self-control. The authors suggested that the features that need to be addressed are the use of eating, shape, and weight as indices of self-control and self-worth; the disturbed eating itself; and low body weight. In contrast, the authors suggested that cognitive behavioural therapy problems

and family difficulties are targets of the leading cognitive behavioural approach (Garner, Vitousek, & Pike, 1997) and do not need to be tackled unless they prevent change. This model has yet to be proven heuristic in a stimulating and innovative approach in the treatment of anorexia nervosa.

The anorexic self may be treatment-resistant because clients both idealize and adore their new-found identity as a refuge from reality. Treatment resistance in clients with anorexia nervosa may be a result of therapies that only address the cognitive and behavioural functions of anorexia nervosa and not the cognitive and behavioural functions of the anorexic self that reinforces and protects clients from the possibility of recovery.

COMPONENT 6

SOCIAL CONSTRUCTIONISM AND NARRATIVE RECONSTRUCTION IN TREATING THE ANOREXIC IDENTITY

The constructivist approach to therapy is more reflective and elaborative, with the therapist assisting the client in developing a personal construction of reality. Of particular relevance is the technique of narrative reconstruction (Epston & White, 1999). This provides an innovative literary perspective on psychological phenomena. An anorexic's story is a narrative construction of depression, worthlessness, unattractiveness, and failure as a result of her experience with family dysfunction, inability to express emotions, and inappropriate internalization of negative life experiences.

JOURNALING AND REAUTHORING OF LIFE STORIES

The therapist and client can address the nature of the anorexic identity through the narrative that is revealed through the journaling process. The therapist may point to a narrative story that is built upon the presence of the anorexic mindset. At this point in therapy it is important to explore and distinguish beliefs that are reality-based from those that are anorexic-based. Gaining perspective by changing the anorexic mindset relates to the misperceptions that food makes one fat, that gaining weight means becoming obese, and that being heavier somehow makes anorexics feel less worthy and less disciplined. Building on this information, the process of therapy may allow for a more realistic perspective for clients with anorexia nervosa. By becoming aware of and deconstructing distorted ideas clients are able to understand how eating makes the anorexic feel like a bad person, how the anorexic does not deserve to eat, and how being smaller means making smaller mistakes. As well, clients may begin to challenge their strongly held

beliefs and misperceptions that anorexia is the only means of achieving a sense of control, identity, and self-worth. Acknowledging these as anorexic thoughts or wrong thinking helps clients develop a more accurate perspective of their lives and themselves.

RECONSTRUCTING THE SELF

Therapy with anorexics should focus on developing an understanding of how clients have constructed their view of personal inadequacy. The role of a therapist is to facilitate the experience of new stories and life narratives that are empowering and more satisfying and give hope for a better future (Bruner, 1986). The focus of narrative therapy is an expansion and enrichment of meaning more than it is a change in behaviour.

DECONSTRUCTIVE LISTENING

Narrative intentions lead us to listen to what people tell us as stories. Listening carefully to the stories of anorexics and striving to understand their experience helps develop both trust and rapport and to have some ideas about the particular constraints their story carries. Deconstructionists believe that is fruitless to search for the real meaning of any text (Freedman & Combs, 1990). Listening to an anorexic's story begins with a not knowing attitude. A therapist must provide an atmosphere of "What if the client feels this way or what if the client feels that way?" As clients engage in storytelling, therapists can discern what constructions are being made and what new constructions may be emerging. In listening with this attitude, clients can view how their story is socially constructed and learn that other stories may be created that suit the goal of recovery.

DEVELOPING NEW STORIES

Once problem-saturated stories are understood as social constructions, different, more fruitful constructions can be created. In the negotiation between new and old stories Freedman and Coombs (1994) suggested that therapists ask: How did you do that? What did you do that led you to feel this new feeling? In the case of anorexia nervosa, hallmark questions in developing a new life narrative include: How did you feel about yourself prior to the disease? How did the disease start? Why do you feel inadequate? Why has anorexia made you feel better about yourself? Has the disease made you happy and content? Do you feel that anorexia has solved your feelings of self-hatred or has it made them worse?

