

**OF HUMAN BONDAGE:
INVESTIGATING THE RELATIONSHIP BETWEEN ANOREXIA
NERVOSA/BULIMIA, SPIRITUALITY AND THE BODY-SELF ALLIANCE**

by

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DECLARATION

I declare that OF HUMAN BONDAGE: INVESTIGATING THE RELATIONSHIP BETWEEN ANOREXIA NERVOSA/BULIMIA, SPIRITUALITY AND THE BODY-SELF ALLIANCE is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



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JOAN ELIZABETH COLLETT

DATE: 28 February 2011

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SUMMARY

A growing body of research recognizes spirituality as a key element in well-being, but the agency of individual spirituality remains unclear. This study explores the role of embodied knowledge in reality construction and its effect on illness by considering how spirituality as embodied existence shapes reality. Spirituality, as a form of embodied knowing, is shown to reach deeply into the fundamental relatedness of existence. The study argues for a mind-body-spirit unity, making no distinction between self and spirit, emotions and subjective experiences situated in the spirit. As the medium between body and self, spirituality gives form to the felt reality of embodied knowledge and meaning, shaping language, cognition, thought and action towards lived reality.

New ways of thinking about eating disorders were stimulated by innovative discoveries through investigating the lived reality of the illness within an epistemology that included subjective experiences as part of reality. While acknowledging the influence of social discourse, the study calls for a recognition of vulnerability in the human condition giving rise to the embodiment of a wounded self or disabling spirituality, manifested in the development of an eating disorder. It uncovers the anti-spiritual properties involved in the lived reality of people struggling with anorexia/bulimia, evident in social withdrawal and/or self-injury. Behavioural patterns of obsession and repetition underscore similarities to addiction and ritual.

The study synthesised pastoral therapy and research. A postmodern approach to illness and a qualitative design with interpretive phenomenology were used. Three young women struggling with anorexia/bulimia participated in semi-structured research interviews. Their narrative accounts provided a chronology of developing, living with and healing from anorexia /bulimia. Emphasis shifted from an approach aimed at fixing the body to focusing on individual experiences of the illness; what she brought to the encounter in her own resources and potential to heal. Healing is envisaged as the ongoing development of a renewed sense of self, an inherently spiritual process orchestrated from within. Previous disassociation of body and self is replaced with reconnection between body, self and other, care of the spirit became care of the body, expressed in harmony and wholeness of being.

Key terms:

anorexia nervosa, bulimia nervosa, disenabling spirituality, eating disorders, embodied knowledge, spirituality; empowerment; interpretive phenomenology, mind-body-spirit unity, narrative, opposing medical discourse, wounded self

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PROLOGUE

THE MOTIVATION BEHIND THE RESEARCH INQUIRY

We spend our lives as a story that is told.

(Psalm 90:9)

Mariska: A life remembered

The seeds from which this research project grew were first sown six years ago when Mariska, a young woman diagnosed with anorexia nervosa, was referred to me for counselling. At the time, she had already been struggling with an acute form of the illness for many years; and she had on several occasions been placed in psychiatric care at various city hospitals. Mariska's parents contacted me for pastoral care and support for their daughter and asked if I could visit her at home, because of the long distances they had to travel and Mariska's need for on-going support. Her weight was already dangerously low and the medical prognosis was not encouraging. A few years later, Mariska died, shortly after her twenty-second birthday.

Our journey is recalled by way of 'remembering conversation' (White 1997:136), which is mindful of and gives credence to new insights and experiences which grew from my involvement with Mariska. Looking back, I honour the life I am privileged to write about. It is through my close involvement with her that I developed a much deeper and more sympathetic understanding of this illness, an understanding which has profoundly affected my life and work as a pastoral therapist. Close interaction with her over several years uncovered creative methods for caring that provided an orientation and a framework within which this research could develop. It also gave me a firm belief in the critical contribution pastoral therapy can make in working alongside the medical model of anorexia nervosa/bulimia in the context of healing.

Mariska remembered having numerous stomach problems as a child, which often resulted in her refusing to eat. She spoke of recurring gastric disorders, of childhood illnesses and medication that suppressed her appetite, leaving her underweight for her age. Her parents confirmed that there had been many attempts to address the problem through medical intervention and psychological counselling. Nevertheless, the eating problems persisted; and

they became more acute with time. At the age of eleven, Mariska had the first of two stomach operations; the second followed some three years later. Shortly after her first operation, she was diagnosed with anorexia nervosa and was hospitalized for the disorder. So began a long and desperate struggle with an illness which was to cripple her life for the eleven years that remained to her.

Having been trained within the framework of a postmodern epistemology, and with the lenses of social constructionism and narrative providing me with further guidance, I joined forces with Mariska and the medical profession as a friend and a caregiver. Looking back, I realize how much knowledge I gained as a participant observer, particularly in terms of the inherent power of the illness. I suggest that the 'problem' was given a 'life' of its own by the unfailing emphasis those in the medical profession placed on scientific objectivity, focusing only on Mariska's emaciated body and invariably resorting to aggressive methods to help her gain weight. I was frustrated by medical reports that repeatedly stated that she had only six months to live, a pronouncement which constructed a 'truth' that was highly damaging to any hopeful possibilities that might have emerged. The prognosis of six months became years; and both Mariska and her parents started to question medical opinion. They became obsessed in their search for other 'cures'. More and more people from various disciplines became involved, which added to the confusion and sense of hopelessness. This made it impossible to adhere to any long-term therapeutic plan, which left Mariska and her parents feeling 'small' against the power of the illness.

Although the 'life' behind the problem speaks of anorexia nervosa, Mariska and her family never openly acknowledged the diagnosis, mindful of the stigma attached to mental illness. They suggested that her weight loss was caused by some virus or obstruction in her stomach as a result of her operations. She became anxious about introducing anything new into her diet, and would spend hours searching the internet for a 'magic pill' that would allow her to gain weight while avoiding the issue of having to eat. The family relationship inevitably became strained because of Mariska's behaviour. Parental intervention invariably caused arguments, which left Mariska feeling rejected and more desperate. Her parents would then blame themselves; and the family became increasingly organised around the problem, bound together in a repetitive, self-defeating cycle. I realized that both Mariska and her parents eventually reached a point where they felt powerless against the illness. From time to time her situation would become critical and she would require emergency treatment at one of the city hospitals. She would be 'force-fed' and then discharged when her condition had stabilized. On several occasions, she discharged herself from hospital. Neither the family nor

the helping professionals failed to grasp the profound impairment of her body's physiological functioning due to the lack of a holistic approach to dealing with the illness.

Mariska confided in me that when doctors saw her for the first time, she felt they did not see the real person, but rather focused on her emaciated body. She claimed that they all tried to help her from the 'outside'. This made her the subject of inquiry and observation, which hindered involved interaction and any collaborative endeavour on the part of those seeking to help her. The 'gaze' turned her body into an alien and threatening presence, making her vulnerable and anxious. She began to relate rather to a diseased body, disliking and blaming that body for her condition.

In her own words:

I do not have a life; it is all because of this body. Everywhere I go I have to take this body with me. People stare, it frightens me, it makes me feel kind of 'other'.

While focusing on the 'objective' disease, the client's subjective experiences of the illness or context-formulated knowledge that maintained and 'fed' the problem were largely ignored. The medical profession labelled Mariska un-cooperative and manipulative – she felt they were uncaring. As a result she became distrustful of those trying to help her. Shield and Carlson (1989:91) explain that trust often hinges on the quality of the therapeutic relationship, because when there is trust, a patient will not feel a sense of abandonment; the patient can begin to communicate with his or her body and explore the illness. As key ingredients of the illness experience, these feelings affected Mariska's identity and her ability to view her life from a 'normal' perspective, which gave the illness a controlling power that ultimately made it irreversible.

Making a decision to be there for Mariska in a caring capacity was not easy. Having had little practical experience of dealing with chronic illness at the time, I had no form of dialogue or established theory base with which to provide meaningful care at this level of practice. I deliberated on how I might get Mariska (and her family) to become enthusiastic about stepping into new situations, and how different perceptions of the problem could bring about new solutions by 'resurrecting diversity in everyday life' as White (2004:vii) recommends. This proved most difficult to achieve. Mariska had grown up being the 'object' of all efforts to help, which centred the illness. She had no sense of herself as an agent who could effectively act in relation to matters that concerned her life. The illness had become so firmly

entrenched that it was difficult for her to envisage a life outside the confines of this framework.

Through their use of language, everyone got caught up and stuck in a 'problem-dominated' narrative that gave the illness momentum on a daily basis. All talk centred around what Mariska had eaten that day, her bowel movements, stomach cramps or whether she had slept the previous night. Mariska also took on a 'sick' role; at times when significant others entered the room, she would double-up with stomach cramps, having seemed free from pain minutes earlier. I did not see her behaviour as an attempt at manipulation, but rather as a kind of reality created by the illness, where this charade had become a way of life for the patient. While she appeared keen to engage in life outside the confines of her parents' home, she remained extremely cautious and full of doubt, as if reluctant to leave behind the 'safety' the illness offered her. She had learned to build walls around herself. When she was invited to think about the illness differently, although she was curious, her first instinct was always to retreat behind closed doors.

In attempting to treat an eating disorder, it is not uncommon for helping professionals, together with concerned family and friends, to create a situation which only serves to aggravate the problems for which the client has sought help. Relatives were severely critical of Mariska and her parents, believing that her behaviour was simply manipulative, which called for a more disciplined strategy. For her own 'well-being', they had her certified and committed to a psychiatric hospital after having her removed from her parents' home by the local police. Although I was overwhelmed at the lack of sensitivity in their actions, and by the stigma and shame felt by Mariska and her parents, there was nothing I could do to reverse the decision. Kleinman (1988:160) writes that in the case of 'stigmatized' disorders, the stigma can begin with societal reaction to the condition. A person so labelled is humiliated by those around her. The stigma becomes internalized in a deep sense of shame and a spoiled identity, while behaviour becomes shaped by a negative self-perception. He adds that whether or not the ill person resists the stigmatizing identity, her world is radically altered. The stigma attached through the cultural significance of the illness label marks the ill person as different and 'other'. In Mariska's case, this meant that she considered herself bad and in need of punishment. She told me how she was given a room that was cold and miserable, with no sun at all during the day. Her cell phone was confiscated and all visitors were prohibited.

I was concerned about Mariska's well-being, as I believed that these actions by concerned relatives only served to give more power to the illness. Montgomery (1993:119) points out that making a difference can sometimes mean just providing comfort, or even simply meaningful human interaction, in the face of deterioration. She encourages a form of caring through which caregivers engage with, rather than distance themselves from, the personal experiences of the individual. Supporting this viewpoint, Durrant and Kowalski (1994:107-137) suggest that if, in the face of complex problems, we focus our attention on those points that allow for movement and change, our involvement with the patient can become not only simple, but also effective. Within the professional community, these experiences are rarely discussed, are often viewed with suspicion within the paradigms of science and psychology, and are often interpreted as counter-transference or as manipulation by the client.

Sensing the need for me to remain in contact with Mariska while she was in psychiatric care, I approached the hospital for permission to correspond with her by fax. In my capacity as her pastoral therapist, my aim was continually to construct a story of hope and healing that would take its place alongside the story of hospital confinement. I wrote several letters to Mariska, which were censored before they were passed on to her. I wrote of ordinary things: life on the farm, the moon rising over the hills, of how I had stained my hands while picking mulberries. I knew that the letters made a difference to both of us. They mattered a great deal to her, because they helped her to stay connected and not give up hope, which instilled a new spiritual buoyancy in her. They mattered a great deal to me because they constituted ways of getting involved beyond the boundaries of theory or hospital treatment.

Mariska's twenty-first birthday was approaching and she was still in psychiatric care, with no news regarding any possible discharge. A week before her birthday, I suggested that she write to the head of the psychiatric unit and share with him the personal loss she had experienced at having been hospitalized for nearly three months. She mentioned that it would soon be her birthday and that it was her greatest desire to be at home to share this time with her family. Happily, her request was granted.

In the months that followed, Mariska gained in confidence – she became more talkative, looked more relaxed and seemed to enjoy my visits. Often between visits she would telephone to move our appointment forward. Her parents also noticed the difference. At mealtimes, she was prepared to experiment with different foods she had not eaten for years, albeit with caution. Once, I remember, she even had a chocolate. Relationships in the family became less tense, particularly with regard to her younger brother, who had always been a

source of irritation to her. Sadly, there were also times when nothing seemed to matter in her day. I would visit her and she would look pale and weak. I would then just sit with her, often reading from her Bible. Her favourite verse was Micah 7:8, which she underlined with a red pen:

*Rejoice not against me, O mine enemy: when I fall, I shall arise;
When I sit in darkness, the Lord shall be a light unto me.*

Often this verse would serve as a metaphor in our conversations, strengthening her in her fight against the illness.

When Mariska died, I was deeply saddened and troubled by the many unresolved issues in her life. She undoubtedly suffered a great deal; and suffering was also an unavoidable aspect for me as therapist, if pastoral counselling was to succeed in its purpose. Had we all somehow failed her, or had she simply failed herself? Could the outcome have been different? My interactions with her forced me to step back and critically reflect on the events that had transpired. They motivated me to obtain valid and reliable data and to try and think differently about eating disorders. This caused me to question very seriously the current societal and professional interpretations of this illness.

The literature revealed little about the actual nature of the ill person's relationship with the illness, and particularly the relationship Mariska had with herself and her body. A further problem is that many practitioners have been trained to think of 'real' diseases and precise outcomes, and hence find dealing with eating disorders messy and threatening. These practitioners do not leave any room for patients' illness narratives and personal experience of the illness. Shield and Carlson (1989:22) state that people often need to have their attention drawn to their own untapped potential – often they simply lack this awareness. Given that the psychological meanings are the most powerful influence on the course of illness, Kleinman (1988:17) suggests that in the care of the chronically ill, credence should be given to the patient's illness experience – listening and witnessing empathically – even if such an approach poses some difficulty due to the regularity and sheer perseverance that chronic illness demands. Predictably, Mariska became a 'problem patient', while at the same time she was beginning to experience her care as a problem in the healthcare system.

Mariska clearly experienced herself as burdened by the confines of the illness, a restriction that was maintained by an inability to view the situation from an alternative perspective that might have introduced new options. If the clinical problem is dealt with in isolation, regardless

of context, the fundamental web of meaning in which the problem is situated cannot be addressed. The meaning that gives rise to the persistent feelings of hopelessness, isolation and self-blame will remain, and may even be reinforced. Introducing previously marginalised voices, including the voice of the patient, can open the door to justice in therapy, and treats the personal as well as the political. Few clients attend therapy believing in their own healing potential – the client needs to be supported collaboratively to achieve this.

I was also curious regarding the dimension of power exerted by the illness, as if the patient had no hope or inspiration to recover. I became particularly interested in the shift of power and how power inherent in the illness could be re-directed from the illness to the personal empowerment of the ill person. It made me pay particular attention to the feelings and perceptions of the patient, how she viewed her health, herself, her body and the status of the illness. I became interested in what eventuality would allow those struggling with an eating disorder to explore – physically, mentally, emotionally and spiritually – what they could do to recover and heal from this life-threatening illness. The emphasis shifted from an approach aimed at ‘fixing’ the body to focusing on the individual and her experience of the illness, what she brings to the encounter in the form of her own resources and potential to achieve healing.

I now turn to the research inquiry, and the stories of the lives of the three women who participated in the study.

CHAPTER ONE

ORIENTATION TO THE RESEARCH JOURNEY

Strictly speaking, the question is not how to get cured, but how to live.

Joseph Conrad, *Lord Jim* ([1900] (1957))

1.1 INTRODUCTION

This chapter contextualises the study by defining the research problem and clarifying my own positioning in terms of the epistemological framework and the research methodology that structured the research inquiry.

I explore new knowledge that illuminate spirituality as embodied in the body-self relationship, focusing particularly on the way in which the spirituality of an individual person has a profound impact on, and is affected by, an illness such as an eating disorder. This positioning integrates spirituality in ways that encourage treating a person as a whole, thereby addressing not only physical aspects, but also social, emotional and spiritual issues.

The objectives of the study are also presented in this introduction, together with an explanation of the importance of achieving these objectives. I indicate the strategy I used to pursue the research aims and objectives, highlighting the merits of semi-structured interviews as an interpretive framework. I also outline the processes which guided me in the analysis of the data and the construction of the research text. The scope and limitations of the study are defined, and an overview of the remaining chapters is given, indicating how the dissertation unfolds.

1.2 EMBARKING ON THE RESEARCH INVESTIGATION

In order to centre and make clear my understanding of spirituality, below, I set out the conceptual framework that guided the study, which considers mind, body and spirit not as separate entities, but as a spiritual unity that underscores the three-dimensional essence of being. I also stress the importance of the body-self relationship, with particular emphasis on the body as the medium which expresses spiritual harmony, and the importance of

understanding and monitoring this relationship in the context of an eating disorder. Specific terms and issues introduced here are discussed in more detail in the chapters that follow.

1.2.1 Conceptual framework

A conceptual framework is provided in order to situate the terms 'body' and 'self' or 'body-self', the primary relation used in this research report. The inquiry's approach was holistic – thus, I conceptualize a human being in terms of mind, body and spirit. I regard the mind as the storehouse of knowledge, the body as our material or physical form and the spirit or self as the core of our innermost being, a springboard between the self and the world. The world suggests our situatedness within discourse(s). It implies a coming-together of relationships through which the self is constituted. Mind, body and spirit are separate entities, but are closely related, so that subjective experiences of the spirit have a very real effect on the physiology of the body. I regard the self and the spirit as synonymous. The terms 'body' and 'self' or 'body-self' therefore refer to the body/spirit relation. My approach stands in opposition to the Cartesian paradigm, which regards the body and the mind as separate entities, and makes no distinction between the self and the mind.

1.2.2 Illness, power and voice

As a condition of critical illness, anorexia nervosa/bulimia constitutes an 'ontological assault' (Sakalys 2003:229). It causes a split between the body and self, compromising a person's power to act. The body becomes foreign and is medicalized; productive functioning is hindered; and relationships and expectations for the future are severely impeded. In essence, a stable sense of self and an ongoing life narrative are threatened by the illness, resulting in a 'biological disruption' (Williams 1984:177) or a 'chaos narrative' (Frank 1995:97-114).

The assault of anorexia/bulimia on the body and a person's sense of self is compounded by a medical perspective which often frames the illness experience in objective terms – the body, especially when it is seen as a diseased body, becomes an object of inquiry, while the unique experiences or local knowledge of the person living with the illness are marginalized or discounted. Such medical meta-narratives can be internalized as valid descriptions of the self and experience, where the ill person takes on the life and thought processes prescribed by the diagnosis, resulting in conflict between the illness narrative and attempts to preserve selfhood (Sakalys 2003:230; White 1995:119).

1.2.3 Illness and the body-self

The fundamental premise of this research is that anorexia/bulimia, sometimes coupled with acts of self-mutilation, are problems resulting from the ill person's relation to the self, in the interface or relationship between the mind, body and spirit. As a critique of dualism, the research inquiry constitutes a shift away from the virtually exclusive concern with the body and disease towards a primary concern for the individual, with the emphasis on the relationship between the self and the body. I am indebted to and informed by the work of nursing theorist and philosopher Sally Gadow (1982, 2000, 2004), and follow her lead in emphasising the importance of not reducing the body of a patient to an object, but to affirm the value of the lived body through the intimacy of physical care and comfort.

I base my critique on the premise that the essence of human existence is embodiment, that the self (spirit) is inseparable from the body, and that 'problems of mind and consciousness can no longer be addressed in abstraction from their existential grounding, the body' (Gadow 1982:87). Employing Gadow's existential phenomenology, Bishop and Scudder (2003:108) emphasise how thinking of the 'lived' body (the relation between body and self), as opposed to a body reduced to the mechanisms of modern medicine, constitutes the dividing line between care and cure. However, understanding the relation between the self and the body in illness remains a problem for many, impoverished, even blinded, by the spirit of dualism: when consciousness and awareness are pigeon-holed in the mind, the body remains 'other' (Corbin 2003:257; Finlay 2006:19-30; Gadow 1982:86, 2000: 89-97; Hawks 2004:12).

1.2.4 Illness and spirituality

Given that 'something is missing', my argument is grounded in the framework of existential phenomenology. Its focus is the existing individual; and it is concerned with finding meaning and purpose through the process of reality construction, both objectively (by discovering truth) and subjectively (by creating truth) (Herholdt 1998:226) in order to arrive at what Webster (2004:9) calls self-understanding. As humans we are spiritual beings and have a spirit (Fosarelli 2002:211; Kliewer 2004:616; Pellegrino 2001:570). Hence, the focus in existential phenomenology shifts to the role of the spirit, making possible 'universal connection with all things and processes – the umbilical cord of the person to ultimate reality' (Hiatt 1986:740). Spirituality from an existential perspective does not primarily aim at the objectification of subjective meaning, but affects how a person relates to meaning (Webster 2004:11). As a reflexive relationship, the 'self' (our spiritual nature) encompasses self-

awareness and self-relatedness, something which is unique to human beings. Spirituality is then illuminated not only as a subjective experience, but as the platform from which we see the real world, in its true perspective, or as the basis on which we relate (Fitzgerald 1997:412). Hence, I argue that spirituality is an embodied relationship in which the body becomes the vehicle capable of touching and being touched by the world. In such a relationship, spirituality plays a significant role in health and illness.

Consideration must be given to the subjective experiences of a person who is diagnosed with an eating disorder. Particular attention should be paid to how these experiences, which are constructed as knowledge, become constitutive of the relationship with the illness. When these matters are considered, the client's own interpretation of reality becomes the focus of practice. Such a focus can come about with an awareness of what constitutes the client's spirituality, with particular emphasis on the nature of embodiment between the body and the self.

In a medical model, in contrast to the lived body of 'unbroken immediacy' (being in the world, feeling able to affect it and being affected by it), the body at the present level of struggle and subjugation is often regarded as an object body, due to the 'existential otherness' of the self and the loss of original unity (Gadow 1982:88). When an eating disorder manipulates and causes severe injury to the body, the relationship between the self and the body is experienced as 'mutually limiting', instead of as 'mutually enabling' (Gadow 1982:91). It becomes possible to transcend this struggle through a relation of full mutuality, which is experienced as unity of mind, body and spirit, with the self and the body as distinct entities, but no longer in opposition to each other.

1.2.5 Illness, spirituality and healing

In allowing myself to understand and participate in the critical care experience of an individual, I was able to focus the research inquiry on the ordering of language as it was used in sharing the self, experience and reality as this person understood them. Narratives were presented as an objectification of the relationship between the illness and the body-self, so that the story became a medium whereby the body-self, expressed as a spiritual unity, could be monitored in the context of the illness, as suggested by Frank (1995:52). The lens was focused on spirituality and its role in determining subject positioning within discourse, when the illness narrative powerfully illuminated fundamental disruptions in selfhood and relationship (the universal world of discourse and experience came together in narrative).

At the same time, I used the therapeutic modality of narrative to explore spirituality as a resource in healing qualitatively in the process of healing and self-care, presenting an 'alternative story' which opened up new knowledge to highlight and incorporate previously neglected lived experience, as White (1995:11-40) suggests. As a result, the ill person was invited to re-negotiate her identity, as described by Sakalys (2003:229), with the process of healing as the human experience of recovery being accomplished from within. Healing can be regarded as a spiritual experience because of its transcendent dimensions, as opposed to curing, which is directed towards bringing about physical change to a diseased body (Fosarelli 2002:217; Lerner 1993:324). Our engagement involved the co-creation of new and more empowering views of the self: a 'standing with clients' and their experiences outside the territory defined by psychiatric and psychological knowledge, as White (1995:121) proposes.

1.3 CONTEXTUALISING EATING DISORDERS: THEORETICAL AND CONCEPTUAL FRAMEWORK

In the section below, I look briefly at the history of this enigmatic illness, its distinctive character, the physiology of the body and the challenges it poses to health care systems, while juxtaposing spirituality as a healing resource to current treatment approaches.

1.3.1 Anorexia nervosa/bulimia within the framework of Western science

Anorexia nervosa has been categorized as a mental disorder within the framework of modern medicine for at least a century. MacSween (1993:13) claims that the term 'anorexia nervosa' was introduced in 1873 by an English physician, William Gull, but that in an 'aside' in his Address in Medicine to the British Medical Association in 1868, Gull already referred to some cases of emaciation in young women for which there was no evident organic cause, describing this phenomenon as 'apepsia hysterica' (digestive problems of hysterical origin). The treatment Gull advocated was considered to be appropriate for persons of 'unsound mind', focusing on 'moral control', through which the patient's 'mental equilibrium' was to be brought back into balance.

Gull's original description of anorexia nervosa laid the foundation for the theoretical classification and categorization of the illness as a 'serious mental disorder' (Klump et al 2009:97) within the framework of Western medicine. The description also contains most of the essential characteristics of anorexia nervosa recognized by contemporary psychiatry (MacSween 1993:13). Today, research and clinical practice is served by a single set of

descriptions of different psychopathologies (Williamson, Gleaves & Stewart 2005:5) in the form of the Diagnostic and Statistical Manual of Mental Disorders, generally known as the DSM, the fourth edition of which has been published by the American Psychological Association (APA), and the fifth edition of which is due to be published in 2012, so that the task of description, classification and elaboration of 'pathology' has driven virtually all research on eating disorders (Bordo 1993:49). Despite inconsistencies in the criteria set out in the main classificatory systems, most theories unconsciously rely on these psychiatric definitions and assumptions primarily designed to describe various psychiatric problems (Garrett 1998:49). These perceptions have been formed largely within the medical paradigm (Garrett 1998:xii), with consequent feelings of stigmatization by those suffering from the illness.

1.3.2 Diagnosis and classification

Fairburn and Harrison (2003:407) report that eating disorders are divided into three diagnostic categories: anorexia nervosa, bulimia nervosa and the atypical eating disorders. Although they are categorized differently, these disorders have many features in common and patients frequently migrate between them. Favazza (1996:206), a psychiatrist and specialist on self-injury, states that as many as half of those suffering from anorexia/bulimia also have a history of chronic self-mutilation. Fairburn and Harrison (2003:408) and Harris (2000:172) also mention that patients tend to engage in substance misuse, self-injury or both. In my research, I encountered incidents of self-injury, although not as frequently as Favazza (1987) suggests. In some cases, an eating disorder may precede self-mutilation, while in others, the reverse is true. Alternating cycles of both behaviour patterns are also experienced; and they are possibly different manifestations of the same problem.

1.3.3 General clinical features

Anorexia nervosa typically starts in the mid-teens, often with the onset of dietary restrictions, which then get out of control (Fairburn & Harrison 2003:409). Individuals at risk invariably have a distorted body image – insisting that they are overweight even though they are skeletal in appearance. There is an intense and illogical fear of being 'fat' and the person perceives self-worth largely in terms of body shape and weight. In the case of anorexia nervosa, the main symptom of this illness is a drastic reduction of body mass due to extreme calorie restriction. In the case of bulimia, self-induced vomiting is used as a means to achieve the same effect. This pursuit of weight loss becomes an obsession; and if the

strategy is successful the victim often does not see this behaviour as a problem (Fairburn & Harrison 2003:407).¹ (See also 3.2 for further discussion).

1.3.4 Treatment

How one envisages the treatment of anorexia/bulimia through the lens of Western science depends on the notion of the self in modernist terms, how it is defined theoretically and how the practice reflects that definition (Jankowski 2003:241). The treatment of anorexia/bulimia (within the framework of modernist science) is based on the Cartesian split between the mind and the body which occurred in the early seventeenth century. The model recognizes the psyche, but not the spirit, and regards thoughts, feelings and emotions as being in the mind (Zawacki 1993:153). Because the model suggests that there is no difference between the mind and the self (Jankowski 2003:241), no consideration is given to how thoughts and feelings contribute to and maintain illness, thereby affecting the physiology of the body. Regarding the human being as having a mind and a body that are essentially separate, as well as assuming the 'truth' that the body can be understood and treated separately from the person inhabiting it, (re)produces practices and ways of interacting with an ill person that demonstrates a subject/object dualism. This dualism has led to treatment models and strategies that are essentially 'symptom-focused', where attention is focused on the body, with various strategies for its repair. In the case of an eating disorder, feeding the patient, together with medical control of her behaviour and environment, becomes the main objective (Garrett 1996:1489, 1997:271; MacSween 1993:13-14).

1.3.5 Complexity

Anorexia nervosa is a life-threatening illness with the highest mortality rate of any psychiatric disorder (Whitney, Easter & Tchanturia 2008:542). 'Dropping out' from psychotherapeutic treatment is a widespread problem in mental health services (Mahon 2000:198). There is also little support for the use of individual therapies, such as cognitive behavioural therapy, interpersonal therapy or cognitive analytic therapy in treatment (Whitney et al 2008:542). Challenged by the reality of health care costs, depending on the health care system of the country involved, therapists dealing with seriously ill anorexic patients have to face some difficult decisions, both clinically and ethically, for which there are no 'clear-cut, evidence-based guidelines' (Vandereycken 2003:410). Although a lot has been written about the

¹ These disorders affect both males and females, although they are often perceived to be mainly a female phenomenon. In this study, I refer to the person suffering from the disorder as 'she', because all the participants were female. This is not intended to exclude male sufferers of these disorders

methods of weight restoration, little is known about the patient's experience of and reaction to therapeutically induced weight gain (Vandereycken 2003:415). Most specialized in-patient programmes for eating disorders use an integrated approach that includes medical, psychological, nursing and social interventions (Vandereycken 2003:418). However, the patient is often expected to follow the pre-determined treatment (a package of rather inflexible components), instead of actively participating in a programme that is suited to individual needs (Vandereycken 2003:418).

1.4 BACKGROUND TO THE RESEARCH QUESTION

Working as a pastoral therapist and having been an 'insider witness' to the unyielding power of the illness, I now provide an overview of the transformation of the everyday world of people struggling with this illness. I pay particular attention to how the illness isolates its victims, shaping and influencing their life and thought processes.

1.4.1 The wounded self

Given the complex ways in which the roles women fulfill in society continue to diversify, together with increasing demands in the lives of many, Matheson (2008:1274) observes that more and more women are at risk of developing addictive behaviours as a form of coping strategy. The role of women in Western society is continually changing, they are more likely to enter non-traditional professions that are inherently stressful, so that it becomes increasingly important to be alert to the risk factors that might contribute to the development of addictive behaviour (Matheson 2008:1274).

Despite numerous studies investigating the aetiology of the eating disorders, the incidence of such behaviour has continued to increase in recent years, suggesting that researchers and clinicians do not yet have a full understanding of the predisposing factors in this phenomenon (Ferrier-Auerbach & Martens 2009:334). Notwithstanding a wealth of information on the eating disorders, I submit that what is lacking is a clear understanding of the motivation behind such behaviour and the risk factors that give rise to it.

In the light of the above, I became curious about and was then challenged by the 'eeriness' that shrouds the eating disorders. Eating in order to survive is one of the most basic human and animal instincts, but the illness constitutes a violation of this innate logic, causing bodily subjugation and injury, weakening resistance levels and ultimately placing the body at

immense risk. At the same time, there are many parallels between eating disorders and addictive behaviour, particularly an addiction evidenced by a strict adherence to a 'dogma' that is followed with 'religious' fervour.²

The concept of addiction is complex, and the delineation of its defining characteristics has fostered considerable debate (Taylor, Curtis & Davis 2010:327). Traditionally, the term 'addiction' was applied solely to the abuse of substances that activate the brain's mesolimbic pathways. However, in recent years a broader conceptualization of addiction has emerged, and the term now includes so-called 'behavioural addictions' (Taylor, Curtis & Davis 2010:327). Goodman (1990:1404) defines addiction as

A process whereby a behaviour, that can function both to produce pleasure and to provide relief from internal discomfort, is employed in a pattern characterized by (1) recurrent failure to control the behaviour (powerlessness) and (2) continuation of the behaviour despite significant negative consequences (unmanageability)

Essentially addictive behaviour involves processes that can function both to produce gratification and to provide escape from internal distress, employed in a continuing pattern characterized by a loss of control despite significant consequences (Taylor, Curtis & Davis 2010:327). What is important is how this pattern relates to and affects the individual's life. Goodman (1990:1405) observes that at a theoretical level, the proposed definition of addiction entails a shift in emphasis, from focusing on a particular behaviour or the objective of that behaviour to represent rather a set of relationships between a behavioural pattern and other dimensions of a person's life. Furthermore, the terms compulsion and dependence have been frequently used to define an addictive disorder or addiction, where addiction would equate to dependence together with compulsion (Goodman 1990:1405). Despite a lack of consensus, most researchers agree that the addictive process involves a compulsive pattern of use, even in the face of health risks and adverse social consequences (Taylor, Curtis & Davis 2010:327). Davis and Karvinen (2002:245,246) observe that the most commonly reported behaviours linked to eating disorders, can be placed in the framework of purposeful acts of self-help. To this effect, (Goodman 1990:1405) states that dependence involves an attempt to achieve a pleasurable, internal gratification of needs, basic or derived;

² See also pages 127, 331, 270, 272, 340 and 362 where I discuss the power, manipulation and control exerted by the illness.

whilst compulsion serves to avoid unpleasant or aversive states of anxiety, grief, guilt and shame.

If bulimic behaviour is considered to be addictive, the latent craving is centred around extreme self-control, especially with regard to body weight and/or appearance (Vandereycken 1990:98). Persons struggling with anorexia restrict food intake thereby producing self-induced starvation. This might be aggravated by excessive exercise or purging the body by inappropriate use of laxatives. Once starvation is established, the disorder takes on an addictive quality. The sufferer can no longer eat without feelings of severe anxiety and guilt. The refusal to eat becomes an end in itself and loses its meaning as a form of control or hunger strike (Churven 2008:185).

It is my submission that the eating disorders should be understood and treated in terms of the addictive properties that underlie the illness. The power inherent in the illness experience seems to silence the sufferers, leaving them unable to express their thoughts and feelings adequately. Deliberate subjugation and manipulation of the body also leaves them alienated from their bodies and innermost selves. At the same time, they experience a separation from their parents, peers and society. Distorted body boundaries severely affect a sense of intimate connection and wholeness (Garrett 1998:26), placing the human spirit in great jeopardy. Lacking any transcendent source of meaning, the victims are cut off from the world and all meaningful relationships.

1.4.2. Of human bondage

Like psychology, spirituality deals with material that often cannot be understood except through analogy with personal experience (Hiatt 1986:737). Hence, the title of this project, *Of Human Bondage*, which was borrowed from a strongly autobiographical novel by Somerset Maugham (1975). The novel follows the story of Philip Carey, an orphaned cripple, in his quest for life and love.

Having been a witness to the different stories told about anorexia/bulimia, I thought this metaphor of 'being in bondage' was well suited to portraying the characteristics of the client/illness relationship in the context of an eating disorder. The participants felt 'in bondage' to a power, no longer able to be in a relationship with others, lacking love and friendship. The subtle promises of anorexia/bulimia seemed to have become the demands of an oppressor, leaving the victim powerless to control something she herself initiated. Clients

commonly agreed that 'something' was happening to them – their stories portray their desperate attempts to rid themselves of what they often call 'the monster' (Epston 1999:150). In *Biting the Hand that Starves You*, Maisel, Epston and Borden (2004:45,61) use metaphors of prison and concentration camps that resonate strongly with such experiences. Those under the regime of the illness frequently speak of 'hell', the 'devil' and 'evil'.

In revisiting the diaries of Ellen West, a pseudonym for a woman who struggled with an eating disorder at the time of the Third Reich (in her case, the disorder was diagnosed as melancholia) (Binswanger 1958:238-267), I developed a sympathetic understanding of the power inherent in the illness experience, something which can only be acknowledged and appreciated when one has witnessed the individuality of patient suffering. Interestingly, the diagnosis of melancholia made in Ellen West's case is much closer to an acknowledgement of the suffering and moral (or spiritual) response to the illness than the current diagnosis, which regards the condition as a mechanical breakdown, in need of 'fixing' through therapeutic and medical manipulation.

By means of the personal narrative contained in her diaries, Ellen West shares her pain and opens a window to her world. Her perceptions and experiences of the illness contribute to an insight into the suffering of those living with this illness. Her personal narrative presented me with a mirror in which I relived and experienced what was currently happening in the lives of those participating in this research inquiry.

Ellen West describes her being-in-the-world (*Dasein*) as having been narrowed and transformed by the illness. She no longer had a sense of inner development; she experienced being cut off from her own body. Nor was there any life outside her body – only an overwhelming urge, stronger than any form of reasoning, to shape her entire life according to one point of view: the wish to be thin, which remained unchanged in the centre of her thinking. She describes it as being caught up in 'dread' or 'evil' that could not leave her without pain, something physical, 'an ache in my heart', so unspeakable and unbounded that she had no means of escaping from it, except by death.

I gained an even deeper insight into the suffering experienced by people living with anorexia/bulimia when I read *The Illness Narratives* (Kleinman 1988:187-193), and the description of factitious illness. He leads us into the spiritual realm when he writes:

Factitious illness points to something darker, more driven, less appeasable, less given to reinterpretation as simply cognitive or affective reaction to illness. Each case of factitious illness discloses deep fissures in our inner world, a scarred soul who demands terrifying re-enactment of the felt experience of suffering. The words depression, anxiety, guilt, and anger do not do justice to the deeply indwelling, self-defeating psychic forces that create and intensify the experience of illness.

1.4.3 Discourse, power, truth and the self

In order to appreciate the power dimension inherent in the illness relationship, and how this power operates, it became necessary for me to understand French historian and philosopher Michel Foucault's conception of discourse and discursive formation, and the many applications of unacknowledged power that affect our daily lives. O'Brien (1999:132) explains that Foucault conceptualises discourse as 'the relations between statements' producing 'practices that systematically form the objects of which they speak', so that individual positioning within discourse produces meaning which influences behaviour and shapes the ways in which people understand and interpret reality and knowledge. In line with Foucault's argument, Wang (1999:192) writes that, contrary to the notion of the human being as a free subject, the human subject is constituted through discursive practices by means of power which is relational in character and exercised in and through social relations. Operating on the individual through discourse, power achieves its effect because it produces 'truths' for people. Instead of directly inflicting force, power functions best by indirectly constructing the subjective experiences (spirituality) of the individual (Wang 1999:191). Hence, Wang (1999:191) argues that for Foucault, the productive nature of power, in Foucault's words, 'does not simply weigh like a force which says no, but... produces things, it induces pleasure, it forms knowledge, it produces discourse'.

It is relevant to this research how discourse constructs 'truths' about women's bodies (and men's bodies) – 'truths' that stipulate what is required to be desirable and beautiful. These 'truths' are powerful and dangerous in terms of the effect they can have on the body/self relationship. According to White (1995:45), Foucault sees the concept of self developing within discourses of truth; and power is effected through the self, seeking its own truth. Clients actively participated in discourses that produced them as subjects with ideas such as 'to be beautiful and acceptable is to be thin', and 'this is something I have to do'. These ideas caused clients to perform operations on their bodies to transform themselves, while in search

of an elusive state of happiness, purity, wisdom and perfection. The power inherent in 'technologies', together with the 'truths' they propagate, indirectly construct subjectivity and shape identity. The individual is subjugated by assuming the spirituality (subjectivity) that is offered through these relations of power by actively participating in these discourses (Wang 1999:192). Similarly, Wang (1999:192-193) points out that discourse (in the Foucauldian sense) is never only linguistic, since it organises a way of thinking into a way of acting in the world. Power becomes political when the ill person is victimized by her own powerlessness, so that alternative outcomes are minimized.

1.4.4 Limiting self-narratives

White (1995:82-83) explains that behaviour experienced as actions against the self is shaped by the meanings constructed around the experience, and that these meanings (also understood as 'truths') are arrived at through the self-narratives told about our lives. Furthermore, any 'problem-dominated' narrative has the effect of embodying the problem within the person's self, while at the same time obscuring its influence from the individual's awareness. In a similar vein, Griffith and Griffith (1994:132) point out that the stories that are most hurtful to the body are those that are not recognized as stories, and that have become so much a part of the landscape of life that the patient accepts them fully, saying 'this is the way life is' and 'this is who I am'. This 'lived' story provides constructed ideas that are accorded a truth status and these develop into 'technologies' that in time transform both body and psyche, because the personal narrative does not merely reflect the illness experience, but contributes to the experience of symptoms and suffering.

Self-inflicted injuries, together with binding self-narratives, are referred to as 'unspeakable dilemmas' by Griffith and Griffith (1994:45), because patients regard these kinds of injury as unsafe to talk about. Therefore, because stories lived and told have enormous power to free or constrain the body, deliberate enquiries into how the self-stories attempted to make sense of events experienced over time became essential in the research process.

1.5 THE RESEARCH QUESTION, AIMS AND OBJECTIVES

Given the epistemological framework for the research inquiry, participant involvement with the world is seen as meaningful only within the context of relationships. All meaning is constituted through the relationships that the participant is in. Because spirituality is embodied in relationship, I posed the following research questions:

- Question 1: How is the spirituality of a person living with anorexia/bulimia embodied in the illness?
- Question 2: How does anorexia/bulimia disenable the spirituality of the person suffering from the illness?
- Question 3: How can the person's spiritual resources be mobilized to disempower anorexia/bulimia?

In contrast to the approaches of contemporary Western medicine in its treatment of anorexia/bulimia, the research inquiry focused on the person rather than the illness, and on how wholeness could be achieved by addressing the split between the self and the body, the self and the other, and the self and nature, which are the most evident factors maintaining and 'feeding' an eating disorder. Facilitating the client's spirituality as a healing resource in the context of an eating disorder directs attention to some of the most important existential issues – the meaning and purpose of life – and to creating a reality that is supportive of her best interests, and the highest level of self and other (Padulo & Rees 2006:79; Patching & Lawler 2009:10-26; Weaver, Wuest & Ciliska 2005:188-206).

Acknowledging that the concept of spirituality is complex and represents multiple and diverse lived experiences, the objectives of the study were the following:

- Objective 1: To investigate the relationship between mental, physical and spiritual health (to objectify the power inherent in naming and diagnosis, so that through these reflections the client could begin to entertain alternative, more facilitative beliefs, as well as opportunities for change and growth).
- Objective 2: To understand the client's reality (spirituality) better in the context of the illness, and her positioning in discourse, particularly focusing on the dimension of power that structured the illness experience. (This objective provided a frame of reference in giving consideration to values, morals and beliefs that guide client choices and actions, in order to reflect on constraining beliefs that increased the power of the illness).
- Objective 3: To encourage the re-negotiation of the client's relationship with the eating disorder by re-authoring stories that have become predominantly narratives of limitation. (Because the illness experience dominated the client's life narrative, re-authoring or re-storying this narrative provided a key to opening these bonds and freeing the body).
- Objective 4: To establish connections with the larger meaning and purpose of our lives. (This objective invited a re-establishment of relationships and connections between the body, the self and others, fostering a sense of belonging, community and the creation of more hopeful realities).

I wish to clearly state that this study does not seek to critically analyse, support or oppose any medical treatment or therapy aimed at curing anorexia/bulimia, where the focus is on the repair of the body. This study is directed towards a healing of the spirit by re-establishing connectedness, where the urge for wholeness or healing becomes a process from within (Sartor 2003:251). In this sense, the term 'healing' reaches beyond coping or adaptation to allow for the possibility of transformation (Gockel 2009:219).

1.6 THE RESEARCH METHODOLOGY

Considering the nature of the research question as a 'messy' variable within a social and cultural context, one that is not amenable to laboratory measurement and control, I chose phenomenology as an overarching epistemological framework in order to gain plausible insight into the experiential meaning of spirituality, as lived and situated in the everyday experiences of the research participants. Based on the philosophy of Husserl, as later developed by Heidegger and Merleau-Ponty, phenomenology seeks to describe the meaning of a phenomenon through the lived experience of human beings (Wright 2002:125). In order to increase knowledge from a holistic perspective that encompasses the mind, the body and the spirit, phenomenology examines the meaning of lived experiences. In the context of this research inquiry, it entails exploring how the individuals experienced spirituality and what meanings they ascribed to this experience, in line with Simpson's (2007:181) argument.

Because phenomenology is both a description of the quality of lived experience, and the meaning of the expressions of lived experience, it is often considered central to the interpretive paradigm and is considered a philosophical discipline and research method (Wojnar & Swanson 2007:172). Hence, in investigating spirituality as a lived experience, rather than as a conceptualized theory, phenomenological hermeneutics as a research method enabled a reflective focus on that which tended to be obscure, providing insight into how spirituality embodies human lived experience.

In the section below, I detail specific philosophical perspectives which provided the foundation for the overarching framework of interpretive phenomenology used to guide this study. Given that spirituality acquires meaning by being situated in a narrative (a plot), I explain the use of narrative and social construction as a means of constructing reality. An ethics of care, within a feminist pastoral framework as interpretive lens, guided the research process in the development of descriptions to arrive at the substance of the phenomenon that was investigated.

1.6.1 Existential phenomenology as an epistemological framework

Phenomenology has been described as a way to ‘break free and see the world afresh’ (Crotty 2005:86), an approach which calls for a return to the everyday world in which the ill person lives in order to gain a better understanding and to make visible the essence of lived experience through her eyes, as recommended by Wojnar and Swanson (2007:173). The term ‘phenomenological’ is used to refer to any orientation or study which is concerned with experience, consciousness, meaning and subjectivity, regardless of whether or not it is grounded in the ideas of philosophers such as Husserl, Heidegger, Merleau-Ponty or Ricoeur (Wojnar & Swanson 2007:174).

Accordingly, the research process employed phenomenology as a perspective offering greater understanding of the participants’ subjective experiences (Wojnar & Swanson 2007:174). Through the phenomenological lens, reality is viewed not simply as material or mental, but as experiential. Given its focus on holistic, embodied knowledge, phenomenology can be seen as an alternative to the Cartesian paradigm. In an attempt to understand and describe the participants’ subjective experiences, with the rubric of phenomenology described as ‘putting oneself in the place of the other’, the emphasis is on common understandings and meanings of practice. These emerge as an exploration, via personal experiences, of prevailing cultural and social discourses (Crotty 1998:83).

The complexity of phenomenology is illustrated by the fact that Wojnar and Swanson (2007:173) have identified seven different phenomenological perspectives. The two most widely used ones are descriptive and hermeneutic phenomenology. Descriptive phenomenology was first proposed by Husserl, the founder of phenomenology (Simpson 2007:181). It is concerned with an understanding of the essence of the phenomenon – an essence universal to all who experience it. This suggests that spirituality as a lived experience, as described by the participants, can be used to provide a universal description of the phenomenon. The notion of the universality of an experience implies that context-dependent knowledge derived from culture and historical periods are not critical to experience (Simpson 2007:181).

Later phenomenologists, such as Heidegger, Dilthey and Merleau-Ponty believed that the individual experience cannot be taken out of its context, because it is the context which provides meaning to an experience (Simpson 2007:181; Wojnar & Swanson 2007:175). Herein lies a critical difference between descriptive and hermeneutic phenomenology: for

Husserl, context was of marginal importance; for Heidegger, context was a principal concern. Heidegger believed that human beings are hermeneutic (interpretive) beings, and, because of their ability to interpret reality, are capable of finding significance and ascribing meaning in their own lives (Wojnar & Swanson 2007:174).

1.6.2 Interpretive phenomenology as a research method

As a qualitative research method, interpretive phenomenology is based on the theory developed by Heidegger (1962), who sought to understand the meaning of being or existence. The phenomenological method is premised on the art of being sensitive – sensitive to the subtle undertones of language, and to the way language speaks when it allows things themselves to speak (Van Manen 1990:112). The role of context in reality construction as the central concern in understanding human lived experiences is highlighted (Wojnar & Swanson 2007:174). To this effect, Heidegger (1962) introduced the concept of *Dasein* (the human way of being in the world) to emphasise that individuals cannot stand apart from their context or from the world in which they live; knowledge is context-dependent and is influenced by a person's past experiences and socio-cultural background (Webster 2004:8; Wojnar & Swanson 2007:175). Interpretive phenomenology attempts to address the situatedness of the individual's *Dasein* in relation to broader social, political and cultural contexts (Wojnar & Swanson 2007:179).

The assumptions of *Dasein* and context-bound knowledge form the fore-structure for understanding the world, and as such have important implications for research (Wojnar & Swanson 2007:174). Heidegger assumed that the fore-structure is closely linked to how one understands the world and that such understanding is linked with how one interprets reality. To me as a researcher, it suggests that my own background and previous experiences, as well as what I hold to be true in terms of reality construction, create the probability of an interpretive foreground, an understanding linked with how I interpret reality. Given this basic assumption, the observer is always part of what is observed, so that ultimate truth can never be determined, only surmised. Hence phenomenology always addresses any phenomenon as a possible human experience (Van Manen 1990:58).