NARRATIVE THERAPEUTIC TECHNIQUES AND THE ANOREXIC SELF

DEVELOPMENTAL CONSTRUCTIVISM AND THE EVOLVING SELF

In recognizing the power in reconstructing a negative view of self, it is also imperative that clients with anorexia nervosa develop an understanding of how the disease began and how the disease distorts reality. Guidano (1995) used a movie-like technique to explore and reconcile discrepancies between the client's experience of a situation and explanation of it. For example, in working with anorexia nervosa, a therapist may move the client step by step through a slow motion replay of the battle with anorexia, panning across a series of scenes, before zooming in on the one that has the most significance to the client.

COMPONENT 7

INTERPERSONAL THERAPY AND INTERPERSONAL THERAPEUTIC TECHNIQUES IN TREATING THE ANOREXIC IDENTITY

Kelly's (1991) original fixed role therapy required clients to enact a hypothetical identity in opposition to their prevailing identity. This may be an example of a short-term intervention for anorexia nervosa. Clients with anorexia view their true selves as worthless and inadequate failures.

THE ANOREXIC IDENTITY AND THE ROLE OF THE CLIENT

The anorexic identity creates a false sense of self in the relentless pursuit of thinness. Asking clients to play a role opposite to what they have constructed attempts to reauthor their negative views of self and enables them to see another side of their story. This, in combination with IPT techniques for resolving role disputes, relationship difficulties, and grief, attempts to address the role of the anorexic identity in creating an alternative self that is not congruent with one's authenticity, one's family, or one's environment. The dispute is often the difficulty clients with anorexia nervosa have in maintaining the façade.

THE FACADE



TALKING TO THE ANOREXIC IDENTITY

Engage clients in an active dialogue with the anorexic. Challenge the anorexic self with allowing the client to reality test the authenticity of the claims anorexia had promised.

THERAPEUTIC TECHNIQUES IN ADDRESSING THE ANOREXIC SELF

Therapist to Anorexic Self: Are you perfect yet?

Anorexic Self: No

Therapist to Anorexic Self: When will you be perfect?

Anorexic Self: I don't know

Therapist to Anorexic Self: Did you not promise that you would bring my client everything she asked for?

Engage the client to challenge the anorexic voice and begin to unravel the untruths of the anorexic.

COMPONENT 8

FINAL COMPONENT OF THERAPY

THERAPEUTIC FOLLOW-UP

Pro- anorexic rhetoric is the voice of the anorexic identity. The anorexic voice is a separate entity that is founded upon the existence and toxicity of anorexia nervosa. For example, anorexic rhetoric instantly offers a myriad of convincing reasons why the professionals involved in their treatment, who point out the harmfulness of self-starvation, are not to be trusted. The sufferer experiences toxic pro-anorexic thoughts not as alien or unwanted but as reality. This view is similar to Malson's (1998a) disassociated state that clients with anorexia nervosa begin to exhibit. In this context, a client simultaneously disassociates from reality and associates with the power of the anorexic voice. The inability of clients to discern between the anorexic voice and the real voice is the initiation stage of the disease. Anorexic thoughts proliferate and come to dominate a person's thinking and actions, leading clients to lose touch with their own values, their own identity, and their relationships. This is the anorexic identity.

REMINDING ANOREXIC CLIENTS OF THE THERAPEUTIC WORK

FOLLOWING TREATMENT

1. Encourage clients to challenge their anorexic reality.
2. Encourage clients to discern between anorexic thought and reality.
3. Encourage clients to identify with the power of pro-anorexic rhetoric and the effect it has had on their ability to be happy, content, and able to live their own lives.
4. Encourage clients to ask, on a daily basis, whether the things that anorexia promised (perfection, beauty, self-acceptance, feelings of adequacy, and accomplishment) have come true.
5. Follow-up at three and six months post-treatment.

WHEN I LOOK IN THE MIRROR

1. When I look in the mirror

2. Today I looked in the mirror and

3. I like myself best when

4. The first thing I do when I get up in the morning is

5. The first thing I think when I get up in the morning is

6. I feel glad to be me when

7. If my mirror could talk, it would say

8. My perfect reflection would be

9. The last time I liked what I saw in the mirror

10. My body is

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