Conducting the research inquiry meant that I was called upon constantly to reflect and be open to challenging my own interpretations, in order to remain true to the data and to invite an interpretation representative of the personal experiences of the participants (Simpson 2007:181). Therefore, my choice of interpretive phenomenology as a research methodology

was grounded in the belief that I, as researcher, together with the participants in the study, come to the research investigation with fore-structures of understanding, shaped by our respective backgrounds and world views. In the process of interaction and interpretation, we co-create new interpretations of the phenomenon being studied in order to render it more meaningful, as suggested by Wojnar and Swanson (2007:175).

Given the interpretive framework of this study, together with the intangible nature of the phenomenon investigated, in the section that follows, I argue the relevance of a qualitative inquiry for framing the interaction between the participants and me.

1.6.3 A qualitative research investigation

In answering the question, 'What is qualitative research', Strauss and Corbin (1990:17) provide the following explanation:

By the term qualitative research we mean any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification. It can refer to research about persons' lives, stories, behaviour, but also about organizational functioning, social movements, or interactional relationships. Some of the data may be quantified as with census data but the analysis itself is a qualitative one.

Denzin and Lincoln (2000:8) explain the concept as follows:

The word qualitative implies an emphasis on the qualities of entities and on processes and meanings that are not rigorously examined, or measured (if measured at all) in terms of quantity, amount, intensity or frequency. Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between researcher and what is studied, and the situational constraints that shape inquiry. Such researchers emphasise the value-laden nature of inquiry. They seek answers to questions that stress how social experience is created and given meaning.

As a research strategy, sensitive to human phenomena, the qualitative research design that I chose served as the foundation for understanding the participants' worlds (the term 'world' suggests a situatedness in meaningful relationships) and introduced the potential for growth and change in their lives. Because humans are conscious, self-willed creatures whose thoughts and actions go against the objective, observable, and stable qualities required of

standard scientific inquiry, positivist quantitative inquiry does not account fully for the diversity inherent in people's social and organisational lives (Bailey et al 2009:29). The term 'interpretivism' is used to capture this contrast, suggesting that the social domain is 'composed (rather than comprised)' of interpretations constructed by individuals (Bailey et al 2009:29). Epistemologically, knowledge is considered soft, embodied, open and evolving because of divergences in interpretations which are legitimate aspects of social life (Bailey et al 2009:29).

Making sense of the data and generating ideas required me to stay close to and immerse myself in the data, in line with Hunter et al's (2002:389) argument. The social meanings that the participants attached to the world around them were tied to a particular perspective and context. These perspectives influenced how I viewed the social text, how I focused on and reacted to the situations at hand, and how I analysed, interpreted and created meaning from data and text (Hunter et al 2002:389). Accordingly, a qualitative research strategy demonstrates the difference between 'factually reported, dry results' (Hunter et al 2002:388) on the one hand, and the insight that occurs when the incorporation of intuition and imagination provides an environment in which creativity is able to flourish, generating new and novel insights on the other.

Next, I outline the design concepts which guided me in examining the experiences of the participants first-hand, in order to attribute meaning to the phenomenon that I investigated.

1.6.3.1 A qualitative research design and its holistic focus

Although physical, objective issues are important in an assessment of anorexia/bulimia, the ability of psychological, social and spiritual factors to produce or enhance physical symptoms is increasingly acknowledged (Patching & Lawler 2009:10-21; Weaver et al 2005:188-206). The holistic approach to healing taken in this study, a qualitative research design with such a focus, assisted me in obtaining a broader perspective of events in my search for a better understanding of the totality of participants' lives, taking into account belief systems, expectations and world views. Because the healing process has concurrent physical, emotional and spiritual aspects (Elkins 2005:140; Kliewer 2004:621), a qualitative research inquiry made possible an environment in which the participants could explore and share their experiences and feelings openly and fully.

In order to gain a better understanding of the illness experience, emotions and the body-self relationship provided insight into embodied knowledge and meaning, with these knowledge becoming integral to the spiritual dimension of health and healing. If the research strategy had only taken cognizance of the physical or objective dimensions, it would have been impossible to understand the participants' spirituality or the process of healing.

1.6.3.2 Qualitative research as a value-laden inquiry

Becvar (1996:xvi) states that if we practise counselling and care differently, we will inevitably create a different world for ourselves and our clients. Developing caring relationships depends on the process of fostering connections with the person who is cared for (Carr 2008:692). Because the connections that people have are 'multidimensional and interrelated', including family, friends, God or a higher power, religious beliefs and practices, the importance of these connections in the life of the ones who are cared for must be recognized, respected and fostered (Carr 2008:692). Acknowledging connectedness as a qualitative strategy is an attitude, a way of being, that may enhance rapport with clients and help co-create a particular therapeutic relationship, one infused with a spiritual dimension which happens when care is taken to enter the experiences of the 'other' while allowing the 'other' to make their own decisions (Hood, Olson & Allen 2007:1199). Moreover, a spiritual perspective focused on the kinds of relational and emotional processes most likely to influence the course of anorexia/bulimia by keeping the integrity of important relationships a central theme in our conversations (Griffith & Griffith 2002:267).

Specific strategies included receptivity, 'being open to and present for the cared-for' (Carr 2008:693), listening for and hearing what is not being said (Carr 2008:693), as well as sharing descriptions of my own journey. Deciding when and how to introduce the topic of spirituality into the conversation and how to proceed, depending on the client's own orientation, was important. It includes a basic process of being open to, struggling with and making connections between particular experiential events and learning how to care for spiritual needs (Hood et al 2007:1200). Furthermore, this perspective allowed for an acceptance of the participants in all of their contextual complexity, so as to suspend judgement and attempt to understand their situatedness in context.

1.6.3.3 Qualitative research introducing more hopeful realities through sources of the random

Becvar (1996:154) agrees with Bateson, who says that 'without the random there can be no new thing'. This statement suggests that people often seek therapeutic support because they become stuck in a problem story. Moreover, they have created a reality whereby their way of positioning themselves, with regard to the 'problem', has become part of the pattern within which the problem is maintained. Being stuck in a particular perceptual frame, attitude or belief prevents the self from getting to know itself through 'gaining a voice' or self-agency. The rationale is that if people lack certain knowledge, or fail to realize that what is addressed can be understood in another way, or seen through a different lens, options for change are limited because of a skewed viewpoint that clouds people's perspectives.

However, it is often that which is omitted that provides the cue to new knowledge, because it is experienced more subjectively (Griffith & Griffith 2002:149-155; White 2004:134-146). Hence clients are often in need of the experience of transformation to another realm, or 'a shift to a more inclusive level of wholeness' (Newman 2004:589). Here, Bateson's central thesis, 'the pattern that connects', becomes significant insofar as transcendence calls for a focus on patterns, based on relationships which create meaning, within a context, over time (Newman 2004:589).

Introducing sources of random is particularly geared towards introducing new language to the pool of words and ideas, in other words, bringing about a different way of talking and thinking about the problem in order to establish new relationships with the body and others, with a focus on the role of the body in opening up fresh possibilities for relationships (Burns 2003:231; Finlay 2006:21; Griffith & Griffith 2002:134). Because qualitative research is people-oriented, the inquiry allowed me, as a researcher and therapist, to provide new information, to be a source of random in the construction of new knowledge, so that more satisfactory realities could emerge, in short, 'doing' and evoking hope.

Since people frequently respond to stories, because of similar experiences in their own lives or by identifying with the character in the story, sharing or telling stories provides a natural technique to access clients' resources. Combs and Freedman (1990:63-207) outline the following benefits of telling stories:

- stories pace people's models of the world and current situations;
- they allow us to access emotional states or attitudes;
- they suggest ideas; and

- they embed suggestions.

In the research reported here (in Chapters Five and Six), the telling and sharing of stories with the participants enabled me to 'plant' certain metaphors, based on my understanding of the client's world view, her unique circumstances, and a form of language that would appeal to her, in order to introduce alternative 'frames' (Becvar 1996:161). Metaphors use imagery and symbolism to bring forth understanding, they offer analogies or a similarity of ideas; and they provide a strong visual image, one that is powerful in communicating meaning (Hunter et al 2002:392). This source of random focuses on the process of 'turning inward' for the client, in order to assist her in the construction of new realities (Becvar 1996:159). Although I had specific reasons for telling stories and introducing certain metaphors, the meaning for the story (identifying with the story and the metaphor) evolved in the telling, and from the clients' understanding of it, as suggested by Combs and Freedman (1990:164).

Ultimately, the usefulness of a given metaphor depended on whether the participant could identify with the story or metaphor I introduced, in line with Combs and Freedman's (1990:172) practice. Becvar (1996:161) stresses the importance of words and metaphors that are most likely to 'structurally couple with', or be 'receivable and believable' by the client. Metaphors involve the process of 'reframing,' which is a specific form of language that suggests new ideas, particularly when persons have a preconceived idea that hinders the construction of more hopeful realities (Combs & Freedman 1990:68). When the client is presented with a metaphor, she is offered a choice: to respond or not. Not only did the use of metaphor facilitate the therapeutic experience for clients, but it also allowed me to gather information indirectly when discussing personal matters, thereby sparing those in my care possible embarrassment (Combs & Freedman 1990:49).

Problems experienced by the participants were tied to basic issues regarding meaning and their own spirituality. Sources of random were introduced, not only to break the cycle of rigidity constructed by the illness, but also to create a greater awareness of the possibility of an 'alternative story'. Poetry and journals were incorporated as part of the participants' autobiographies to foster a process of re-authoring the problem story, and to thicken and enrich new story lines.

Poetry assisted the participants in making sense out of life by framing 'ways ... of seeing and thinking about things, character, social life, states of consciousness' (Hass 1999:21). Poetry

can be regarded as a discourse that leads to discovery, as Komunyakaa (1999:22) reminds us:

The poet has become the philosopher, the composer and caretaker of the most fundamental and urgent questions voiced to the agency of human existence.... It reconnects us to the act of dreaming ourselves into existence. Poetry is an *action*...poetry in our complex society connects us to lyrical tension that has everything to do with discovery and the *act* of becoming. (Komunyakaa's emphases)

Given the focus of this research, the use of poetry was encouraged because 'art is the highest expression of the human spirit' (Oates 1999:22). Similarly, Merwin (1999:22) comments:

Poetry is physical. It enlists the participation of the senses, beginning with the sense of hearing, of vibration, and its pace derives from and attends the body's motions...gives voice to the unsayable in our lives.

Poetry sets in motion the process of turning inward, it moves us, and in moving us, changes us in a conscious way. The purpose of poetry is to evoke the imagination so that we might hear ourselves as a part of life within us, and beyond us, so that the need for poetry becomes part of what makes us human.

Journals give 'a voice to pent-up emotions' (Becvar 1996:159), and provided the participants with an intimate way of having conversations with the self, with others and with God. Griffith and Griffith (2002:124) suggest that an awareness of the presence of God can be a way through which new meaning enters. Expressing their thoughts in writing also assisted the participants to see their problems in a different context. These writings helped to alleviate the anxiety of their everyday existence in the shadow of an eating disorder. Keeping a journal opened up spaces for new self-narratives, which had a healing effect that rendered them less vulnerable to acute episodes (White 1995:145).

1.6.3.4 Qualitative research and the social construction of reality

In line with the research paradigm, I was sensitive to the kind of knowledge being created through our interaction in the context of the investigation. As the principal agents in the process of healing, the participants needed to feel that a connection existed between themselves and me, and between themselves and something larger than the self, as

suggested by Becvar (1996:71). As it was the purpose of the research to construct and develop knowledge that would bring about qualitative differences in the lives of the participants, my relationship with them directly affected the outcome of the investigation, as well as the writing of the research report. As a qualitative researcher, I 'situated and recontextualized' (Janesick 1994:210) the research project within the shared experience of the participants and myself, with the research design serving as the foundation for creating new knowledge. Knowledge became reflective of the research process, 'assimilating assumptions, location, history, context of knowing and the knower' (Altheide & Johnson 1994:488).

1.6.4 Qualitative research as an ethical project

The concept of what is deemed to be in the patient's best interest is much debated in the literature (Stringer 2009:32). Bloch and Green (2006:9) make the important point that we need to put 'heart' into ethical decision-making and 'that a person's character is at the heart of moral deliberation'. They also suggest that a principle-based approach to ethical decisions leaves out too much of the personal or private in difficult situations. They argue for a more 'complementary' framework to make people in care more sensitive to the real situation, since deontology (a respect for the patient's autonomy) and utility (a measurement of consequences) are regarded as theories that do not help clinicians in practice, particularly in conflict situations (Bloch & Green 2006:8). In my experience of eating disorders, patients are often reluctant to be hospitalized, despite the risk to themselves and others. Deontology would argue that the patient's views should be respected, while utilitarianism proposes that the case should be adjudged based on possible consequences. Neither theory can resolve a complex situation, as they may be in conflict (Bloch & Green 2006:8).

The care of clients afflicted by an eating disorder calls for a 'special moral quality' (Pellegrino 2001:571). The significant morbidity associated with the condition, coupled with only partially effective treatments, requires the development of truly novel interventions to maximize the anticipated benefit to the person while minimizing any foreseeable risks. These are considerations which inevitably involve ethical issues.

Diagnosis has enormous potential to have a physical, physiological and emotional impact on the well-being of the individual, so that care in this context takes on moral and ethical obligations that can have far-reaching consequences (Stringer 2009:30). Flaming (2006:221) points out that, for both Foucault and Ricoeur, ethics is a way of being, not something we

practise occasionally. Both philosophers insist that ‘to be ethical we should be concerned about our selves and our relationship with other selves or the other’ (Flaming 2006:221). It is universally accepted that the sanctity of human life is paramount. The primary goal of medicine is undoubtedly to cultivate the health of the social organism (Pellegrino 2001:570) with abiding conflict when a patient declines medical treatment, particularly where such a decision involves the risk of death.

1.6.4.1 Ethical practice and ethical conversations

With regard to ethical practice, Bloch and Green (2006:7) argue that psychiatrists lack a coherent framework for ethical decision-making because the rationale and methods used to resolve ethical questions differ radically. I contend that this form of reasoning may very well be applied to other helping professions as well, including my own therapeutic practice. Bloch and Green (2006) also turn to the ethics of care, a variation of virtue ethics, as a possible way of arriving at sound ethical decisions in clinical practice. Originally expounded by Aristotle, virtue ethics links people and actions in a virtuous circle and draws particularly on the role of emotion in moral deliberation ‘affording primacy to character and interpersonal relationships’ (Bloch & Green 2006:10). It is suggested that the cultivation of ethical qualities, or character traits, will lead people to act ethically in clinical situations in order to advance the common good (Bloch & Green 2006:9; Pellegrino 2001:570). Here, emotions have a part to play in moral reasoning, because being a virtuous person suggests the cultivation of the ‘right’ motives, such as ‘patience, tact, honesty and discretion’ (Bloch & Green 2006:11) in order to make the right decisions in particular situations.

However, most ethical conflicts arise over how to define a particular situation rather than the best method for dealing with that situation, because practice is a mixture of professional duties, personal choices and interpretations (Carson 2001:201). Although situations may present themselves as real, there is more than one way to describe reality. We need to be conscious of the fact that our own descriptions of events or situations are personal choices that we must make, and that these choices ultimately reflect how we see those entrusted to our care and ourselves professionally (Beveridge 2002:102; Carson 2001:200; Watson 2007:1284).

In line with postmodern sentiments and arguing for a more ethically aware framework for psychiatric practice in particular, and medicine in general (and, in my view, this is equally applicable to all helping professions), Carson and Lepping (2009:4) state:

If we are going to develop a truly ethical psychiatry, it cannot be one where the psychiatrist does all the imagining and evaluation, in other words, being judge and jury in one person.

The dilemma for the medical profession is that there is no 'authentic other side' (Carson & Lepping 2009:3), but such a view overlooks the fact that in all professional/client encounters the relationship is always mutual. They argue that the deeper problem for the medical model is the doctor's belief that the client is mentally disturbed, that this gets in the way because it leads to an 'instinct to mistrust' the client (Carson & Lepping 2009:3). In such a situation, there is no empathic relationship between the doctor and the client, with ethical decisions being made in a prescribed, 'process-driven' way (Carson & Lepping 2009:3).

Based on the work of Foucault, Flaming (2006:221) argues that a 'self' cannot reform the power/knowledge relationships in which we all find ourselves, especially if that 'self' is connected too tightly to a dominating 'truth' game. Flaming (2006:221) explains that truth games, an idea from Foucault's earlier writing, are what Foucault calls 'general politics of truth: that is, the types of discourse which it accepts and makes function as true'. Hence, Carson and Lepping (2009:3) are of the opinion that the first step to practising ethically is to accept the assumption that a set of guiding principles and a virtuous character may not be the only useful attributes in a best practice scenario. Rather, it is more about according weight to the possibility that the client may have a story to tell. The clinician is not necessarily in the position of knowing better on behalf of the client.

We need to develop a clinical method that would engage both clinicians and patients in collaborative interaction where both have equally valid stories to tell. In making a choice for the others' story, narrative methods encourage a more reflective and ethically conscious practice, because narrative makes it possible to engage in ethical discussions (Beveridge 2002:101; Carson 2001:203; Watson 2007:1283). Accepting parallel truths, rather than one dominant truth, provides the basis for ethical conversations and ethical competence, allowing the clinician to get closer to the client as a person, where seriously listening to the client's story provides insight into the client's contextual circumstances and frames a response. This 'conversational model' gives weight to all narratives, which is in keeping with the assumption that there is no absolute truth and no absolutely right or wrong decision when it comes to ethical dilemmas (Carson & Lepping 2009:4).

1.6.4.2 My own ethical practice

The inclusion of spirituality, in the context of eating disorders, calls for a variety of important and compelling ethical issues that must be considered in order to proceed in a thoughtful and ethically sound manner (Plante 2007:893). Ethical living happens in particular acts and has an effect on people (Flaming 2006:225). It is this concern for others that should propel us toward acting to prevent harm (Plante 2007:896). The development of an ethically aware framework for practice is of paramount concern, and is designed to be sensitive to each clinical encounter with the client, involving more genuine openness, serious conversations, and respectful listening in order to build trust (Carson & Lepping 2009:2-3; Griffith & Griffith 2002:267; White 2004:41-57).

The undertaking to act in the client's best interests and cause the client no harm is the pivotal point of any professional relationship (Stringer 2009:30). With this in mind, allowing clients to forgo medical treatment or therapy, thereby putting their lives at risk, would surely constitute a breach of this ethical code (Stringer 2009:32). Engaging with clients struggling with an eating disorder calls for a responsibility to recognize ethical issues that may arise during their care, and to apply ethical reasoning critically to clinical decision-making. I submit that when the client's vulnerability is exacerbated, healthcare obligations become more demanding (Stringer 2009:30).

The 'respect, responsibility, integrity, competency and concern' (RRICC) model of ethics was developed to highlight the primary values supported in all ethics codes associated with various mental health professions, both in the United States and abroad, together with implementing these values and how to give effect to these concerns (Plante 2007:894). This is relevant not only to psychiatrists and psychologists, but also to social workers, and marriage and family counsellors around the world. It supports the primary values in all ethics codes and also highlights the ethical issues for the integration of spirituality and psychotherapy. I now briefly discuss each of these ethical values which combine to provide the framework for my own practice. These issues are also discussed in more detail in Chapter Four, where I unpack my interaction with the research participants.

1.6.4.3 Respect

I am not only called upon to be respectful of the religious and spiritual beliefs and traditions of others, but also to be respectful at all times without bias. Agape, defined as unconditional

and inclusive love (God's love for humankind), has found its clearest exposition in the Judaic-Christian tradition. For agape to become the basis of an ethics of care, the need for love and respect as the precondition of ethics cannot be tied exclusively to one religious or ethical tradition (Kendrick & Robinson 2002:294). It is essential to be aware of and thoughtful about how religious and spiritual matters can influence those with whom we work (Plante 2007:895). Agape finds its ultimate focus when equal consideration is given to each person as an individual of worth, and when this is actively sought and embodied in practice (Kendrick & Robinson 2002:294). This means being mindful of ethical principles such as respect, responsibility, integrity and competence. Having concern for others and being aware of possible ethical dilemmas constitutes ethical practice, stimulated by seeking on-going personal and professional training and development.

1.6.4.4 Responsibility

Flaming (2006:224), in line with philosophers Foucault and Ricoeur, posits that our actions are unethical if we bring suffering or subjugation upon the client. Flaming (2006:224) explains this by using Ricoeur's own words:

...suffering is not defined solely by physical pain, nor even mental pain, but the reduction, even the destruction, of the capacity for acting, or being-able-to-act, experienced as a violation of self-integrity.

To be ethically responsible is to respond to the needs of others, whatever they may be, with 'much modern ethical reflection now focusing on the need for love as the pre-condition of ethics' (Kendrick & Robinson 2002:294). Working as a pastoral therapist calls for responsibility, on my part, to be aware at all times of the importance and influence of biological, psychological and social influences on the health and well-being of the person that I engage with. Here I am obliged to maintain contact with the medical team (in my situation, two medical doctors and a dietician) in order to monitor the client's physiology. It means that while psychiatrists and psychologists need to be aware of the spiritual and/or religious issues in the lives of patients, I should also seek appropriate intervention on behalf of clients experiencing medical or biologically related problems (Plante 2007:895). The ethical adventure in the work would involve constantly questioning my interactions and behaviour to give transparency and accountability to my actions regarding those in my care (Flaming 2006:225).

1.6.4.5 Integrity

Integrity is an ethical value which insists that in my dealing with clients I am open and honest about my own skills and limitations in order to avoid deception. Integrity calls for careful attention where professional and personal boundaries can become blurred, particularly in the integration of therapy and religion (Plante 2007:895). Being an active and involved member of my church or religious group does not make me an expert in theology or pastoral care. Putting aside my own predisposition or bias might mean having to recommend the involuntary commitment of a client to hospital or psychiatric care to avoid further self-injury or harm.

1.6.4.6 Competence

Providing effective, therapeutic care also means giving attention to possible ethical dilemmas, where appropriate training and on-going interaction with other professionals plays a crucial role. Together with this, attending quality workshops and conferences, and keeping informed via published articles or journals dedicated to my field of interest, further provide a vital resource in assisting me to meet the challenges demanded of any caregiver (Plante 2007:900).

1.6.4.7 Concern

At the heart of the helping profession should be a concern for the well-being and welfare of others. This concern is grounded in seeking to give care through benevolent attending, which contributes to sustaining the client during times of vulnerability. Ethical formulae, be they utilitarian or principle-based, are ineffective if we do not respond to the common humanity of the other (Kendrick & Robinson 2002:291). In this regard, Kendrick and Robinson (2002:294) plead for

...an ethic that urges us to see the neighbour in the stranger and even the enemy seems to be a fine start to a postmodern ethic that looks for common ground.... The other belongs to a common humanity and is therefore of equal value. Social freedom acknowledge the difference of the other and thus the need to accept the freedom of the other to make decisions. Such principles provide the basic criteria for judging any ethical response.

Thus, empathy and concern convey a sense of 'mattering' to the client (Kendrick & Robinson 2002:296), and become embodied in a relational narrative where understanding of the other on his or her own terms informs practice. In this way, the mode of caring is evidenced in transcendence, where the extending of the self promotes the well-being of the other (Kendrick & Robinson 2000:704).

Gergen (2002:278) points out that the challenge for Practical Theology is to view relational responsibility not as an ethical imperative, but as an invitation for continuous and mutual exploration together. Founded within the epistemological perspective of a constructivist view of human behaviour, the roles of the researcher and the participant are replaced by a collaborative relationship that leads to the generation of new knowledge. In the light of my own positioning within this framework, the distinction between a 'world out there' and a mind 'in here' is subject to question. All knowledge is socially constructed in the continuous flow of interaction between human beings and the environment.

1.7 A SOCIAL CONSTRUCTIONIST APPROACH TO HUMAN INQUIRY: THE SOCIAL CONSTRUCTION OF REALITY

Social constructionism is primarily a reaction against a realist, objectifying approach, particularly the notion that knowledge can be objectively measured and verified in order to determine reality or truth. In the social constructionist approach of Kenneth Gergen (1985; 1994) the fundamental premise is the 'ontological' notion that there can be no objective knowledge of reality outside or independent of the human mind. Social constructionism reflects the idea that the truth people create, in the process of social exchange, is reality and that the vehicle they use is language. Language constructs a particular view of reality and of the self – it is through language and relationship that meaning or social reality are communicated (Hermans 2002:115). Furthermore, what something means to an individual is established in discourse conveyed by language, and has relevance to the position the self occupies in discourse. Our context of existence cannot be more clearly seen or more securely interpreted than through language; it is in language that our world designs are located and communicated (Richardson 2000:928-929).

According to Hermans (2002:118), Gergen defines truth or knowledge as equivalent to meaning, with meaning born in relationships. Gergen affirms that relatedness precedes individuality, and that relatedness is not determined by a pre-existing world, but that we come into this world already related. Our sense of reality, of trust, of security is critically dependent on a human relationship. Relationships become the key concept in understanding

knowledge; the self needs others to construct selfhood. What is real or true for an individual is what is bound to traditions, networks or relationships (Hermans 2002:120). The self does not and cannot exist in isolation: rather than comprehending mental phenomena as structures of the mind, the way in which we speak, and what we believe and experience, is born in and through our relations with others and the environment. This theory is expanded in such a way that relation is understood as a social construction.

In this regard, Gergen (1994:185) writes:

I want to propose a relational view on self-conception, one that views self-conception not as an individual's personal and private cognitive structure, but as discourse about the self – the performance of languages available in the public sphere. I replace the traditional concern with conceptual categories (self-concepts, schemas, self-esteem) with self as a narration rendered intelligible within ongoing relationships.

The notion that relationships between people are essential for existence is an approach to reality construction which emphasises community and connection, while rejecting dualism and separation between the self and the body, between the self and others.

The social construction paradigm therefore proved useful to me, because by description or representation we can determine or alter reality by describing it differently and so are able to transform our world (Gergen 1991:148). This meant that the lens of social constructionism provided an alternative approach to reality, and thus for the meaning-making ability of the ill person. The inquiry focused on the relationships the participants were in and how these relationships determined certain truths. For example, a relational identity was constructed by anorexia/bulimia concerning the body and the self (because of their relationship with the illness), where the truths participants' held about God, religion and spirituality, their understanding about health and illness and the role of the self or spirit were seen as a liberating power with the potential to make a difference.

Using a social constructionist paradigm and lens yielded significantly new and improved ways of understanding participants' worlds, so as to bring about a relational transformation in which a participant could experience herself and others as open, growing and changing in and through relationships. In the framework of social constructionism, stories are central to understanding how individuals interpret daily experiences and events in order to provide

meaning in their lives. Morgan (2000:5) explains narrative as a 'thread that weaves the events together, forming a story'.

1.8 NARRATIVE AS PHENOMENON AND METHOD

The therapeutic power of narrative is considered two-dimensional, in that narrative can be both a phenomenon and a method. Narrative as a phenomenon studies the structured quality of experience in story form, thereby powerfully illuminating issues ordinarily concealed and making visible the discourses of inquiry (Clandinin & Connelly 1998:155). Accordingly, in this research project, narrative inquiry uncovers untold stories that would otherwise remain underground because of the medical meta-narrative contained in diagnosis (Matusek & Knudson 2009:700; Sakalys 2003:230).

Participants' experiences were recorded and shared by them in story form. Experience in this view is embodied in the stories they lived (Polkinghorne 1988:68). These events and actions were selected in terms of their relevance for the narrators, so that time and place, plot and scene worked together to clarify the relational character of spirituality in the participants' lives, as advocated by Clandinin and Connelly (1994:415).

In recounting stories, the participants relied on the body, with the body becoming the instrument through which stories were told and life was lived (Burns 2006:6; Finlay 2006:20). Because narrative provides a linguistic representation of reality, narrative practices have an effect on the physical state of the body, insofar as these practices mediate the relationship between the body and the self. The problem-dominated story sustained a 'non-embodied spirituality' (Griffith & Griffith 2002:287) through which the body was denigrated as merely an accessory, and a self/spirit threatened by the illness crisis.

Given the social construction of reality, interpretations are not fixed but remain fluid, as reality is flexible and on-going. Accordingly, what is perceived and given meaning remains open to many possibilities (the construction of multiple selves), and is thus open to editing and revision, and can be changed (Sakalys 2003:231). Herein lies the therapeutic modality of narrative; it has the ability to bring forth new meanings, thereby changing the contextual circumstances in which the illness is situated. Making visible the effects of the illness on the body and changing from the problem-dominated story to one that is more hopeful happens within language, and these differences were exploited for the benefit of the participant (Griffith & Griffith 2002:93-94).

The progression of anorexia/bulimia, as it was experienced by the participants, created new possibilities for a better understanding of the illness. Collaborative engagement within a feminist-inspired inquiry sought ways that could help those struggling with the illness to achieve the empowerment of the self, to reclaim their lives and bodies. In line with a feminist pastoral approach, interaction moved away from interventions which focused on issues of weight and eating behaviour to focus on the ill person, on what she felt and experienced given her situatedness within the context of anorexia/bulimia (Matoff & Matoff 2001:45; Matusek & Knudson 2009:699).

1.9 TOWARD A THEOLOGY OF PRACTICE: FEMINIST PASTORAL THEOLOGY

This inquiry was grounded in the norms for pastoral theology derived largely from liberation, feminist and narrative theologies, whose common characteristic is their practical nature. Although there is considerable diversity in the many models of pastoral theology, these models nevertheless reflect some common ground within contemporary postmodern theology, and provide an opportunity to determine their implications for Christian praxis (Graham 1996:113).

Theology is born of human actions, text and practice – the politics of pastoral care is to give expression to the Christian tradition. This is the foundation of theological understanding and praxis. Pastoral practice in contemporary society stems from accepted values and should inform purposeful practices. What is normative and authentic should be enacted and embodied in praxis, so that pastoral counsellors provide an authentic presence proclaiming and demonstrating the reality of God in the lives of all people (Cartledge 2004:34). Similarly, Graham (1996:122) supports a call from Hauerwas on Christians to preserve a community that tells the stories that make Christian virtues possible. For me, the emphasis is not the contemplation or comprehension of theological doctrines, but moving towards *doing* theology, becoming involved in the lives of ordinary people, where we often struggle together to enlarge the Christian story and in so doing, we may get closer to my understanding of what God intends the world to be. At the same time, I am aware of complex ethical and political dimensions in this caring relationship, because all interaction is subject to the values and power structures inherent in society, so that providing care also becomes an exercise of power (Graham 1996:98).

Cautious of this dimension of power evident in relationships, this study was grounded in the praxis of a feminist pastoral theology, which is sensitive to the human experiences of living. It

is the central premise of this thesis that all human experience should be seen as holistic and integrated with knowledge constructed by means of social interaction. The focus was on the lives of the three women who participated in the study, particularly on the impact of discourses relating to gender and culture on their experiences in the context of anorexia/bulimia, and how these experiences were languaged and given reality in contemporary society (Graham 1996:113). Narrative became the basis of our face-to-face interactions.

Storying played the role of providing theological disclosure within the framework of the overarching Christian story. The knowledge, co-created and constitutive of the interaction between the participants and me, as intuitive and mystical, stand in opposition to dogma, which requires exact understanding. As we cannot know God, as God is abstract, the participants themselves were responsible for discovering meaning for themselves by metaphoric reference based on Scripture. Within this context, a feminist pastoral theology became instrumental in evoking a Divine-human encounter, with knowledge derived from impressionistic and imaginative ways of knowing, as suggested by Herholdt (1998:223). This was done by making use of language in creative ways to imagine God, to refashion a language of pastoral care that communicated the essence of human nature and destiny, and to embody these images in context (Graham 1996:121). In a sense, I moved to enter the participants' theology and created space for them to story their own theology, in a sense, doing a participatory practical theology.

Experiential reality for the participants became truth, where they entered a world of meaning with their own reflections providing religious affirmation of their personal lives. They were not called upon to master abstract truth, but were challenged to make sense of the world by participating in the creation of ways of living. They came to know God through relationship, structuring healing from within, as God's influence is regarded as internal rather than external, or working from the inside out, with no dualism between what they experienced objectively and subjectively. This was a process whereby the self or spirit was redefined. Within the research context, these metaphors not only offered avenues into poetry, literature and models of care, but also served to resolve and direct theological understanding.

I drew on the work of Charles Gerkin (1984) (with acknowledgement to Gadamer), who pointed out that the heightened attention of the pastoral counsellor becomes the primary discipline of pastoral theology in the coming together of a widening of horizons. It was in the intersubjective 'play' (Gadamer, cited by Gerkin 1984:47) between myself and the

participants as members of a conversation that something truly transcended what each participant brought to the encounter. It is within such a context that new realms of understanding, based on deeper levels of experience, are articulated in order to stimulate new realities and develop skills informed by new insights. These critical perspectives served as part of the criteria, where my orientation to a feminist pastoral theology established guidelines for theological reflection and praxis.

In the next section, I provide an overview of the situational context and processes which formed the background to the study and the structuring of the research text.

1.10 INITIATING THE RESEARCH PROCESS

I explain access to the research setting and introduce the participants. I make clear my own positioning in terms of the researcher's role in developing relationships and fostering safety, support and mutual trust. Lastly, I explain the methods I used in collecting and analysing the empirical data.

1.10.1 Accessing the setting

Subsequent to my involvement with Mariska*,³ (see Prologue), I took a special interest in eating disorders and began to read widely on the topic. I developed a growing interest in the life experiences and coping strategies of these women. Practising in a professional capacity as a pastoral therapist, I am often confronted with issues that marginalize women, which sometimes affect their lives in very hurtful ways. As an invited speaker at many women's forums, I have been surprised at how often problems associated with anorexia/bulimia are raised by young women or the mothers of teenage girls. It also became clear that there was little understanding about the problem. Given the stigma of mental illness that is always present with eating disorders, there was often an unwillingness among family members to become involved when their involvement was needed. They genuinely did not know how to deal with the situation and preferred to adopt a wait-and-see attitude. Often there were people in the audience who knew about my involvement with Mariska*. It was from such an interchange that I was contacted for pastoral care and support by the parents of Mariska, Mare-Lee and Heidi (the participants in this project).

³ There are two Mariskas in this study. Mariska the participant must not be confused with Mariska*, whose life story is remembered in the Prologue. Changing the name might have addressed the problem, but all three participants opted to use their own names – after all, it is their stories that are told. From this point on, the Mariska in the Prologue is marked with an asterisk to distinguish her from the Mariska who participated in the research.

1.10.2 Introducing the participants

Since I live in rural Western Cape and am part of a farming community, my research sample was relatively small, involving only three participants. However, I do not consider this a limitation of the study, as my primary goal was not to achieve a representative sample or generalizable findings.

The participants all came from white middle class families, varying little in terms of age, education and religious affiliation. At the start of the inquiry, Mariska was a first-year student at university, and Mare-Lee and Heidi were still at school. All three considered themselves to be Christian (if only by way of a loose affiliation). Most would describe Mariska as coming from a fundamentalist background, but at the time, she was not attending church regularly. Mare-Lee came from a more traditional religious background, regularly read her Bible and often attended church with her parents. Heidi said that she never attended church, although she felt her father was strong in his Christian values.

At the start of the study, two of the participants had been diagnosed with anorexia/bulimia. They were highly critical of the definition and diagnosis of an eating disorder. The third participant had been on a diet for several months and had lost approximately twenty kilograms on a weight watchers' programme. She had begun to engage in uncontrolled vomiting to prevent weight gain. Because I wanted to understand the illness experiences from their perspective better, they became the motivation and compelling force behind this research.

1.10.3 Establishing rapport and gaining trust

Initially Mariska, Mare-Lee and Heidi came to me for therapeutic assistance. Hence, our earliest conversations centred around them and how we might move forward towards healing. We did not discuss their participation in the research inquiry at this stage – I felt this was a time to focus on the problems they were experiencing, allowing them to feel safe and comfortable in our relationship, where they were able to trust me and speak openly. When the illness became acute at times, an effort was made to avoid hospitalization (if possible) and to prevent further conflict and fragmentation of their family life. I mentioned the team support and on-going collaboration I had with two medical doctors (male and female) together with a dietician, and that it might become necessary to involve them from time to time.

Although other postmodern approaches to narrative therapies extend to more formalized, problem-focused and psychotherapeutic interaction (Combs & Freedman, 1996; White & Epston, 1990), the approach was not strictly 'therapy', and was based on the assumption that therapeutics occur in relation to pathology (Sakalys 2003:233). Instead, it became an approach that focused on a particular form of relational communication, which emphasised the emotional connection between the participants and me.

1.10.4 Becoming co-researchers

Because of my long-term involvement with the participants, I was fortunate to be included in their everyday lives, an arrangement which gave me an opportunity to establish a rapport with them. As time passed, their defence strategies, in the form of managed fronts, forms of denial and a reluctance to open up, gradually diminished, as also reported by Ortiz (2001:199). Interaction became dependent on on-going collaboration, and the participants became more like conversational partners. When I sensed that they no longer saw me as just one more person who wanted to make a diagnosis, I shared with them my journey with Mariska*. I indicated that I felt strongly that there is a need for new and fresh knowledge concerning eating disorders in order to provide a more empathic understanding of the illness and how healing might be achieved.

I shared information with the participants regarding the research inquiry, making clear the focus of the research and how their stories would be included as an important contribution in the co-creation of new knowledge. They were all willing and enthusiastic to share their stories. Informed consent, whereby they agreed to participate in the study, was obtained from all the participants. I explained the nature of their involvement, the approximate amount of their time that it would take and the option of withdrawing from the study at any time (without affecting our relationship in any way). The time and duration of our interactions were negotiated, in line with their availability and study commitments. They granted me permission to audiotape the conversations, although I never made use of this option, because I preferred to preserve an informal atmosphere during our conversations. I did, however, make notes, having requested their permission to do so. I also explained to them that my written notes would be transcribed into draft form and that a copy of each draft would be submitted to them, so that they could remove and/or qualify the content. Confidentiality was ensured, as well as their anonymity. I assured them that all their transcripts and other records would be kept safely (see appendices).

1.10.5 The interview as interpretive framework

Fontana and Frey (2000:646) citing Holstein and Gubrium, claim that the use of interviews to acquire information has become a 'universal mode of systematic inquiry', used by both qualitative and quantitative researchers to obtain a rich, experiential description of an event or episode in the life of respondents. However, Denzin (2001:24) cautions that the interview should not be read as 'a method for gathering information but rather as a vehicle for producing performance texts and performance ethnographies about the self and society' – interviewees become performers, with their words and narratives performed by others. Interviews can take structured, semi-structured or unstructured forms, depending on the theoretical and methodological concerns of the interviewer.

Because of the possibility of an individual face-to-face verbal interchange, interviewing constitutes the most common and powerful way in which to try to understand participants (Fontana & Frey 2000:645); and hence, the technique was adopted in this study. The bulk of the data represented in the research report was collected using the interpretive framework of semi-structured, biographical interviews employing narrative as a 'conversation-guiding-method', as Rosenthal (2003:927) calls it. Loosely structured interviewing was chosen because of its ability to provide a multitude of different forms of data, given its qualitative nature. Traditionally, this form of interviewing is viewed as 'the open-ended, ethnographic (in-depth) interview' (Fontana & Frey 2000:652) where much of the data is gathered using informal interviewing methods in the field, rather than closed-ended questions (Fontana & Frey 2000:653). Two issues distinguish interviewing techniques following a semi-structured approach from structured ways of interacting, as explained by Fontana and Frey (2000:653):

- the interviewer can also answer questions asked by the respondents;
- the interviewer is open to showing emotion and personal feelings and thereby deviates from the pattern of the 'distant', 'rational' interviewer.

Hence, the structured interview sets out to capture data that can be coded in order to explain phenomena investigated within pre-determined categories, whereas the unstructured interview attempts to understand complex phenomena without imposing any categorization of the data, which is considered to limit the field of inquiry (Fontana & Frey 2000:653).

My own interpretive framework was based on social constructionist and feminist theory. In using the interview as an information gathering tool, the aim was to jointly construct meaning representation through story. The semi-structured interviews became the places where

'performance texts' (Denzin 2001:24) were produced, providing a dialogue between the body and the self by privileging participatory, intimate, precarious and embodied experience.

As a tool to reflexively and dialogically write and bring participants' worlds into 'play' (Denzin 2001:25), the semi-structured interview constitutes an 'emergent process' (Fontana & Frey 2000:654), 'an active text', a site where the meanings that are constructed are performed. When it is performed, the text creates a world in which the participant makes known her 'situated meaningfulness' in discourse (Denzin 2001:25). The semi-structured interviews, by means of narrative, opened up understanding of a personal and public self. In a sense, however, there is no essential or private self. Nor is the interview a mirror of the so-called external world or a window into the subjective lives of participants. Because the interview stands in relationship to the world that it creates, a view of self and world, as narrated by the participant, is linguistically produced through on-going reflection and dialogue, which is always dependent on a context and on the processes of perception and interpretation. Thus, the interview is a 'fabrication', a 'construction' and a 'fiction' (Denzin 2001:25) where only selected materials from the actual world are ordered or re-arranged. We are persuaded to believe that we see the real world being staged, but there is no real world – only interpretations and their performances (Denzin 2001:30).

1.10.6 The data analysis: a construction of the research text

Based on the field experiences of the participants and me, the findings were constructed into a research or public text and were reported as a conversation with an audience. There is no single style for reporting the findings of qualitative research (Bochner 2000:268; Sandelowski 1998:375). Denzin (2001:25) argues that the present moment, the post-experimental (1966-present) era, is defined by a 'performative sensibility' where, as qualitative researchers, we are open to experiment with different ways of presenting an interview text. As a qualitative researcher, I could choose not only what 'story' I told, but also how I would tell it Wolcott (1990:18), so that the representational style and format decided on would be the ones that best fit the research purposes, methods and data.

Basing my scripts entirely on the interview material, through my writing, I enable the participants to perform as if on a stage, using their own words, poetry and journal notes. It is 'performance writing' (Denzin 2001:36) where, by using their own words, participants are brought to life in the unfolding drama. Denzin (2001:34), drawing on Smith, suggests that the underlying idea in performance writing is to fashion an interview text that works as '*physical,*

audible, performable vehicle' (Smith's emphasis), where words become a means, or a method for evoking the character of the person. In the texts created, I wanted to show what Smith calls 'tension of identity in motion' (Denzin 2001:35), pointing out that there are no essential selves connected to inner structures of meaning, only different performances, different ways of being in the world.

Using the methods of narrative collage (Denzin 2001:29), performance writing 'opens up' rather than tells. It is writing that speaks performatively, making visible and enacting what it describes (Denzin 2001:36) with the players moving backward and forward in time. Denzin (2001:29) also introduces the figurative use of '*montage*', which is a picture created by superimposing different images one on another, and '*pentimento*', an image painted over by the artist, denied or repressed but becoming re-visible, adding a new dimension to the scene. I found these concepts useful in the interpretation of the data collected, and it was within this framework that I tried to understand and give credence to the individual stories.

The postmodern interviews therefore produced a script where storied sequences did not follow a necessary progression. The narrative text was edited from snapshots in time, sustained by different images which illuminated the lived experiences of the participants. These images were represented through poetry, dialogue, monologues, blank spaces, and journal entries, with my own voice coming through at times, speaking to the audience by means of reflexive interaction, then arranged and re-arranged. Shapes and images previously out of focus, or invisible and thus denied, evolved into a composite new creation (Denzin 2001:29), bringing about new meaning in the lives of the participants.

1.11 SCOPE AND LIMITATIONS OF THE RESEARCH INQUIRY

1.11.1 The medical model of anorexia nervosa/bulimia

The research inquiry did not examine the causes of anorexia/bulimia directly. Nor did I propose strategies for curing or subverting the illness. The emphasis was rather on healing. Given the epistemological framework for the inquiry and emphasising healing and recovery, consideration was given to contextual experiences of the illness-as-lived, with the inquiry addressing issues pertinent to such an understanding and perspective. Given its holistic approach, the inquiry emphasised self-transformation, self-understanding and transcendence as spiritual dimensions of healing, by focusing on the spirit or self of the ill person and the role of her spirituality in health and healing.

The attention paid to the lived experiences of illness gives a different perspective to the relationship between diagnosis and compliance in a medical treatment plan. Within a medical framework, the body of the patient is seen as an object of science, whereas in a framework of care and holistic healing, the lived-body is regarded as the suffering body when faced with chronic illness. Emphasis shifted from an approach aimed at fixing the body to focusing on the individual and her experience of the illness, what she brings to the encounter in the form of her own resources and potential to achieve healing. Healing is not merely about the body – it concerns the humanity of the person wounded by the illness, emphasising the spiritual dimensions of the illness.

1.11.2 The spirituality phenomenon

The research participants involved in the study come from a Christian background, so that spirituality in the context of the research project was expressed within religious frameworks which are Christian, in the context of a Western spirituality. The research did not include participants from other religions. This was not an intentional strategy – had such participants been available, they would undoubtedly have brought new insights and knowledge to the study.

Furthermore, I argue that, because we are human, we have a spirit and therefore a spiritual nature, but this does not mean that we are all religious (Goddard 1995:809; Miner-Williams 2006:814; Pellegrino 2001:570). Religion is institutionalized, formal, with structured beliefs regarding God, whereas spirituality is open and evolving, always alive to new possibilities (Goddard 1995:809-810). Also excluded from the study were spiritualities expressed specifically in community action and social justice, as evident in some strands of the feminist, liberation, ethnic or Marxist movements. The reason for this is that spirituality is not argued as a world view, or world vision, which has at its heart the creation of an awareness of certain cultural and political values (Perry & Rolland 1999:272-292).

1.11.3 Race, gender, age and geographical setting

The research participants involved in the study were female, white, and between the ages of 15 and 22 years. The study did not include males or people from other race groups. It also did not include older women living with the illness. The research study was conducted in a semi-rural area of the Western Cape, which affected the number of potential clients who could participate in the study.

1.12 OUTLINE OF THE REST OF THE RESEARCH REPORT: THE WAY FORWARD

This study incorporates eight chapters, each contributing to the evolution of the thesis. A brief synopsis is given below.

Chapter Two

This chapter focuses on the concepts of the self and the spirit and argues for the inclusion of spirituality to bring about healing within a framework of holistic care.

In order to explain why spirituality remains a neglected perspective in treatment approaches within modernist medicine, I focus on global movements in mental health organisations towards the integration of spirituality and science. I also highlight the on-going speculation regarding the non-objective status of spirituality, difficulties concerning its definition, and factors which continue to hinder the inclusion of spirituality as a viable construct within modernist medicine.

In support of my argument for spirituality, I provide an understanding of how spirituality could function to bring about healing in the context of eating disorders. I create an understanding of the self, the spirit and spirituality within the framework of Existentialist philosophy and open the door to quantum theory and the complementarity and relatedness of all life forms in arguing for spirituality as an embodied and relational experience.

In order to bridge the division between the body and the self, as enforced not only by the demands of anorexia/bulimia, but also by Cartesian dualism (this 'split' is echoed in the chasm between science and spirituality), I emphasise the body/spirit relationship as giving effect to spirituality, the medium overcoming the separation of the self from the body, the self and the world, structuring lived experience in the overall framework of health and illness.

Chapter Three

In order to highlight spirituality as the missing component in healing, I discuss treatment strategies for anorexia/bulimia in both the modernist medical and postmodern approaches to the illness, underpinned by a narrative metaphor. I discuss the shortcomings of both approaches, which I ascribe to the exclusion of the body-spirit relation, the key element in holistic healing.

I open the door to a better understanding of the wounded self and a disabling spirituality, which goes to the heart of this thesis, making visible the spiritual struggle evident in the lived reality of anorexia/bulimia. I emphasise power and control as underlying dimensions of anti-spiritual properties of addiction and ritual. I discuss transcendence as a dimension of spirituality which brings healing full circle in the context of anorexia/bulimia, starting as a spiritual journey from within and moving outwards to include others in the discovery of the self.

Chapter Four

In this chapter I outline the research methodology employed in the study, grounded in an epistemology of feminist pastoral theology and the act of interpretivism as the overarching framework in the co-creation of knowledge. The chapter highlights forms of embodied knowledge as participatory consciousness, which not only contributed to the reliability of the data, but also underscored the ethical commitment of this enquiry to all those involved in the research.

I discuss the structuring of the different texts as the inquiry moved from field to research text, to public text, commenting on the uses of the biographical method in providing phenomenological significance to the participants' lived experiences in the context of anorexia/bulimia.

Chapter Five

This chapter tells of Mariska's journey to healing. Although her story may initially seem dark and troubling to the reader, it is a story of endurance and courage. She relives and shares the anguish of living with anorexia/bulimia, staged in her own voice by means of her journals compiled during the study and our narrative interactions. Moving from darkness into light, her story bears witness to the resilience of the human spirit.

Chapter Six

This chapter opens the pages to Heidi and Mare-Lee's stories as they invite the reader into their lives in the early stages of developing an eating disorder. They describe the cruel power of the illness, their feelings of self-hatred and worthlessness, and the spiritual struggle between the self and the body which gave effect to the illness symptoms. Their stories testify

to the enormous capabilities of the spirit to heal, where a growing love for the self becomes synonymous with caring for the body. Because healing does not happen in a vacuum, the once suffering body seeks connection outside the self with the 'other', nature and God, giving effect to the development of wholeness evident in the re-establishment of relationship.

Chapter Seven

This chapter, together with Chapter Eight, brings the research investigation full circle. Heidi, Mare-Lee and Mariska offer their reflections (some two to three years after therapy and the completion of the research) on their experiences of healing, and share their stories in looking back at how far they have come. Their stories are told in the form of first-person narratives, and contribute to an identification and exploration of the knowledge of life and practices of living that are associated with positive identity conclusions.

Chapter Eight

In the first part of Chapter Eight, I use the participants' earlier stories (as set out in Chapters Five and Six), together with their later reflections (in Chapter Seven) to reflect on the research journey, culminating in a model for healing which emphasises the research questions and research objectives. I reflect on the research methodology, the impact of the inquiry on my researcher-self and the implications for the research.

CHAPTER TWO

SCIENCE AND SPIRITUALITY: TOWARDS BRIDGING THE DIVIDE?

2.1 INTRODUCTION

Given the aim of the research project, and having reviewed the currently available literature, in this chapter, I attempt to construct a dialogue between the self and the body, between spirituality and science, in order to arrive at a better understanding of the lived human experience and the process of healing in the context of eating disorders. Although spirituality (as a concept) and eating disorders (as a condition) have featured prominently in the literature in recent times, both remain challenging constructs to define, in that these phenomena have eluded and baffled clinicians, therapists and counsellors around the globe.

Maisel et al (2004:1) express their frustration at this situation regarding understanding and treating eating disorders by posing the following question: 'How exactly does anorexia/bulimia transform a person from someone making an appearance in her life to someone disappearing from it, from someone dieting to someone dying,...?' Bordo (1993:67), situating the body of a woman with an eating disorder within the framework of modern medicine, describes the condition as 'opaque and baffling to the Cartesian mind of the scientist'.

In reviewing the literature which argues for a consideration of spirituality as a resource in healing and recovery, two issues are relevant. Firstly, despite the burgeoning literature dealing with the concept of spirituality, many medical professionals, counsellors and therapists, particularly those whose work is still informed by modern science, continue to regard spirituality as 'mystical' ways of knowing and therefore do not value it highly for its 'marginal' contribution to 'objective' science. I have also encountered this attitude in my own life and work. Secondly, although there is a wealth of literature lobbying for the inclusion of spirituality in health and healing, information remains scant and inconclusive, on the premise that not all expressions of spirituality are relationally constructive (Sandage & Shults 2007:263). And indeed, I am persuaded that in some circumstances, and with particular

reference to eating disorders, the use of spirituality can at times be destructive, having an adverse effect on the subject's mental health.

This chapter is divided into three sections, detailing the progression of ideas and knowledge relating to spirituality and eating disorders.

The first section presents a brief discussion on movements within the mental health profession to address the sacred, spirituality and religion within therapeutic frameworks. I briefly review obstacles envisaged with regard to an integration of spirituality and medical science. Of note is the problem concerning the definition of spirituality, together with a lack of counsellor training and education on how spirituality could be used as a resource in healing. This is paralleled by ongoing speculation as to whether or not spirituality could be meaningfully integrated within a modern framework, given the non-objective status of spirituality. I briefly discuss definitions of spirituality and religion, highlighting the lack of consensus regarding these constructs. I round off the section with my own reflections on the integration of spirituality, given the current modernist model of medicine.

In the second section, I offer alternative perspectives for understanding the experienced world in a move that signifies paradigm changes (Richardson 1994:516). I situate new knowledge which have had an impact on this study within a postmodern epistemology, complementing both science and spirituality. I explore other ways of knowing in order to celebrate the personal, subjective, emotional and imaginative forms of knowing which reach deeply into the fundamental relatedness of existence. I discuss developments within mind-body medicine as an emerging field which questions Western rationality and the notion of a separate self, in order to bring us closer to understanding the role of human thoughts and emotions in the construction of reality.

In a move towards restoring a participatory and embodied understanding of what is involved in the construction of knowledge, I focus on the integrity of all life forms beyond the self. I briefly look at quantum theory in order to indicate how and why this field of science complements and plays an important part in my understanding of spirituality and the complementarity of all life forms. In order to strengthen my argument concerning spirituality as embodied existence, I centralize the body in order to argue its role in the construction of knowledge critically. I call for a re-imagining of the self and the body in contrast to Western thought and binary oppositional terms, in order to consider and include the lived experience of those suffering from anorexia/bulimia in models of treatment and recovery.

The third section goes to the heart of this thesis. Although a growing body of evidence has recognized spirituality as a key element in our physical well-being and in the delivery of holistic health care, exactly how spirituality functions continues to elude scientific research. In my opinion, this is a result of inadequacies in the definition of spirituality and the lack of conceptual frameworks regarding spirituality, so that clarity on the meaning and concepts of spirituality becomes paramount (Heath 2006:157). I unpack my own position on spirituality as embodied existence, situated within a theological and existential framework. I situate and frame, within this overarching paradigm, a theoretical and operational understanding of the concepts spirit, self and spirituality. I expound on the relation between discourse, language and embodied experiences for the purposes of structuring spirituality as a lived and storied reality, giving effect to ways of being in the world.

2.2 SPIRITUALITY, RELIGION AND THE SCIENTIFIC PARADIGM

The dominance of the medical diagnosis of anorexia/bulimia and the seriousness of this illness has led to eating disorders traditionally being viewed through the lens of modernist science. The medical approach to illness assumes that the body functions as a machine in need of repair (Carr 2010:1381; Hawks 2004:12; Kelly 2009:24; Miller & Crabtree 2000:610; Ornish 1993:104). This is a reductionist approach that overlooks a holistic appreciation of a person's life experiences and situatedness in cultural and social discourse. The potential for positive life change, through an understanding and healing of a person's spirituality, is rarely, if ever, considered in the medical model's definition of recovery (Adame & Knudson 2007:160; Patching & Lawler 2009:11; Weaver et al 2005:203).

The premise of this research project is that eating disorders should also be considered and treated within the context of a wounded or disabling spirituality, which gives rise to the manifestation of the illness. Given this scenario, I briefly discuss some efforts undertaken globally to promote the integration of spirituality within medical discourse, as well as provide my own reflections concerning inherent difficulties with this integration.

2.2.1 Mental health: opening the door to spirituality

Over the last two decades, there has been a movement within the mental health professions to understand and address the sacred, spirituality and religion within therapeutic frameworks, with a strong focus on the potential benefits to individual health (Koenig 2005:1235, 2009:284; Pellegrino 2001:570; Pergament & Saunders 2007:903; Plante 2007:892; Post &

Wade 2009:131; Ralph & Corrigan: 2005; Sperry & Shafranske 2005). The incorporation of religion and spirituality into psychotherapy has been identified as one of the most important developments for the future (Ottens & Klein 2005:32).

An indication of this growing trend is that, in recent years, the integration of religion, psychology and science has been legitimized and has received significant professional and public support. One such instance is *The Southern Medical Journal's* inauguration of the journal's Spirituality/Medicine Interface Project. The goal of the project is to assist physicians to understand the religious and spiritual beliefs and practices of their patients better, as well as how these affect health and well-being. Considering that this is the first time that a mainstream medical journal has attempted to examine both the positive and negative effects of religion/spirituality on health and health care systematically, this move suggests that there is a growing realization of the need for a more holistic approach in a pluralistic system (Hamdy 2005:1233; Koenig 2005:1235). Special issues and sections focusing research on spirituality have also appeared in other scientific journals, including the *American Psychologist*, *The American Journal of Physical Medicine and Rehabilitation*, *Annals of Behavioural Medicine* and the *Journal of Health Psychology*. The intention is to stimulate, inform and improve the quality of scientific research on spirituality, religion and health (Miller & Thoresen 2003:26). Furthermore, professional organisations such as the Society of Behavioural Medicine have now developed new special interest groups that focus on religion and health integration; and large foundations such as the John Templeton, Lilly and Fetzer Foundations, as well as major government granting agencies such as the National Institute of Health (NIH), have funded large-scale projects in this area (Miller & Thoresen 2003:26; Plante 2007:892).

Richards and Bergin (1997:6) suggest that prominent mental health organisations now recognize the importance of religion as one type of diversity that professionals are obliged to respect. Also, the American Psychological Association's (APA's) 2002 and 2003 directives to be respectful and knowledgeable about patients/clients' religious and spiritual frameworks address educational opportunities for both psychology professionals and students in training how to be responsible and aware about religious issues and influences (Plante 2007:894). Other professional organisations, such as the American Counseling Association (ACA), are increasingly focusing on the importance of the spiritual dimension in counselling, whilst the (American) Council for Accreditation of Counseling and Related Educational Programs (CACREP) in 2001 established guidelines dealing with fundamental competencies to be included in counsellor training and education (Leseho 2007:442).

Also of note is the wider movement over the last decades to (re)integrate spirituality into health care, led by pioneers such as Harold Koenig, M.D., a psychiatrist who has written extensively on the integration of religion and mental health. His latest work, *Medicine, Religion and Health: Where Science and Spirituality Meet* (Koenig 2008), is a substantive investigation of the growing research base examining the relationship between religion and health.

Moreover, qualitative clinical research is appearing more frequently in clinical journals, especially in the field of primary care, a fact which further emphasises this trend – *Qualitative Health Research and Culture, Medicine, and Psychiatry* are bridge-building publications with an almost exclusive emphasis on qualitative clinical research, providing qualitative studies, together with reviews by individuals trained in qualitative research (Miller & Crabtree 2000:613-614). Ongoing research applying eminent qualitative research methodologies will continue to provide a more solid scientific foundation for the integration of spiritual and psychotherapy topics (Adame & Knudson 2007:157-178; Loveland, Weaver-Randall & Corrigan 2005:35; Plante 2007:893).

2.2.2 Spirituality: a welcome or unwelcome guest?

Despite the impressive efforts to develop the integration of spirituality and science, this body of theory, research and clinical technique remains somewhat fragmented and incoherent. As a result, this approach does not have a prominent place of equality alongside other therapeutic strategies (Richards & Bergin 1997:9). There is also a growing concern about how these common approaches might be brought together in a meaningful way to facilitate the incorporation of spirituality in health practice (Koenig 2009:284; Ottens & Klein 2005:32; Plante 2007:893).

Most scientific and psychological studies during the last century have avoided inquiry regarding any connection between psychology and religion because of the influence of Freud's perspective that there was no value in the study or practice of religion (Plante 2007:892). However, in recent years, many in the health care profession including psychologists, have become interested in the constructs of spirituality and religion as part of their professional work, although training programmes are still lacking. Post and Wade (2009:131) are of the opinion that the practical question for clinicians is no longer whether to address the sacred in psychotherapy with religious and spiritual clients, but rather when and how to address the sacred. Although a greater emphasis on religion and spirituality is

needed in the graduate training of mental health professionals, there are few opportunities to integrate these concepts in clinical work (Aten & Worthington 2009:227; Bishop et al 2003:36; Miller & Thoresen 2003:25; Plante 2007:893; Post & Wade 2009:144). However, even with a shift towards the inclusion of the spiritual dimension in counselling, some writers have observed that the exclusion of spirituality and religion in training that still prevails suggests that there is a mainstream reluctance to accept spirituality as a meaningful part of the counselling process (Cadge et al 2009:709).

In a recent study, Cadge et al (2009:702-721) concluded that, due to limited formal training regarding religion and spirituality in medical contexts, the majority of physicians regard spirituality as relevant to their professional jurisdictions but not as encompassed within them. Although these physicians may acknowledge the advantages of incorporating the client's spiritual or religious orientation into counselling, they often remain hesitant to do so. Cadge et al (2009:702-721) further note that, although survey data have demonstrated that most people ascribed considerable importance to spirituality and religion in coping with illness, significant differences between religious and spiritual backgrounds between physicians and patients constituted a gap which significantly influenced health care.

Miller and Crabtree (2000:340) point out that although there is a shift away from strictly positivist positions within clinical biomedical research, this field is still dominated by 'positivism and patriarchal bias' (Miller & Crabtree 2000:340), and neglects the patient-physician clinical encounter, together with storytelling, relationship and interpretation as areas of common ground for critical conversations towards the practice of patient care. Another observation is that psychologists and other social scientists have generally distanced themselves from religion and spirituality because of the demand for a rigorously scientific approach to both research and clinical practice (Ottens & Klein 2005:33; Plante 2007:892). Weaver et al (2004:1245-1248) have investigated how often studies in general medical journals seek to take into account the role of religion and spirituality. They conclude that relatively few studies published in three major general medical journals between 1998 and 2000 measure any aspect of religion or spirituality.

Miller and Thoresen (2003:25) are of the opinion that many in medical science remain uninterested in or uninformed about the current literature concerning religion/spirituality because of an ongoing debate as to whether spirituality can or cannot be measured scientifically. In the process, they overlook both the advances made to include special divisions or interest groups devoted to this area of study and the large array of measurement

techniques currently being developed for the study of spirituality and religious variables. This observation is also made by Koenig (2005:1235): despite the exponential increase in articles published in medical, nursing and social science journals on the integration of religion and spirituality into health care, most physicians remain unfamiliar with this literature. However, in spite of its lack of centrality and importance to psychologists and other health-related researchers, it appears that spirituality and religion are variables of greater significance to the public in general.

2.2.3 Difficulties in defining spirituality

Sandage and Shults (2007:262) comment that over one hundred different definitions of spirituality have emerged in the recent literature, with the result that the sheer volume of ideas on the topic has become overwhelming, posing a barrier to integrating spirituality into therapy. Despite the emerging interest in spirituality, there is no consensus on a definition, because the concepts of spirituality and spiritual care are broad and difficult, if not impossible, to isolate and define (Bash 2004:15; O'Hanlon 2006:6; Steen Engels & Twhett 2006:109; Vogel 2000:17). Whilst there are certain commonalities, conceptual disparity is evident, causing much confusion and ambiguity, leaving spirituality as a theme fragmented.

This difference of meaning as expressed in definitions also causes procedural tensions, where spirituality becomes part of the responsibility of the health care provider, and may involve inappropriate intervention. It has been observed that, although the significance of the spiritual dimension is verbally acknowledged in the nursing domain, its inclusion in care is often circumvented in the realities of practical care. There is little discussion on the usage of spiritual language in clinical practice, and how people in the helping professions might engage in spiritual discourse with their clients. Hence, nurses often provide spiritual care from a personal, rather than a professional, perspective. Such integration remains an ethically troubling development, particularly because of matters relating to competence, boundary issues and the appropriateness of implementing spiritual interventions (Carr 2008:687; Pesut 2009:420).

In addition to the above concerns, there is also the need to recognise that a person's relationship to the spiritual is highly personal and intimate, and both spirituality and religion are complex, multi-dimensional phenomena. It therefore remains difficult to insist on a single comprehensive definition of either term, and any single definition is likely to reflect a limited perspective or interest (Bash 2004:15; Hill et al 2000:52; Leseho 2007:446; Miner-Williams

2006:814). Although the term 'religion' has been both an individual and an institutional construct throughout most of the history of modern psychology, it has more recently evolved in a different direction (Hill et al 2000:52; Miller & Thoresen 2003:28). Mention is also sometimes made of spirituality's tie to theology. The empirical reality for many is that they experience spirituality within an organised religious context, and they fail to see the distinction between these phenomena. Accordingly, there has been a tendency to equate spirituality and spiritual care with religion and religious care, but, although they are related, they are clearly not the same. However, as Hill et al (2000:62) observe, given the complexity of both constructs, the possibility of their frequently overlapping should be given due consideration.

Hill and Pergament (2003:64) have argued that religion and spirituality are related, rather than independent, constructs. They frame their interpretation of the term spirituality as often referring to the personal and subjective side of religious experience. They are of the opinion that although the term 'religion' is becoming actualized into a fixed system of ideas or ideological commitments, for committed believers, religion and spirituality contain a set of beliefs and practices which are not divorced from their daily lives, to be applied only when convenient. Instead, for these people, religion and spirituality are ways of life to be sought, experienced and maintained consistently. For these authors, the sacred is the common denominator of religious and spiritual life; and the issue of getting to know God constitutes the central objective of religion.

Pesut (2009:419) points out that, although many people identify themselves as spiritual, and may remain grounded within religion, this does not necessarily imply participation in institutionalised religious life. Miller and Thoresen (2003:27) understand spirituality at the level of the individual reality, as distinct from the material reality, consisting of practice (prayer, meditation, worship), belief (morals, values, deity, transcendence) and experience (of the individual), and does not necessarily incorporate religion. They see religion as an institutional and social construct, because religions are defined by boundaries and are differentiated by particular beliefs and practices, with requirements in terms of membership.

In general, there is some agreement that greater consistency in defining religion and spirituality is needed, particularly a need for a focused, clinical definition of spirituality (Aten & Worthington 2009:225). Others are of the opinion that the most critical issue is whether spirituality can be independent of theology or whether an 'independent' spirituality would then

also avoid positions and biases that are relevant to the existence and nature of God (Slife & Richards 2001:197).

Goddard (1995:814) writes that although spirituality is often manifested in relationships with God, a deity, or persons, it can be present solely within an individual, and removal of this relational attribute does not contradict the conceptualization of the essence of spirituality as integrative energy. For Koenig (2009:285), definitions of spirituality have been weakened through conflation and confusion with both mental health and humanistic values and qualities such as happiness and hope. He is of the opinion that for the term spirituality to have validity and greater reliability, it must return to its traditional anchoring in the religious or the sacred, that spirituality should be defined in terms of religion.

Although differences of opinion regarding spirituality and religion are not the focus of this thesis, they are presented here because of the impact of this ongoing speculation has on the integration of spirituality as a key element in the delivery of holistic health care. However, trying to define multidimensional constructs such as spirituality and religion is perhaps to create more confusion, because many people remain unaware of the potential benefits of both spirituality and religion for personal well-being. Because it is founded on institutionalised beliefs and practices to which members of a congregation adhere, religion is more social in nature and also culturally specific. Spirituality, on the other hand, is not quantifiable, a person cannot have more or less of spirituality (Miller & Thoreson 2003:25). Rather, as an open, evolving phenomenon, basic to every human being, spirituality is established in relationship and ongoing interaction between the self and the 'world'. Spirituality cannot be the same for any two people, because it rests in the subjective and is therefore also not open to rigorous scientific study.

Of particular interest is the debate concerning the ties between spirituality and theology or God. I argue that people can be deeply spiritual, connecting to that which is held sacred in life, to what is all around them, to others, nature and God, without being deeply religious. I agree with Gergen (2002:287), who states that if we are sensitized to the sacred dimension of relatedness (the basis on which my argument for spirituality is founded), we can glimpse the possibility that God is not a separate Being – out there in the heavens – but that God is immanent, the presence from which we cannot be separated. Within the framework of this argument, there is no place for religious dogmatism. We need not view God as distant and separated from humankind, but can rather see that our relationships are in the here and now

and possess the capacity to manifest the sacred. Gergen (2002:287) draws on Acts 17:28, in pointing out that God is the reality 'in (which) we live and move and have our being'.

2.2.4 The role of spirituality: paradigms, perspectives and professionalism

Although attention to the patient's spirituality as a moral obligation of care is now widely accepted (Pesut 2009:426; Sperry & Shafranske 2005), the problem of conflicting perspectives remains. If health, illness and patient care are defined in terms of disease conditions, the subjectivity and uniqueness of patient experience is suppressed in favour of the objectification of the person who is the patient. A critical question is how care of the subjective well-being of a patient can be balanced with concern for a successful medical outcome which will benefit that patient (Beveridge 2002:101; Nortvedt 2003:134; Sakalys 2003:230).

2.2.4.1 The acquisition of knowledge

I am of the opinion that the intense debate concerning the integration of spirituality within medical discourse stems from the many positivist philosophical assumptions that still underlie knowledge acquisition, a tendency that overlooks the more fundamental issue of the paradigms which dominate Western society, so that the thrust of the argument centres on positivist versus interpretivist assumptions. Bailey et al (2009:35) contend that often it is these philosophical assumptions which remain unrecognized and unquestioned that influence practice. Having drawn on the relevant literature, I now unpack my argument, not to level a charge against the value of positivist science, but to explore its practical limitations regarding the integration of spirituality.

As Bochner (2000:266) observes, the criteria involved in integrating spirituality into the medical paradigm is what separates 'modernists from postmodernists, foundationalists from anti-foundationalists, empiricists from interpretivists, and scientists from artists'. He adds that the difference lies in whether 'objective' methods and procedures can be applied to the choices we make, or whether these choices are inseparably tied to our values and subjective experiences. The critique, to put it concisely, is that philosophical assumptions affect practice, so that the procedures we choose are steered by fundamental assumptions about the world and knowledge in general. When spirituality is investigated as a phenomenon within the framework of modernist science, practitioners' implicit and explicit assumptions may be irreconcilable with the phenomenon itself (Bailey et al 2009:28). Ultimately, these

assumptions sway choices involving practical applications of theory, leading to confusion about how, and if, theory and practice should be integrated (which I discuss in the next section).

2.2.4.2 Spirituality: a holistic phenomenon

Modernist medicine lacks an overarching, epistemic framework that includes human subjectivity as part of reality, evident in the biomedical model's focus on the anatomy and physiology of the human body, largely to the exclusion of the spiritual dimensions of health and illness (Beveridge 2002:102; Herholdt 1998:216; Jankowski 2002:71; Kelly 2009:24). Some serious limitations are created by the difficulty of defining the constructs 'spirit', 'soul' and 'sacred'; such 'phenomenological' realities do not easily lend themselves to operational definitions and scientific investigation using traditional methods of psychological science (Elkins 2005:142). As a result, people struggling with an eating disorder are likely to find that medical knowledge is impersonal, in the sense that it is knowledge that is detached from their immediate, subjective experiences (Kirmayer 1992:330; Nortvedt 2003:134; Patching & Lawler 2009:10).

In the modernist framework patients are not viewed holistically, something which is in my opinion unacceptable, particularly when spirituality could be a resource to be integrated in coping with illness. As humans we are spiritual beings and have a spirit, spirituality is embodied existence - atheists and believers alike, have a spirituality (Elkins 2005:142; Lukoff & Francis 2005:177; Pellegrino 2001:570). Neither spirit nor spirituality can stand alone and only their aggregation constitutes a sound basis for practice (Pesut 2009:422). Spirituality cannot and does not float suspended in time and space, it has a context,; the embodied, relational integration of mind, body and spirit. Spirituality on its own does not lend itself to being 'measured'; removed from the spirit, spirituality is and remains an empty concept (Bash 2004:13). Spirit is not seen as an entity, but as a function of the whole person, with spirituality giving form and effect to lived reality (Hiatt 1986:740). Hence to talk about spirit or spirituality is to refer to the whole human being as situated in-the-world, which can only be understood by giving consideration to context. This notion points to the coherence of experience as we relate physically and morally in the construction of ultimate reality. Accordingly, as lived reality, spirituality is a holistic phenomenon, not open to reductionist ways of understanding.

2.2.4.3 Spirituality resting in an 'unscientific' world

Denton (2005:759) warns that as we enter spiritual inquiry we enter the difficult territory of the 'invisible, unverifiable and unpredictable', suggesting that there can be no exact or rational explanation of spirit or spirituality. In that sense, there is no such 'thing', objectively speaking, as 'spirituality' (Bash 2004:15). Human thoughts, actions and intentions violate the objective, observable and stable qualities required in standard scientific inquiry. They render positivist assumptions inadequate because of the indeterminate nature of social reality and differences in interpretation regarding various aspects of social life (Bailey et al 2009:29). Hence, there can be no fixed body of 'truth' pertaining to individual spirituality; the onus is on each person to discover and create meaning for him- or herself by means of metaphoric and imaginative reference (Herholdt 1998:24). This individualised and subjective interpretation includes perceptions about the essential nature of the world, a view that colours the interpretation of life events (Boswell, Knight & Hamer 2001:21).

It follows that spirituality is a creative, but also a nebulous and unstable, phenomenon, subjective rather than objective. Discovering and creating what is perceived to be truth in the construction of reality happens as part of an ongoing, non-linear, interconnected and interdependent process, deviating from the cause/effect principle of modernist science. Knowledge becomes a way of knowing that includes the personal experiences of observer and observed (Herholdt 1998:225). This calls for participation and commitment to discover and understand a person's experiential reality, which becomes 'truth' as the individual enters a world of meaning.

If individual spirituality is assessed by means of measurement scales, the patient or client is called upon to master an 'abstract' truth, instead of being challenged to make sense of the world by participating in the creation of new realities, in terms of which the self (spirit) is redefined. Bash (2004:14) is of the opinion that any approach to spiritual experience that is not based on the client's own subjective interpretation is not only unethical but profoundly 'flawed' and dangerous, in that 'tools measure what they measure – and not what else may be present or relevant'. With such an approach, one therefore runs the risk of missing the more subtle, spiritual experiences which might give greater insight into a client's life.

The above discussion identifies and emphasises the creative possibilities of spirituality as a socially determined, complex and dynamic process. Postmodern, interpretivist assumptions address spirituality in ways that give rise to, and reaffirm, the subjective interpretations that

enable meaningful action. However, I am of the opinion that to begin incorporating these interpretations and critiques of the medical model would be to transform that model itself. I agree with Elkins (2005:143), who is of the opinion that a broader view of science – one that values subjectivity and phenomenological realities – is needed, together with research methods that can more appropriately handle such subtle but important phenomena.

Having reflected on the difficulties concerning the integration of spirituality in the mental health profession, I now open the door to paradigm changes in order to find a place for spirituality as the missing component, the incorporation of which would result in a holistic approach to health and healing.

2.3 BRIDGING THE DIVIDE: NEW PARADIGMS OF HEALING AND EMPOWERMENT

When existing paradigms are no longer helpful, we have to make room for new ways of thinking. Denton (2005:756) quotes Hart, Nelson and Puhakka's assessment that we have begun to see 'an opening in the horizons of knowing', an opinion that she agrees with. Lincoln and Guba (2000:185) also observe that we are 'entering an age of greater spirituality within research efforts', which may in turn permit us to 'reintegrate the sacred with the secular in ways that promote freedom and self-determination' and 'promote others' being, as whole human beings'.

In this section I discuss the 'ripples' that have occurred in modernist thinking and how paradigm changes are bridging the divide caused by dualistic conceptions in areas of health care and counselling, opening the door for spirituality as a resource for healing.

2.3.1 A postmodern approach to illness

Kvale (1992a:8) argues that irrespective of whether postmodernism is regarded as a rupture within or a continuation of modernity, postmodern discourse is about changes in the questions we ask and the contexts where we look for answers. A postmodern approach to knowledge gives recognition to practical, embodied forms of knowledge, rather than just theoretical knowledge (Carr 2008:1380; Corbin 2003:258; Finlay 2005:272). A postmodern view of understanding recognizes a move from the inwardness of an individual psyche to a being in the world with other human beings (Kvale 1992a :15), with the focus of interest now not solely on the individual or the individual mind, but also on the interface between mind, body and spirit and on the continual interaction between the self and the world.

2.3.2 Knowledge as context-dependent

The fact that individuals who experience prolonged psychiatric disability can go beyond the limits of their condition and reclaim full lives was, until recently, rarely mentioned in professional literature, perhaps because the idea of recovery is seen as being heretical within the dominant medical model (Leete 1989:199; Ridgway 2001:335; Scotti 2009:844). Weaver-Randall and Salem (2005:175) explain that practices that rely solely on the medical model as a way to understand mental illness tend to focus on pathology and disease. They also point out that traditional mental health institutions operate on the belief that any recovery from mental illness can only be achieved via professionals and professional technologies. This is so because the medical model emphasises expert knowledge founded on professional training; adherence to this model leads to hierarchical structures which serve to give professionals control (and power) over the setting (Weaver-Randall & Salem 2005:175). For people with a psychiatric diagnosis, these professionals, and the organisations and institutions within which the patients receive treatment, information and support have a powerful effect on the patients' understanding of mental illness and their self-belief about recovery (Leete 1989:199; Ralph 2005:134; Ridgway 2001:339-340; Weaver-Randall & Salem 2005:174-175).

2.3.3 A holistic approach to healing

The conflict between the moral demands of the patient's immediate subjective experiences and the longer-term benefits of medical treatment can be overwhelming, and poses a significant challenge to most health professionals. Together with this, the concept of health has in recent years emerged as something far more than just disease-free biological functioning. While physical issues will always remain a priority in most health assessments, there is increasing agreement that health or illness is strongly influenced by a multitude of factors, particularly the psychological, social and spiritual influences in the patient's life (Hood et al 2007:1198; Kingdon 2005:621; Matusek & Knudson 2009:697; Morse 2009:579; Wilde 2003:171).

Arguing for a holistic understanding of humans in administering care, there are also indications that the configuration of the 'bounded, masterful self' created by modern, individualistic ideology is an empty or needy self, with subjective or interior inadequacies (Cushman 1990:604; Kochunas 1997:13). In this thesis I regard such a self as a wounded spirituality, which often defines emotions and hence illness. Accordingly, spiritual

experiences, values and beliefs are considered integral considerations in encounters between patients and health care providers (Pesut 2009:426; Shafranske & Sperry 2005:11-25). Griffith and Griffith (2002:298) write that spirituality in its manifold expressions can bolster connections between the ill person and others and restore relatedness between her and her God. The authors are of the opinion that spiritual talk and practices can have an effect on the physical state of the body, emphasising that embodied knowledge structured in the interface between mind, body and spirit are relevant and crucial to administering care. In this thesis, I argue that spirituality, constructed as relatedness between self and body, can bring peace to a 'warring' relationship between the self and the body for a person struggling with an eating disorder.

2.3.4 Positioning and ethics

Addressing patient care within a postmodern framework suggests that if the subjectivity of the patient is allowed to be voiced clearly to the caring community, the subjectivity of the illness itself must be taken seriously. It then becomes a matter of striving for an 'engaged' as opposed to a 'disengaged' interaction between a patient and health care providers in order to minimize the patient's subjective experiences of vulnerability and suffering, and at the same time to value the unique status of the individual (Beveridge 2002:101-103; Norvedt 2003:136; Watson 2007:1286).

Founded within the postmodern framework, and drawing on the work of Gadwo (2004:375-384), the 'relational narrative' of care is now understood to provide an important theoretical basis for working ethically – the relational narrative becoming exclusively an ethical lens. Gadwo (2004:373-384) describes an ethical, relational engagement as a respectful engagement between two individuals, with the intent of understanding as fully as possible the narratives individuals create to make meaning of their lives. Within this engagement, individuals have the capacity to reframe meanings and to consider alternative, more hopeful possibilities for their lives (Pesut 2009:423).

Such an approach has made it possible to gain a deeper understanding of the meanings that patients and health care providers bring to the situation and the relevant ethical issues involved. Gadwo (2004:381) suggests that an ethical narrative falls short of criteria in the determination of objective knowledge, whilst terms like 'poem' or 'story' do not fit into the framework of a rationalist view. By contrast, understood as a co-authored interpretation of the 'good' being sought, the relational perspective within the framework of a 'spirited

epistemology' (Vella 2000:7) is remarkable for a concomitant shift in power between the person in need of care and those administering care (Hess 2003:139).

2.3.5 A socially constructed, embodied self: making room for spirituality

In order to gain a deeper understanding of the meanings that patients and health providers bring to any situation, and given the relevance of ethical issues, a re-conceptualisation of the self is called for. The result is a socially constructed self that is constantly being redefined, moment by moment, as the person interacts with the world and with the self being conceptualised as an embodied self, with unity of mind, body and spirit (Jankowski 2003:242). In place of the fixed, core self created by modernist science, where those struggling with the label of psychiatric diagnosis have to cope with feelings of alienation and emptiness, a postmodern approach makes room for multiple selves or a host of possible selves, each of which are equally valued and functional, depending upon the social context, providing people with choices regarding to how they want to live their lives (Jankowski 2003:593).

A further result of the postmodern re-unification of mind and body is the elevation of embodied experiences as a legitimate way of knowing (Ellingson 2006:302; Finlay 2005:272; Griffith & Griffith 2002; Heshusius & Ballard 1996c; Kirmayer 1992:328). The holistic or embodied self has resulted in an increased awareness and openness to spirituality, with spirituality offering an understanding of the richness and possibilities of relational life. Many people turn to their own spiritual resources for healing, with this trend increasingly defining postmodern culture. An underlying premise of this thesis is that the nature and insight of embodied knowledge provide both the key to understanding the lived bodily reality of those struggling with an eating disorder and a road to healing.

2.3.6 Local knowledge versus expert knowledge

Consistent with the above argument, and given a new understanding concerning the relatedness between context and the construction of knowledge, we find a growing development of various theories and models of recovery from mental illness founded on the perspective of those who have experienced such illness (Adame & Knudson 2007:157-178; Leete 1989:197-200; Ralph & Corrigan 2005; Ridgway 2001:335-343; Scotti 2009:844-846). The postmodern premise that the acquisition of knowledge in any discipline or profession must attend to the nature of reality and knowledge as socially constructed, with the self

coming to know itself in and through relationship, is a consideration now being addressed (Gergen & Gergen 2006:119; Hess 2003:139; Wallace 2002:103). New conceptions of healing and recovery emphasize a continual journey of the self towards growth, so that healing becomes a highly individualized process, with a redefining or re-establishing of the self in the process (Deegan 1996:91-98; Loveland et al 2005:27; Ralph 2005:132,135; Ridgway 2001:335-343).

Such a standpoint provides insight into the distinction between curing and healing. It also emphasises the spiritual connotations of healing. Healing calls on the client's own resources to assist in the process, with recovery coming from within (a turning inward), and not from some outside intervention by the psychiatrist, psychologist or counsellor. Furthermore, with client empowerment and freedom of choice as central themes in the process of healing, healing from within is essential if the client is to break the cycle of disempowerment and dependency on the medical system.

Postmodern science is technically about a new paradigm suggesting change at all levels of existence, to the theory of knowledge and our understanding of reality (Herholdt 1998:219,220).

2.4 THE UNIVERSE, EXISTENCE AND SPIRITUALITY: THE CONNECTION

My commentary on spirituality in this thesis serves to express striking parallels within the field of quantum physics and the work of Bateson (1979) in examining the complementarity of ecological paradigms (which interpret existence as relatedness between humanity and nature, expressing not only the creative and dynamic interaction of all life, but also emphasising the wholeness of all life forms).

In addition to my argument for an epistemological paradigm of social construction which emphasises the relational character of the self (Gergen 1985; 1994; 2002; Gergen & Gergen 2006:119), I also argue that social construction does not happen in a vacuum: it has to have a foundation (a biological and spiritual dimension) in order to develop. That is to say, reality cannot be constructed independently of the living system that brings forth reality. As Hay and Socha (2005:593) confirm, 'relational consciousness' is a dimension of spirituality necessary in the construction of reality and understood as a natural human phenomenon shaped by the biological predisposition of individuals.

2.4.1 Consciousness as a non-dichotomous relationship

Following on from the above, my argument for relatedness and connection as dimensions of spirituality should be read within the larger framework of Bateson's work (1979), particularly in his explanation of 'patterns that connect', which speaks of love and wisdom to characterize both knowing the self as interwoven within larger realities, and knowing larger realities as part of the self. Bateson here intends for us to recognize the relatedness and connectedness of our knowing and how this is also embedded in our stories.

Quantum theory speaks of opening ourselves up to new possibilities, putting aside what we think we know and recognizing how we each create our own internal and external realities (Leseho 2007:451). In line with a holistic view of human interaction with the world, some parallels between quantum physics and spirituality may be drawn, since spirituality is also embodied in relatedness, which underscores existence. Spiritual awareness and consciousness are paralleled in the news from quantum physics: Davies (1990:100-102) writes that quantum theory provides the most convincing scientific evidence yet that consciousness plays an essential role in the nature of physical reality. The world (and human nature) is not a collection of separate things; rather, it is a network of relations. Davies (1990:112) supports his argument by drawing on British quantum physicist David Bohm, who writes: 'A centrally relevant change... is thus the dropping of the notion of analysis of the world into relatively autonomous parts, separately existent but in interaction. Rather, the primary emphasis is now on undivided wholeness.' Davies (1990:112) also agrees with Werner Heisenberg, the German theoretical physicist who developed the Uncertainty Principle and who argues that the 'common division of the world into subject and object, inner world and outer world, body and soul, is no longer adequate'.

The central paradox of quantum theory is the unique role played by the mind (consciousness) in determining physical reality. The philosophical implications of the theory, the argument for free will or determinism, stem from the simple act of observation, causing potential outcomes to cohere into a single substantive reality (Davies 1990:107). In this regard, Perkins (2003:39) supports Dr Casey Blood, Professor Emeritus of Physics from Rutgers University, who argues as follows:

Ordinary thoughts and emotions are in the physical realm because they correspond to firing patterns of neurons... . But the choice of thoughts and physical actions, the experience of deeper emotions, and intuition are in the realm of the non-physical... . Each individual mind makes its own autonomous

choice of which branch of the individual brain wave function to perceive. Each mind has free, autonomous choice of which potential action or thought to focus on and bring into ordinary consciousness as the objective reality... . Thus, the isolation between beings lessens as our perspective approaches that of Pure Intelligence/God/Creator.

Given a quantum interpretation, Blood clearly supports free will, with the mind having autonomous choice in determining reality. Here the mind becomes the bridge between physics and mysticism. However, as I understand his interpretation, it is the choice of thoughts and physical action, tied to what Blood calls the non-physical 'deeper emotions and intuition' which happen in the spirit, giving form to spirituality, that are ultimately responsible for determining reality. Furthermore, quantum theory, which interprets the essential nature of existence as a flow of continuous potential which unfolds into discrete physical manifestation under certain conditions, accords with my understanding of spirituality embodied in existence, with relational consciousness/awareness determining freedom of choice and positioning within discourse. This flow of potential (spirituality) is then the force that finally determines whether we are healthy or ill, the power that must be tapped into in order to heal (Perkins 2003:35). Consistent with my understanding of healing as coming from within, Perkins (2003:34) sees healing as 'conscious knowledge of the presence of the "sacred" in the ordinary, the everyday, as experienced by the feeling heart', thereby placing emphasis on the human potential to evoke that which is sacred from within.

2.4.2 The self within larger spiritual realities: God and existence

Davies (1990:101) claims that there is an increasing awareness that quantum theory contains remarkable insights into the working of the mind, and the reality of the universe with important consequences in the search for an understanding of God and existence. The restoration of a participatory and embodied understanding of what is involved in the construction of knowledge is perhaps a response to the integrity of life forms beyond the self (Heshusius & Ballard 1996b:175). Many physicists and scientists now acknowledge that scientific notions about the functioning of the universe (as in quantum physics) are compatible with religious and spiritual views of reality (Richards & Bergin 1997:36). Becvar (1996:21) observes that Paul Davies regards the universe as creative and as having organised its own self-awareness through conscious entities. Becvar (1996:21) also concurs with Erwin Schrodinger's notion of the hidden oneness of all human minds. For the religious the 'higher authority' is God, accorded different names by believers of various faiths. Today,

physics does not rule out the possibility that God and spiritual realities exist, but has opened itself up to leaving such beliefs well within the realm of rational plausibility (Richards & Bergin 1997:36).

Following on the above, much of the ecumenical discussion in recent years has explored the presence of the spirit within, upholding all creation (Brinkman 1998:207). Drawing on ideas embodied in Hegel's philosophy, Gaybba (1998:45) argues that the whole universe is infiltrated by a life-giving, energizing spirit, and that the world's religions were expressions of the different ways in which this spiritual heart of the universe was experienced.

In this regard, Hay and Socha (2005:591-592) show that Hardy (a fervent Darwinian) defined religious experience operationally as 'being aware of or influenced by a presence or a power, whether called God or not, that is different from one's everyday self'. This awareness was not confined to *homo sapiens*. Hay and Socha (2005:592) also note sporadic scientific speculations about the existence of religious awareness in other animals. Field reports of communal dancing in apes have been interpreted as possible religious rituals and graphic descriptions have been provided of apparently religious behaviour in baboons in response to the rising and setting of the sun. I am of the opinion that these reports reflect the ongoing confusion between religion and spirituality. Personally, I am sceptical about religious behaviour in apes and baboons. However, given the evolutionary growth of our own humanity, I find it entirely conceivable that such primates may, on occasion, display a type of spiritual awareness.

A recent exposé by *Carte Blanche* (a television programme featuring investigative journalism) on the plight of chimpanzees at a Cape Town primate sanctuary raises further interesting questions. Given the concept of a wounded spirit, I was moved by the striking parallels observed in the behaviour of these animals and humans, evident in acts of self-injury and social withdrawal. The chimpanzees at the sanctuary had been rescued from a situation in which they had allegedly been traumatized and ill-treated, which included being kept in isolation for long periods of time. The footage showed how these animals structured their daily existence: sitting alone and rocking backwards and forwards in a foetal position. They were all self-mutilating, pulling out their hair or tearing at their skin with their nails. In humans such behavioural patterns would suggest mental illness. So why were the chimpanzees behaving in this manner? I am not suggesting that chimpanzees are spiritual beings, although they may have a primitive spiritual nature. I consider it more likely that their genetic 'blueprint' links them to a specific 'function circle', (Binswanger 1958:197) which

provides community and shared forms of social behaviour. As sociable creatures, they had somehow been wounded by isolation, resulting in loneliness and a loss of connection which manifested in their disturbing behaviour.

To return to Hay and Socha (2005:595) – they suggest that Hardy's contributions were directed to discussing a survival-enhancing experience, which he took to underlie religion, and which I interpret as spiritual awareness. However, I agree with Hay and Socha (2005:591-592) that the subject of investigation is the realm of awareness, or consciousness, not only in humans, but also in animals. This supports the idea of spirituality (or spiritual awareness), complementing the quantum revolution, in the search for a holistic understanding of God and existence, with a connectedness between all life forms going much further than logic or reason. Emphasis is placed on the unity that is believed to exist between all living things and on the importance of the human body in structuring experience and emotion, thus developing individual knowledge and an understanding of reality. The notion that reality is constituted by events and relationships, rather than by separate substances or particles is significant (Richards & Bergin 1997:36). Hermans (2002:116) is of the same mind as Gergen, who suggests that our 'account of the world is not demanded by what there is, [rather] our modes of description, explanation and/or representation are derived from relationship'. Again, relationships are not separate from the individual, nor is the mind solely responsible for the construction of reality. Rather, the embodied relationship between mind, body and spirit provides the flow of human potential that ultimately structures existence. These views challenge the accepted nature of modernist certainties and question how we know, what we know and who tells us what we know. They underscore the growing shift away from positivism, determinism and mechanism – a shift which alerts us to spirituality as a natural phenomenon in humans and in animals, as well as providing insight into the spiritual realities of the universe. This spirituality does not contrast spirit with matter, but rather constructs both as aspects of reality, not opposed but intimately connected (Herholdt 1998:218-219; Traitler 2008:28). The modernist world view, which regards the body as matter separate from the mind, is giving way to a holistic view of created order, one that emphasises spirit over matter (Traitler 2008:28). Spirituality as embodied existence not only replaces Cartesian dualism, but becomes instrumental in determining growth and well-being.

Moreover, in my opinion, the common assumption that things that are not easy to study, or are not objectively verifiable, do not merit scientific attention is further challenged by developments within science itself, which is the topic of the section below. This has further

relevance for spirituality, which modernist science disregarded because of its non-objective status.

2.5 SCIENCE, THE BODY AND SPIRITUALITY: CHALLENGING AUTHORITATIVE TRUTH

In 2004, Professor George Ellis of the University of Cape Town produced a compelling body of work on the fundamentally, complementary nature of science and religion, earning him the Templeton Prize for Progress toward Research or Discoveries about Spiritual Realities, the world's largest annual monetary prize to an individual in this field. Issuing a statement at a news conference, Ellis (2004:4) stressed the limits of science, and of the scientific method, in understanding what aspects of existence science can and cannot comprehend. He claimed that these boundaries were becoming clearer and that science cannot and never will be able to handle issues of aesthetics, ethics, metaphysics or meaning. He explained that human thoughts, emotions and social construction are all causally effective and cannot be encompassed by present day physics. He added that even the most advanced theory of physics today is unable to give a complete account of the factors that are effective in shaping the physical world, because it is unable to encompass human thoughts and intentions.

2.5.1 The mind, body, spirit connection

With the rise of postmodernism came questions concerning authoritative truth. The notion of a dialogue of mind, body, spirit and emotions is picked up in the work of Carl Jung (1933, 1964). Jungians emphasize the idea of a collective unconscious and a mind-body dialogue as a means for understanding the self and preserving well-being (McCabe 2008:144). Jung's strong emphasis on a realization of the sacred was observed by other writers; for example, Walsh (1999:31) comments that Jung was one of the few leading therapists and theorists who believed that healing the psyche necessitated a reconnection to the spirit. Gergen (2002:284) observes that Jung (1933:142) wrote with passion about the loss of the mysteries of the spirit through science, because Jung said that "it is easy enough to drive the spirit out of the door but when we have done so the salt of life grows flat – it loses its savour". Borg (1997:49) observes that the sacred, as real and present, was so important to Jung that Jung had the following inscription in Latin carved over his front door, as a reminder to both himself and his patients: 'Bidden or not bidden, God is present.' The same inscription appears on his tombstone.

2.5.2 Illness symptoms and the mind-body connection

In a book entitled *Healing and the Mind* which is a companion to the television series *Healing and the Mind*, Bill Moyers (Flowers & Grubin 1993), the voices of different writers in the field of medicine work together to address two questions: How do thoughts and feelings influence health? How is healing related to the mind?

The mind/body relationship is a fascinating marriage between what people say, think and feel. People's physiological processes (Griffith & Griffith 1994, 2002) depict the wholeness of human experience, which is understood in this project as individual spirituality. Regarding this relationship, Griffith & Griffith (1994, 2002) point to an entity or unique mix that makes every person inimitable. Scholars of mind-body medicine admit that something is happening in the interplay between mind and body, that there is a 'thread' they witness, but they do acknowledge that it is also difficult to quantify (Anderson 1993:29). This interplay has frequently been witnessed in those diagnosed with terminal illnesses such as cancer and AIDS, where some patients surrender and quickly succumb, while others fight back and often live longer than anyone would have anticipated.

An important issue is whether those in the helping professions who accept the existence of an inner dialogue in psychological healing will also accept that there is a spiritual component in the process (Goddard 1995:810; McCabe 2008:149; Miner Williams 2006:812). The idea that there could be a spiritual energy source, integrated with mind and body, is a challenge to mainstream, traditional theory (Griffith & Griffith 2002:42; Richards & Bergin 1997:92). Given the strategy common in empirical science to exclude any form of knowledge beyond the bounds of objectivity and probability, the ongoing debate surrounding mind/body interaction has all but eliminated the possibility of admitting the presence of a life-giving spiritual force that we can tap into for personal well-being.

However, in opposition to Cartesian dualism, the connection between what we think and how we feel is perhaps the most dramatic corroboration of the fact that mind and body are not separate entities, but part of a fully integrated system. A growing corpus of medical literature about treatment of mind-body problems is evidence of progress, offering new hope to patients whose bodies become ill when the patients are psychologically stressed (Flowers & Grubin 1993; Griffith & Griffith 1994, 2002).

Griffith and Griffith (1994:16) define mind-body problems as 'those human problems that can only be described through both the psychological language of feelings, intentions, and choices and the physiological language of cells, organs and chemical messengers'. They are of the opinion that mind-body problems are often coupled with secret understandings that cannot be discussed openly, often related to the abuse of power in relationships (Griffith & Griffith 1994:6). This point is highly relevant for my research project in view of the effects of the discourses on anorexia/bulimia and binding social practices in structuring the relationship between the mind and the body, and resulting in injury and abuse of the body. Abuses of power based on these discourses then silence personal expression, paving the way for a disabling spirituality, which becomes the ground from which symptoms arise or are exacerbated.

Although eating disorders are categorized in the medical model as a form of mental illness, very little is known about the patient's actual experiences of the illness with regard to the relationship between body and self (spirit) and the individuality of patient suffering. MacSween (1993:149-150) is of the opinion that this omission can be ascribed to the medical model's mechanical conceptions of the body, as matter animated and owned by a mind conceived as separate from the body, with little or no emphasis on the embodied reality of thoughts and emotions. I argue that, in order to address healing in the context of eating disorders, consideration of the wholeness of human existence and its relational integration is essential, and that an emphasis on the human body and its role in determining spirituality and vice versa is paramount.

Reclaiming the body from the power of anorexia/bulimia requires searching for a life-loving and affirming spirituality, which must start with the consolation and healing of the body (Traittler 2008:27). This view of the wholeness of human life is juxtaposed with mind-body and self-other dichotomies constructed by modernist medicine, and mirrored in the disassociation between mind and body of those suffering from an eating disorder. In line with feminist theology and spirituality, which emphasises a theological reflection on the body, this thesis makes the body sacred in appreciation of the wholeness of human life, rather than viewing and treating the ill body as a 'machine' in need of repair.

2.5.3 The human body as subjectivity: both sacred and vulnerable

Heshusius and Ballard (1996a:11) state that although some authors may subscribe to a 'new paradigm' where the general importance of the mind-body connection may be mentioned,

explicit emphasis on the body as the primary source of knowing is promoted by only a few. It is noteworthy that the few who reflect on the significance of human existence begin with the phenomenon of embodiment. Therefore little attention has been given to the human body as subjectivity (Gadow 2000:90). Gadow (1982:86-99, 2000:90) argues that recognition of the importance of the role played by the human body in illness, health and healing will only become widespread when all forms of experience, at best and at worst, are recognized as irreducibly embodied. Drawing on Existentialist philosophers Merleau-Ponty and Sartre, Gadow (2000:90) argues that embodiment is one of the terms of existence 'with the body no longer a brute object without selfhood'. Similarly, Polanyi (1966) and Bohm (1984) warned that it is only when we come to appreciate the role of the human body in constructing emotions that we will begin to understand knowledge. This has implications for understanding the role of the body in structuring and determining individual spirituality in the context of eating disorders, either towards pathology or healing.

In line with the above viewpoint, Bordo (1993:144-155) argues that there is a fine distinction between having a body and being in a body, and that this distinction is not widely appreciated and understood by therapists and health care providers who adopt the conceptualisation of the mind-body dualism. The form of knowledge known as interior or bodily knowing is evident in sensations, perceptions, emotions, actions and thoughts experienced by people as they move about their world in their physical bodies; and this knowledge cannot be intellectually contested because it is invisible, yet it lives through our being (Heshusius & Ballard 1996a:5).

Arguing for this form of embodied knowledge, Bohm (1984:383) contends that knowledge is not something individuals carry in their minds, but something that becomes an active, ongoing process, present not only in abstract thought, but becoming part of desire, the will and action, and filtering through into the whole of life through interaction and communication. Polanyi (1966:75-76) claims that understanding cannot take place without the body, suggesting that all knowledge is embodied, intuitive and personal. What is personal is also subjective, because the knowledge that the body holds can become instrumental in the move from a constrained and narrow conception of anorexia/bulimia as a mental illness to a broader understanding of this condition as a symptom of a wounded or empty self.

Giving consequence to knowledge as embodied and constructed by means of and through the body, coupled with the vehicles of language and social interaction, has great relevance for women struggling with an eating disorder, viewed through the lens of modernist science.

Bordo (1993:66) states that, since the seventeenth century, science has 'owned' the study of the body and its disorders, placing the body under the 'proprietaryship' of the scientist/analyst, the only professional equipped to understand and analyse the working of the body. In this regard, however, Harakas (1992:90) concurs with Kass, who asks whether 'modern medicine, grounded in modern reductive and mechanistic science' does in fact give 'an adequate account of the living body – as an organic whole'; or 'as a personal centre of awareness, felt need, and self-concern; as a vehicle of individual self-presentation and communication'. Furthermore, Harakas (1992:89) is of the opinion that fewer still accord our 'bodily existence a heuristic value for assessing not only the meaning of human life, but also the sense of human identity'.

2.5.4 The body: no longer 'objective' but 'lived'

Wainwright and Turner (2004:330) share Elliot's view that 'the body is something we are, we have, we do in daily life; the body is crucial to an individual subject's sense of self, as well as the manner in which the self relates and interacts with others'. Kielhofner and Mallinson (1997:365) observe that 'what kind of world they inhabited through those bodies, and what we can learn and say about their world through interaction with their bodies' represents problems at the core of the failed strategies visited upon the body of a woman with an eating disorder. Therapists and other health care providers conceptualise and treat the body as an object to be comprehended and managed through objective methods. Furthermore, the body is considered a troublesome object, diseased or damaged, and in need of regulation (Kielhofner & Mallinson 1997:366).

In summary, my argument is that 'damaged' or 'diseased' bodies must be addressed not merely as objective bodies, but also as lived bodies. Gadow (2000:89) points out that bodies, post-dualism, are not objects existing independently of interpretive structures, but are shaped and constituted by social worlds through cultural meanings. This argument would support the proposition that there is an inevitable and strong relationship between an interconnected (embodied) view of anorexia/bulimia, the body, social discourse and identity. In other words, for women living in Western, capitalist society, several narratives influence how they experience their bodies. Gadow (2000:89) contends that the social narrative of a woman's body as an object culminates in a science narrative which conceptualises bodies entirely as objects, without subjectivity or spiritual essence. Elaborating on the trilogy of works by Harré on the nature of being, Wainwright and Turner (2004:330) comment on the different levels of being – at the first level we are, in Harré's terms, organic 'physical beings' in fleshy bodies, at

the same time we are individuals with a 'personal being' and finally a 'social being', existing for ourselves as 'I', as well as for others as 'we'. These modes of being culminate in what is understood as a 'spiritual being' constituted through cultural meaning, reproducing power through compliance with social and cultural discipline.

In line with the above, any efforts to discover the world inhabited by the person struggling with an eating disorder should involve consideration of her 'lived bodiliness' (Kielhofner & Mallinson 1997:366). In order to integrate the body into the process and production of knowledge requires us to look at knowledge in the context of the body from which it is generated (Spry 2001:725). It is important to note how social processes and structures, situated within discursive fields where language, power relations and discourse intersect create meaning and construct subjectivity (spirituality), and ultimately determine subject positioning in an ongoing process of becoming in the world (Youngblood-Jackson 2004:674). Rawlinson (1982:83) suggests that it is through these embodied possibilities that identity is being constructed, something which has great relevance for this project and the research question.

In my opinion, such bodily reflection is critical if we are to see ethics embedded within and not as external to paradigms, given the contemporary challenges to ethics and care-giving in the rapidly changing world of counselling, diagnosis and practice. Bodily reflection creates the place where the spiritual meets social inquiry and contributes to the dialogue around spirituality and its role in health and illness. In the section below I present my argument for spirituality as embodied, lived experience.

2.6 SPIRITUALITY

Davies (1990:88) adopts philosopher Thomas Reid's idea that 'I am not thought, I am not action, I am not feeling; I am something that thinks, and acts and suffers'. Reid's words emphasise the embodied nature of spirituality, the interrelatedness and interdependence of mind, body and spirit, with spirituality as the medium between the self and the world.

2.6.1 Relationality and contextualisation as dimensions of spirituality

My understanding of spirit and spirituality developed in agreement with many contemporary, theoretical paradigms in the social sciences that emphasise relationality and contextualization as the basic condition for the construction of reality/knowledge. Unlike

Cartesian dualism, this approach emphasises embodied forms of knowledge construction and relational ways of being as ultimately determining existence, construed in this thesis as individual spirituality. In the context of eating disorders, I argue for spirituality as a resource neglected in the process of healing. I place spirituality under the spotlight as an open, ongoing journey through which the individual finds new meanings, and comes to identify and understand herself through critical reflection on her 'being in the world', while sensing an increased spiritual awareness from which new actions and choices evolve, which are based on these reflections.

Because the eating disorders have been locked into the framework of modernist science, the body is treated as an object, controlled and manipulated with the sole objective of weight gain. At the same time, the body undergoes a different form of 'suffering': being starved and manipulated in favour of weight loss. As the bridge to healing the self and/in the body, my argument for spirituality signifies a new discourse concerning the body, emphasising the body as the site which makes the construction of knowledge possible. Such an approach challenges modern conceptualizations of a 'disembedded' and 'disembodied' self (Jankowski 2003:241), paralleled by bodily postures of withdrawal and isolation. It is a move towards embracing a holistic and embodied self, with increased awareness and openness to an enabling spirituality that can become part of a lived experience in the fight against anorexia/bulimia. This connectedness to self and the other involves experiencing a 'oneness' embedded in relational forms of being. It is an approach which emphasises the re-establishment of connection as the element, both instrumental and crucial, that we need to engage if we are to challenge the severance between the self and the body of a person struggling with an eating disorder (Jankowski 2003:243).

Given the holistic focus of this thesis, I argue for spirituality as situated in context, not open to separation from the spirit (self) and the body, hence lived experience. My interpretation of spirituality is founded within an Existential framework, where the focus is on the 'existing individual' who is concerned with meaning and purpose (Webster 2004:9), together with Bateson's (1979) and Bateson and Bateson's (1987) teaching on 'patterns that connect'. I argue for spirituality as embodied existence, with relationality and connectivity providing the means by which individual spirituality is constructed and made visible. In support of my view, I draw on the teaching of Heidegger (1962, 1996) who identified the basic condition or structure of existence as 'being in the world', and in so doing provided a statement about an essential condition that determines existence, that humans live in the world and are not separate from it. To this effect, and with insight provided by the work of Bateson on

spirituality and the mind, Leseho (2007:441) states that the pattern of circularity, of interactions and of relationships evident in nature conceives human beings not as living a life isolated from the world but one that is always connected to it.

The concepts of connectivity and relationality have particular relevance for spirituality. In general, these concepts refer to relationships, meaning that life is based on physical, biological, social, psychological and spiritual exchanges between the individual and the world (Bertelsen 2005:683). Similarly, Gergen and Gergen (2006:119) write that human beings cannot exist outside relationships, instead they see human behaviour as meaningful only within the context of the relationship in which it occurs. Based on the teaching of Heidegger (1996:52), behaviour cannot be understood in any condition outside of or before being constituted in relationships through shared existence with the relationship also becoming the basis on which truth or knowledge is established.

Below, I explain the relational integration of mind, body and spirit, and that between self and world, by expounding on the concepts of spirit and spirituality, emphasising spirituality as embodied existence, evident in and through cognitive, relational and behavioural patterns. I also argue how storied experiences become lived reality, manifested in bodily conduct, which has the potential to be empowering or disabling. I focus the lens on freedom of choice and transcendence as dimensions of spirituality.

2.6.2 Spirit, self and spirituality: a theoretical and operational framework

I define the 'self' as analogous to 'spirit', the core of our innermost being (Goddard 1995:809), also sometimes referred to as 'subjectivity' and the 'court of the highest appeal' (Binswanger 1958:199). The spirit, referred to by Becvar (1996:32) as 'soul', is that aspect of ourselves that 'speaks to our connection with the Divine', a connection that 'unites' all that is. In this thesis, I argue that the spirit or self – what Existential therapists refer to as the '*Eigenwelt*' [own world] (May 1958:63) is the core from where we organise, providing a life force, understood to interface with and motivate action through the body. Situated within my own personal epistemology, and in agreement with Becvar (1996:29), I do not regard the mind as the highest utility, but rather understand this to be the spirit. I regard beliefs, emotions and feelings as contained in the realm of the spirit, so that understanding flows from the spirit, constituting 'a way of being in the world' (Becvar 1996:29) observed in attitudes and behaviours that are derived from a person's experience of the spiritual dimension, conceptualized as giving form to individual spirituality (Hiatt 1986:737). Like

Davies (1990:89), I believe that some aspects of the self lie on the borderline of personal identity, and also that one of the most fundamental properties of the perceived 'self' is that it is indivisible and separate.

Expanding on the above and drawing on Gergen, Wallace (2002:103) claims that the self (spirit) is a social construct, a product of its various relationships, rather than a pre-existing interior reality. In a similar vein, based on insights from Kierkegaard, Webster (2004:50) states that spirit is understood to be the means by which one relates to oneself.

Davies (1990:89) is in agreement with David Hume's statement that

...[w]hen I enter most intimately into what I call myself I always stumble on some particular perception or other, of heat or cold, light or shade, love or hatred, pain or pleasure. I can never catch myself at any time without a perception, and never can observe anything but the perception.

According to Hume, the self is nothing but a collection of experiences. However, Davies (1990:89) concedes that the concept of the self is nebulous, but that experiences go a long way toward shaping the quality of self, even if they do not explain it completely.

Self (spirit) and spirituality make possible the essence of what it is to be human, mediating values, beliefs, emotions and attitudes by relational and behavioural means. These feelings, contained in the realm of the self (spirit), are not owned, but are performed within a web of relations. If people are understood as becoming human only in relation to others, as Cushman (1990:599) states, the self (spirit) is an aspect of what Heidegger called the horizon of shared understandings, or 'the clearing' carved out by particular practices of a particular culture.

As humans we are co-existing beings, not in the merely shallow sense that we like being together, but in the deeper sense that the pre-condition for existing as humans is that we participate in our formation (and that of others), dependent upon the maintenance and development of the personal, relational, cultural and societal forms of existence (Bertelsen 2005:691). This has great significance for understanding and situating spirituality. When I refer to spirituality, I do not think of an underlying structure, but rather of spirituality as constituted by the dimensions of experience, evident in relationships founded on the practices of making meaning. As the 'how' of relatedness to self, others and God, spirituality

becomes the 'paramount concern that organizes understanding and action' (Griffith & Griffith 2002:220). In agreement with Hay and Socha (2005:593), I argue that this interaction becomes possible because our spiritual nature encompasses self-awareness and self-relatedness, abilities unique to being human, so that spirituality is not only a subjective experience, but constitutes the basis on which we relate and respond to experience (Denton 2005:757; Fitzgerald 1997:412; Sandage & Shults 2007:262).

Envisioned as an ongoing 'dance' in the domain of relations between the self and embodiment, in the wholeness of all that is beyond the self (Griffith & Griffith 1994:5), I understand spirituality to depict the 'dramatic representation of human beings' understanding of themselves, the world around them and the Deity they worship' (Hughes 1996:30). Knowledge (including knowledge about the self) is always self-created through a 'host of metaphors', and 'a sum of human relations' (Nietzsche 1979:84), so that self-understanding concerns the construction of knowledge objectively (discovering truth) and subjectively (creating truth) (Herholdt 1998:226). As the 'integrative force' between self (spirit) and body, spirituality shapes and gives meaning and reality to life in and through relationships, so that the relationships we are in shape and determine individual spirituality.

It follows that the self (spirit) is not a given, nor is it fixed; but rather it is in a constant process of being redefined, moment by moment, through interaction with the world (Jankowski 2003:242). Identity development becomes a story without closure, constantly open to renewal and change, rather than a fixed construct shaped only by previous experiences. In line with Foucault, Miehl and Moffatt (2000:342) regard the self as a 'relationship of reflexivity'. Wallace (2002:103) perceives it to be a continual re-arranging and reframing of one's selves, testing and negotiating their interconnectedness. Accordingly, performativity constitutes embodied engagement between the body, the self and the world, with the unique meanings that individuals attribute to their situation becoming the key components of spirituality (Pesut 2009:423). Moreover, conceding that the self (spirit) is open to experiencing itself in many different possibilities, spiritual evolution is understood to involve the freedom to choose, so that the self's (spirit's) capacity to transcend immediacy becomes the basis of human freedom (Binswanger 1958:194).

Moreover, the 'dynamics of world-design' (Binswanger 1958:197-198) and the concept of transcendence, together with the recognition of language as situated in discourse, opens a window on relational forms of being or spirituality. In the next section, I explain the connection between narratives, the body, spirituality and illness in order to provide a

framework within which storied experiences, related to everyday emotion, cognition and action, shape subjectivity (spirituality). This is in support of my argument that spirituality can also be problematically engaged when the self-narratives available to the ill person cause the body to remain in a 'symptom-producing bind' (Griffith & Griffith 1994:2).

2.6.3 Understanding the role of spirituality in healing: the reciprocity of the body, the self, spirituality and language

Maisel et al (2004:29-42) indicate that few problems have the same capacity as the eating disorders to reconstruct a person's self. In the reality of the individual there is a painful self-consciousness in which the self is conceived as a problem to be solved, an object to be changed. With the gaze of others causing self-doubt, a person suffering from an eating disorder becomes attuned to what she thinks the world expects, and experiences an embarrassed self-consciousness if these expectations are violated. Todres (2004:5) believes that the shock of self-objectification, of viewing one's self from an outside perspective, results in a pre-occupation with the body, particularly with the need to alter its shape, causing a painful 'standing out' of the ill person.

2.6.3.1 Beliefs and the ordering of discourse

Two critical questions for this study are: What influences our beliefs? What causes us to believe what we do? Wright, Watson and Bell (1996:19) posit that we all have our own unique being, based on a particular genetic history and interaction with others and the environment, so that knowledge is constructed in the beliefs and practices of our relationships. This then also provides an understanding of a self that is not stable, but that is produced in relationships with others and everyday practices (Youngblood-Jackson 2004:673). Foucault's (1977,1980) writing on the bodily ordering of persons through discursive practices which operate in modern society is also helpful here. Wright et al (1996:21) observe that Foucault used the term 'discourse' to describe the constellation of assumptions that underlies ways of viewing the world at any given time. Wang (1999:193) also adopts Foucault's argument that discourse provides 'relations between statements' or 'structures of knowledge', so that discursive practices become embodied acts of discourse, 'practices which systematically form the objects of which they speak'.

The social structures and processes that shape our beliefs are situated within discursive fields where language, power relations, discourse and social contexts exist and intersect to

produce meaning that structure subjectivity (spirituality) (Youngblood-Jackson 2004:676). Drawn from social and cultural stories propagated in society, beliefs consist of 'propositional statements' which provide a truth status which defines what is real, so that beliefs exist as prejudices and biases in the form of thoughts and emotions, providing a sense of reality for the individual (Griffith & Griffith 2002:139). Operating in and through discourse, beliefs influence what we can and cannot know, see or do not see, say or do not say in complex and subtle ways. These relations not only construct subjectivity (spirituality), but provide a range of practices and subject positions within discourse (Youngblood-Jackson 2004:674).

As Wright et al (1996:25) observe, we are our beliefs – they are not just personal biases, but are at the heart of who we are and how we understand and make sense of reality. Weingarten (1998:4) explains that a belief contained in a dominant discourse may be so familiar that we cannot distinguish the messages we are getting. Once a supposition has been given 'truth status', it often merges into the horizon of our understanding, so that our awareness of its importance on our lives becomes lost, because the supposition is no longer recognized as an optional path or choice. Accordingly, whether we are aware of a discourse or not, it can powerfully shape the stories we tell and the stories we hear. Beliefs contained in discourse can be constraining, where they perpetuate problems and restrict options for alternative solutions (Wright et al 1996:5).

For the purposes of this thesis and the research question, beliefs are seen to reside in cognition, in emotions and in behaviour, and engage the body in particular emotional states by employing specific metaphors, stories and practices in particular contexts (Griffith & Griffith 1994:133, 2002:144). These stories are not isolated events, but are the basic 'units of human experience' (Griffith & Griffith 1994:34). Wright et al (1996:37) echo Cousins' argument that 'beliefs become biology', something which has great relevance for eating disorders, because the 'truth' entertained by the discourse is internalized in structuring the perception of reality. Because of its embeddedness in the physical state of the body, these beliefs constrain and 'threaten a spirituality of relatedness', particularly relatedness, between the self and the body, others, nature and God (Griffith & Griffith 2002:146). Constraining beliefs which conserve or maintain the illness are repeated and become a lived reality, as these experiences become part of the narratives which structure not only the body, but also life (Griffith & Griffith 2002:146; Wright et al 1996:23). For the story to endure, the body remains in pain (Griffith & Griffith 1994:38).

2.6.3.2 *Stories: freeing or constraining the body?*

The place of the self or spirit, situated in discourse and the ways in which interaction between self and world is made possible, is represented in language. Gubrium and Holstein (2000:495) maintain that language is not just more or less correlated with what it represents, but is already a 'form of life'. Individual engagement between the self and the world demands the application of the entire self in understanding the world, so that human/environment interaction is not only dialogical, but also relational and embodied (Burns 2003:230-231; Canciene & Snowber 2003:244; Griffith & Griffith 1994:120; Hess 2003:144; Kirmayer 1992:330). In this regard, White and Epston (1990:42-44) write that our sense of self (our spirituality), as we come to know it, emerges when interpersonal conversations are internalized, which are then organised into stories that we use to understand our experiences. To this effect, narrative is an epistemology providing insight into cognitive and affective dimensions of experience, so that narrative coupled with relationship is foundational to relational narratives and a configuration of the self (Hess 2003:141). Identity and meaning are constructed by the stories we tell about ourselves, and that others tell about us, with language as the vehicle creating and re-creating our world.

In order to explain the association between language, the body and spirituality, narrative is understood to emerge from the lived realities of bodily conduct, rather than through other means, such as the recollection and acknowledgement of past experience (Peterson & Langellier 2006:174). Emotions (spirituality) acquire meaning by being situated in a narrative plot, becoming functional in and through the body (Gonçalves & Machado 2000:352). Gergen and Gergen (2006:119) state that within a social constructionist perspective, narratives are discursive actions and gain significance from the way in which they are employed within relationships. Therefore, although the source of narrative is employed within social relationships, narratives are absorbed into one's personal functioning when used with some frequency and become embedded in certain courses of action so that one comes to live the narrative.

As the tie that binds together cognitive and affective dimensions of experience (Day 2002:74), narratives are incorporated within and regenerated through the body across time and space, so that stories are told in and through the body (Petersen & Langellier 2006:175; Smith 2007:395). The storyteller is positioned as the narrator, while simultaneously occasioning emotions and living the experience within and through the story (Charmaz 2002:315). Through narrative, the body participates in speaking and listening, reading and

writing, seeing and gesturing, and feeling and being touched, so that in the process of meaning construction, as we interact and communicate with our bodies, we perform an action within relationship. Youngblood-Jackson (2004:680) believes that language engages us to perform an action that conforms to an established model within a discourse. Language then does not reflect the intention or action of the individual; language as social practice produces the discursive possibilities of performance where the 'doer' becomes a product of that language. The reason for this is that knowledge or meaning is not something which exists within each individual mind, it is rather the relationships that we are in that construct meaning, with the body giving rise to meaning, and meaning in turn influencing the body (Hermans 2002:125).

Wallace (2002:103) shares Gergen's view that 'when I perform I am carrying a history of relationships, manifesting them, expressing them'. Gergen's words suggest that the self is positioned in a complex construction of discourses and relationships, so that individual spirituality is not only constructed but also performed, as the self is continually challenged to remodel itself in this web of interaction by creating and recreating itself in daily interactions through discursive positioning. Although the eating disorder is socially defined, it becomes subjectively lived as vulnerability (spirituality) (Gadow 2000:90), because emotions are embodied thoughts (Kirmayer 1992:330). The brokenness in the relationship between self (spirit) and body of the person struggling with an eating disorder gives form to bodily postures of withdrawal and alienation experienced as disconnection, not just between self and body, but between the self and the world, which is indicative of a wounded or disabling spirituality – the main idea of this thesis.

The bodily presence of isolated disconnection can be a barrier to clinical empathy, and those in caring positions feel at risk when the client's emotional distress becomes too overwhelming. Reynolds, Scott and Austin (2001:236) observe that the knowledge needed for ethical care is constructed when professional and patient strive together to understand what meaning the illness has within the experience of the patient. This point is further argued and developed in Chapter Eight, where I discuss my own model of practice.

2.6.4 Spirituality – when the connection between mind and body produces or resists illness

The pertinent question now is how the felt sense of bodily experiences (spirituality) becomes enabling or disabling for a person, and influences the body to heal or remain ill.

2.6.4.1 Reality is constructed and felt

Arguing for the significance of spirituality in our well-being, I wish to emphasise that human actions and experiences, evident in illness symptoms, are not open to being empirically identified or theoretically explained if they are abstracted from the context of the human life-world, or the reciprocal influence between individuals and their environment. That is, human experience cannot be comprehended by means of consciousness or ways of thinking that separate the body (Carr 2010:1381; Corbin 2003:258; Griffith & Griffith 1994:133, 2002:144; Hess 2003:144) because reality does not exist in a ready-made form: we 'construct' it (Ravn 1991:98). In order to understand the process, the role of perception, experience and expression in the construction of reality, together with the effect on the body towards the manifestation of illness, becomes significant.

Cowling (2000:24) considers perception, experience and expression to be sources of 'pattern formation' and 'facets of pattern', so that experience (in the form of individual spirituality) involves sensing and being aware as sources of knowledge. What is good in life in terms of 'experience' cannot be determined objectively, but must be experienced as such (Ravn 1991:103). Perceiving something and experiencing something cannot be separated; perception is conscious knowing in the midst of experience, and to express the experience is to manifest it (Cowling 2000:24).

2.6.4.2 The dynamics of world-design: the situatedness of felt experience

Cowling's 'pattern formation' rests on what Binswanger (1958:211) describes as 'the dynamics of world-design', which has great relevance because of the implications of freedom of choice and transcendence for a person in creating his or her world. Following Binswanger, emotions, thoughts, feelings and moods are not properly described as long as we neglect to set out how the experience of these emotions is in the world, or 'has' world and exists. This implies that we as caregivers cannot understand the individuality of patient suffering unless we endeavour to understand the world of the person struggling with an eating disorder, the 'how' of relatedness and the construction of meaning. When it comes to world-design, in line with Heidegger (1962), Johnson (2000:137) states that world is not a 'thing', but rather the totality of entities that exist in our environment. The world is the interconnected context of involvements that gives meaning to everything one encounters, an interlocking pattern of relations. Hence a 'world-design' is also self-design, understood as potential modes of being

for the self, expounded on in forms of situatedness in discourse, ways of being in the world (spirituality).

2.6.4.3 The self, spirit and body mediating illness

As the life force motivating action, the self or spirit is an entity distinct from the body, but not opposed to it. The self or spirit is not merely consciousness mediated into dialogue; instead, the self or spirit is also embodied. The body is not capable of generating its own aims, but is the means whereby the self (spirit) enacts its aims (Corbin 2003:258; Gadow 1982:93). With the self (spirit) experienced as free subjectivity, the body becomes its vehicle and instrument, so that the self (spirit) makes possible the body as meaning (Corbin 2003:258; Gadow 1982:89). It is the experience of lived bodiliness that constructs a mode, or set of modes, which orientates the self (spirit) towards a way of being in the world (Corbin 2003:258; Gadow 1982:88; Rao 2006:50).

Gadow (1982:91) writes that the body does not develop certain modes of being to suit itself, but rather the body is presented with these modes by virtue of human interaction in the world. To this effect, the body becomes the source of, the location for, and the means by which a person is emotionally and physically positioned within and towards society (Corbin 2003:258; Frank 1991:61, 1995:50; Smith 2007:395), providing understanding of spirituality as lived experience. At the same time, the emphasis is on the body and the self (spirit) in a 'fateful embrace' (Corbin 2003:258) – what happens to one affects the other. Suffering, as something more than physical in chronic illness, is also emotional and spiritual because the self (spirit) is affected by what happens to the body (Corbin 2003:258).

2.6.4.4 Spirituality: the link in mind-body illness

Situating eating disorders within the framework of mind-body problems, understood as arising in the interface between the mind and body, Griffith and Griffith (1994:63) suggest that many such problems are experienced by the ill person as 'having no voice' due to the power of the illness, arising from within emotion (in the realm of the spirit) due to a problem of 'fit' between relationships. Of particular importance here is the felt sense of disassociation between self and body experienced by a person struggling with an eating disorder. Spirituality as relational embodiment is expressed not only through language, but also in the immediacy of bodily experiences (Griffith & Griffith 2002:57), because experience consists not only of words and sentences, but is felt in the sensations and movements of the body.

People not only ascribe to discourse, they also enact or perform the discourse in behaviour, as well as in spoken words (Griffith & Griffith 2002:63). These authors agree that mind-body problems are the performance of this dilemma with the mind and body interacting to produce illness, often holding the body in a 'symptom producing' bind.

In support of my argument that spirituality is embodied existence and that spirituality can be problematically engaged, Smith (2007:395) observes that bodies are not just represented by what they do, but are created in the stories they tell and witness. The body is therefore these modes, coupled with language which further constructs a way of being in the world (Charmaz 2006:314; Hermans 2002:117). To this effect, Gubrium and Holstein (2000:503) caution us that the everyday realities of our lives, whether normal or abnormal, are realities we are involved in which produce, time and time again, the worlds we inhabit. Hence, with relevance to the research question, consciousness (spiritual awareness) constructs the world as much as it perceives the world (Gubrium & Holstein 2000:488).

It then follows that beliefs, situated within social discourse, together with perception, cognition and experience, construct a 'world' for a person with an eating disorder, exerting meaning in the relationship between the body and the self, giving effect to bodily postures of withdrawal and alienation, indicative of a particular reality (spirituality) that is being lived (Griffith & Griffith 2002:63). Then the 'problem' becomes the dilemma and stories attached to it, rather than the patient, so that storied experiences hold great power for freeing or constraining the body. Moreover, these self-narratives seem able to dominate a person only when the body is set in a specific state of being, as long as it can draw strength from the specific emotional posture embodied in a specific physiological state (Griffith & Griffith 1994:59).

Given the context in which the illness flourishes, the physiological state induced by starving the body also keeps the body in an emotional (spiritual) bind as long as the body is rebuked and held accountable for past failures. A self-narrative that so constrains the body becomes familiar to such an extent that the ill person 'knows' it as a valid account of 'reality'. Then the personal narrative does not merely reflect illness experience, but rather contributes to the experience of symptoms and suffering (Kleinman 1988:49). The patient knows her suffering, but remains confused, as she does not recognize the source from which it flows. Given this situation, the relevance of pattern formation becomes important, particularly because of the implications of freedom of choice and transcendence being coupled with and giving effect to a particular world-design. Politically, this also presents the recognition that she could enact

other possibilities or follow alternative directions, although the apparent organisation of her life might appear to make that impossible.

2.6.4.5 The missing link to healing: transcendence as a dimension of spirituality

As a dimension of spirituality, transcendence is explained as ‘the dynamic force that keeps a person growing and changing, continuously involved in a process of emerging, becoming and transcending of the self’ (Goddard 1995:809). Binswanger (1958:211), who is influenced by Heidegger, stresses that the unity of being which emerges in an open process of continuous interaction between self and world (as opposed to a dichotomous relationship), is evident in transcendence. Transcendence gains significance through Existentialist and philosophical thought, where it is considered a ‘sacred space’ creating the distinction between humans and animals, based on the ability to exercise choice. Whereas animals are seen as tied to an innate blueprint, referred to as a ‘function or situational circle’ (Binswanger 1958:197) humans are granted freedom of choice, and hence the ability to transcend immediate situations. Significantly, human existence affords the possibility of choosing between different potentialities of being through a diversity of world designs. This fundamental condition which makes freedom of choice possible, coupled with the ability to transcend immediacy, is referred to by existentialists and philosophers as ‘subjectivity’, and is expounded on in this thesis as spiritual awareness or spirituality, underscored by or expressed as healing from within.

2.7 CHAPTER OVERVIEW

In order to argue the research questions, in this chapter I explained my understanding of spirit and spirituality in order to give effect to the mind, body, spirit *relation*, understood as spirituality, in structuring all forms of experience as embodied knowledge. I situated spirituality as embodied and relational experience, the medium which gives effect to all forms of knowledge constructed through interaction between self and world. I based my argument for spirituality on the teachings of Heidegger and those who followed on from him, and who emphasise the concept of ‘being-in-the-world’ as existence.

When spirituality is defined in this way, the integration of spirituality as a component of holistic care becomes important. Although considerable strides have been made through large organisations which have funded ongoing research in this area of caregiving (discussed under point 2.2.1.), spirituality is still largely neglected. Due to the perspective

held by many operating within the biomedical model, which regards spirituality as not fit for integration, spirituality is largely overlooked when it comes to clinician/patient health encounters.

Against this background, I touched on shifts from the framework of modernist thought towards an understanding of knowledge as local, contextual and embodied. Of note are the changes in perception in the discipline of mind/body medicine which acknowledge thoughts and emotions as affecting the physiology of the body in health and illness. Despite attempts to bridge the separation between the mind and the body brought about by Cartesian dualism, this field of medicine still lacks explanations of the interplay of thought and emotion: *how* the one affects the other, as well as an understanding of where emotions are situated. If emotions are situated in the mind, we revert back to Cartesian dualism and its disregard of embodied knowledge.

On the basis of my understanding of spirituality as embodied knowledge, I argued for postmodern approaches to illness which situate the human body as actively involved in the world, giving effect to all forms of knowledge in terms of what is felt in the spirit, hence spirituality. In consequence, I unpacked the social construction of beliefs in discourse together with the processes of cognition, perception and experience culminating in a particular world-design. I then focused on the role of language in shaping what we know whilst giving effect to embodied knowledge becoming lived reality. A person struggling with an eating disorder gives effect to these knowledge in 'performing' the illness, with spirituality expressed and lived in the immediacy of bodily experiences. I also discussed freedom of choice and transcendence as dimensions of spirituality, crucial in an understanding of the reconfiguration of discourse in opening up space for the construction of an alternative reality, bringing forth healing from within.

In Chapter Three, I discuss the treatment of anorexia/bulimia within the framework of both modern and postmodern approaches. I emphasise the notion of human vulnerability in the development of illness, in order to situate the role of spirit and the concept of a wounded self (spirit) as manifesting a disabling spirituality, embodied in anorexia/bulimia as ritual and addiction. This discussion goes further to highlight that healing is a unique, individual experience perceived as ongoing and open, with the self coming to know itself in new and more empowering ways through the development of coping mechanisms which are crucial to recovery.

CHAPTER THREE

TREATMENT APPROACHES TO ANOREXIA NERVOSA/BULIMIA: SITUATING THE STORY OF THE WOUNDED SELF IN ILLNESS

3.1 INTRODUCTION

Anorexia nervosa is a complex disorder of unclear aetiology (Hebebrand, Treasure & Schweiger 2004:827; Tozzi et al 2003:143). According to Lock and Gowers (2005:599-600), anorexia nervosa was first mentioned in the medical literature in 1873, by Gull and also by Lasègue. However, despite this recognition of the illness as early as the late nineteenth century, the illness has remained intractable, since between six and 15 percent of patients still die (Lock & Gowers 2005:599-600).. It is regrettable that despite the progress of medical science, a clear understanding of the illness remains elusive, and effective treatment strategies have been slow to evolve (Carney et al 2006:65; Lock & Gowers 2005:599,600). The high cost of medical treatment, including hospitalization, needs further consideration, as the psychological and societal costs of these interventions remain significant (Lock & Gowers 2005:607). With a lack of positive scientific evidence as to the cause(s) of anorexia nervosa, the success of medical and/or psychotherapeutic intervention in altering the prognosis for someone with the condition remains uncertain (Hebebrand et al 2004:827; Lock & Gowers 2005:599; Ben-Tovim et al 2001:1257).

The chapter focuses on anorexia/bulimia in the context of a disabling spirituality. In the chapter, I direct attention briefly to the medical model of treatment, and look at postmodern approaches employing the narrative metaphor. I highlight the shortcomings currently experienced in these approaches, with a view to improving the theory on, the practice regarding and the treatment of the illness.

In the second part of the chapter I explore the vulnerability of people suffering from anorexia/bulimia, given the construct of a wounded self, in order to throw light on meaning-making strategies and lived experiences. I explore the process of healing as a journey, embracing the physical, social and spiritual dimensions of recovery.

3.2 CLASSIFICATION OF THE EATING DISORDERS

Eating disorders comprise a diverse group of illnesses, which include anorexia nervosa, bulimia nervosa, the binge eating disorder, and other non-specific eating disorders (Carney et al 2006:1). Anorexia nervosa and bulimia nervosa, more commonly referred to just as the main eating disorders, have been studied and investigated using a medical frame of reference and are classified as a mental illness (Patching & Lawler 2009:20). The dominant meaning ascribed to the term anorexia nervosa is rooted firmly in the scientific positivist tradition, based on a model of physical disease and psychological disorder (Carney et al 2006:38).

As with many other psychiatric presentations, the two classification systems commonly used for the categorization of the eating disorders are those of the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV) 1994 and the ICD-10 (World Health Organisation, 1993). The DSM-V is scheduled to be published in 2012, eighteen years after the DSM-IV criteria were released and twelve years after the text was revised as the DSM-IV-TR (Walsh 2009a:579). Both these classification systems use the term 'anorexia nervosa' to denote a full syndrome presentation, whereas patients presenting with symptoms that do not meet all the criteria are diagnosed in the DSM-IV system as suffering from an 'eating disorder not otherwise specified' (EDNOS) and in the ICD-10 as having 'atypical anorexia nervosa' (Bryant-Waugh 2006:76).

Anorexia nervosa is widely known as a disease of self-starvation, characterized by a relentless pursuit of thinness, often resulting in a dangerously low body weight. Bulimia nervosa is commonly known as the binge syndrome, typified by a pattern of gross overeating, followed by compensatory behaviour such as self-induced vomiting (Patching & Lawler 2009:11). Of the various eating disorders, anorexia nervosa, which affects between half and one per cent of all women, has the highest mortality rate. Because it is a life-threatening condition which mainly affects adolescents and young adults, anorexia nervosa is viewed very differently from the other eating disorders because of poor information on its aetiology; and there is an ongoing debate on how best to respond to the illness (Carney et al 2006:1). Ramjan (2004:496) indicates that, according to the National Mental Health Strategy (Australia) (NMHS 1998, 2000), those suffering from an eating disorder are obsessed with having control over three issues: their eating habits, their body weight and food. The typical progression of these disorders includes irrational thinking patterns, increased rigidity

regarding eating habits and a gradual withdrawal from society (D'Abundo & Chally 2004:1103).

In recent years, there has been growing dissatisfaction with the current criteria of classification, as many patients of all ages who have presented for treatment fall into the 'not otherwise specified' or 'atypical' category, resulting in a strong movement lobbying for change (Bryant-Waugh 2004:76). Practical difficulties continue to exist in applying strict diagnostic criteria to younger individuals, particularly when it comes to reliably confirming the presence of the core psychopathology of anorexia nervosa (Bryant-Waugh 2004:77). Furthermore, despite the usefulness of the categorization systems, it is important to respect the fact that across many different qualitative studies undertaken, participants were of the opinion that applying such emphasis to categorization devalues the experiential perspective of living with an eating disorder (Matusek & Knudson 2009:703; Patching & Lawler 2009:11).

3.3 TREATMENT APPROACHES WITHIN THE MEDICAL FRAMEWORK

Despite extensive research exploring the aetiology of eating disorders, there appears to be little progress in understanding these illnesses or in developing a successful programme of management (Carney et al 2006:66; Patching & Lawler 2009:10). Disagreement regarding the aetiology of the eating disorders have affected methods of treatment. The range of individually focused psychological treatments include psychodynamic psychotherapy, interpersonal psychotherapy, developmentally oriented individual therapy, cognitive behavioural therapy, dialectical therapy, nutritional therapy and, recently, cognitive remediation therapy. Even with limited evidence, the adherents of each particular school of psychotherapy have been the strongest advocates for their respective approaches (Lock & Fitzpatrick 2009:289).

According to Bryant-Waugh (2006:76), even the *National Clinical Practice Guidelines on Eating Disorders* issued by the National Institute for Clinical Excellence (NICE 2004) and the British Psychological Society, London, admit that 'the body of research into the treatment of anorexia nervosa is small and inconsistent in methodological quality. The conclusions that can be drawn are limited' Almost exclusively, research has been conducted using a medical/diagnostic approach, within which framework data collection is derived from brief, self-report questionnaires or structured clinical interviews (Patching & Lawler 2009:10). This paradigm fits in neatly with the diagnostic template for understanding the eating disorders;

however, it remains a reductive approach which tends to provide a fragmented picture and pathologises the experiences of the sufferers (Patching & Lawler 2009:10).

It is beyond the scope of this project to discuss all these different approaches critically. Hence, I only briefly unpack particular approaches considered helpful by clinicians within modernist medicine because these approaches relate to research, treatment and recovery. Treatment approaches within the medical framework do not acknowledge the lived realities of those struggling with anorexia/bulimia, and fail to address the spiritual or experiential realities of the illness. A clearer understanding of the development of the condition is imperative in order to arrive at an appropriate methodology and meaningful findings (Patching & Lawler 2009:10).

3.3.1 Cognitive-behavioural therapy

Wilson and Fairburn (1993:262) explain that the development of the model for cognitive-behavioural therapy (CBT) was based on a cognitive model of bulimia nervosa developed by Fairburn (1981), and adapted from Beck's cognitive therapy for depression.

CBT is aimed at initiating changes in cognitions that are considered dysfunctional rather than behavioural. It follows from this model that the modification of abnormal attitudes regarding weight and body shape, together with the replacement of dysfunctional dietary restraint with more normal eating patterns, should be the primary objectives of treatment. CBT is a mix of both cognitive and behavioural procedures. If it is assumed that one's thinking has an effect on one's behaviour, then CBT would be expected to exert an indirect influence on behaviour (Wilson & Fairburn 1993:262). However, in clinical practice, particularly with regard to anorexia nervosa, these two treatment strategies are often combined with behavioural programmes to promote healthier attitudes, and cognitive therapy to modify the maladaptive thoughts that sustain them (Carney et al 2006:54).

Although emphasis is placed on behavioural change during the early stages of treatment, the cognitive view of bulimia nervosa is repeatedly related to the particular problems of the patient. During the second stage of treatment, patients are taught to identify and alter dysfunctional thoughts and attitudes concerning shape, weight and eating habits, so that change is achieved by patients' engaging in behavioural experiments designed to challenge dysfunctional assumptions. The third stage entails relapse prevention strategies to ensure ongoing change following treatment (Wilson & Fairburn 1993:262).

More recently, according to Carney et al (2006:56), the Oxford Group – Fairburn, Cooper and Shafran have recommended the adoption of a trans-diagnostic theory and treatment by implementing a new and enhanced cognitive behaviour model (CBT-E) to provide refinements to CBT. Such a move was advocated because of self-apparent commonalities between anorexia nervosa and bulimia nervosa, when viewed cross-sectionally. Although the development of new and innovative strategies geared to better treatment for patients is commendable, the clinical effectiveness of this new, enhanced CBT has yet to be determined. Carney et al (2006:56) are of the opinion that although CBT-E may be beneficial for bulimia nervosa patients, there is some doubt that the model will be as effective when treating more resistant cases of anorexia nervosa.

It is not clear why CBT is effective. There has been little experimental work regarding its action, and the findings of treatment studies provide only indirect evidence regarding its mechanisms (Wilson & Fairburn 1993:265). CBT is considered an appropriate approach for all eating disorders, but has been more extensively used in the treatment of bulimia nervosa and far less widely in cases of anorexia nervosa (Fairburn & Harrison 2003:413; Wilson & Fairburn 1993:262). There have been few controlled studies on the treatment of anorexia nervosa or atypical eating disorders, with the result that many of treatments have little or no evidence to support them (Fairburn & Harrison 2003:413). Although CBT appears to be superior to therapy with anti-depressant drugs, CBT has not yet been demonstrated to be consistently more effective than other psychological treatments (Wilson & Fairburn 1993:261).

3.3.2 Individual psychological therapies

There have been a number of individual studies on adults with anorexia nervosa, including studies on the use of CBT and Individual Psychological Therapy, nutritional counselling and other psychodynamic therapies. However, none of these reports suggest that these individual treatments are particularly effective and no data to support their suitability for younger adolescent patients is available (Lock & Gowers 2005:602). Although there are a number of studies on psychological therapies in the recent eating disorder literature, methodological issues make it difficult to compare the results from different studies, as these are often conducted on patients who are also receiving other treatments alongside the specific therapy of interest. The NICE (2004) guideline also concluded that there was insufficient evidence from trials to suggest that any particular specialist individual

psychotherapy was superior to others in the treatment of adult patients (Lock & Gowers 2005:603).

Although it is not considered a form of psychotherapy, nutritional counselling has frequently been used in treating adolescent anorexia nervosa, as an adjunct to either medical care or individual psychotherapy. Again, in cases where data is available, those in various studies have not responded well to this intervention on its own, so that data on the effectiveness of dietary counselling in adolescents remains inconclusive (Lock & Gowers 2005:603).

3.3.3 Family approaches

There is insufficient data at this time to suggest strong and unmistakable support for any specific treatment for adolescent anorexia nervosa, though family therapy appears to be the most promising (Lock & Gowers 2005: 607). According to Lock and Gowers (2005), the earliest formulation of family approaches were those by Minuchin and his colleagues who described family treatment as addressing the dilemmas of anorexia nervosa in the context of the so-called psychosomatic family. Minuchin regarded the person with anorexia's family as 'inflexible', 'enmeshed' and 'over protective', so these family characteristics were believed to lead to the evolution of psychosomatic illnesses, and anorexia nervosa in particular, thereby suppressing individual autonomy and emotional expression. He believed that an inappropriate bond between adults and children leads to challenges to parental authority. Minuchin's work was not peer-reviewed and lacks controls, so that considerable uncertainty remains about the effectiveness of structural family therapy for anorexia nervosa (Lock & Gowers 2005:604).

In addition to Minuchin's work, there were the trials based on family therapy that evolved from the Maudsley Hospital's approach in the 1980s. The approach focuses on familial management of the symptoms of anorexia nervosa and the consequences for the patient and her family, rather than on any underlying pathological behaviour inherent in the patient and her family. Instead of viewing the family as being at the heart of the development of the eating disorder, the Maudsley approach collaborates with and instructs parents to take up the task of re-feeding their child, whilst preventing severe dieting, purging, over-exercise and other related problems (Lock & Gowers 2005:604).

The empirical base supporting Family Therapy at the Maudsley Hospital, though limited, is considered to be at the forefront in the treatment of adolescent anorexia nervosa. Moreover,

despite difficulties and limitations, the approach is considered generally convincing and has been recognized as such by different authorizing bodies. At the same time, the advantage of Family Therapy over other strategies remains uncertain (Lock & Gowers 2005:605). Treatment approaches developed from the conventional diagnostic/biological/medical model are formulated on the modernist approach, so that the model provides minimal acknowledgement of the social and human aspects of the condition, which hinders appropriate treatment and recovery regimes for those struggling with anorexia/bulimia.

Dignon et al (2006:943) claim that psychiatrists normally identify the family (and its individual members) as the 'cause' of the disorder. The family is viewed as controlling and as failing to equip the adolescent for adulthood, so that she develops a fear of growing up, with ongoing difficulties adjusting to the adult female role. Such a perspective sees the development of an eating disorder entirely at the level of the individual patient and fails to recognize socially constructed feminine identity (especially in the Western world) as potentially problematic (Dignon et al 2006:943).

3.4 PROBLEMS CONCERNING TREATMENT WITHIN THE MEDICAL FRAMEWORK

In this section, I consider recovery, diagnosis and coercion within the medical model with the view to stimulating dialogue in favour of a more collaborative approach.

3.4.1 Recovery

Although the question of how many patients recover from an eating disorder is important, no clear answer can be given, because there is no consensus on the definition of recovery (Noordenbos & Seubring 2006:42). Most information attained concerning recovery is from the outside perspective of investigators and clinicians, who see recovery in the light of behavioural responses, such as weight restoration, the duration of a symptom-free state and improved scores on clinical instruments (Weaver et al 2005:189). Research also indicates significant differences in the reported rates of recovery, varying from 24 to 76 per cent, due largely to the definition of and criteria for recovery (D'Abundo & Chally 2004:1095). Specific variables found to predict recovery include having a higher percentage of ideal body weight at the time of clinical presentation, a shorter duration of the illness before treatment, together with improved relationships with family and friends (Weaver et al 2005:189). These variables continue to cause much debate regarding what exactly needs to occur for the individual to be considered to have recovered from an eating disorder (D'Abundo & Chally 2004:1095; Weaver et al 2005:189).

Reported recovery rates are further influenced by methodological procedures, including follow-up, the time elapsed before such evaluation, sample characteristics, the constructs of recovery and attrition rates (D'Abundo & Chally 2004:1095; Weaver et al 2005:189). Alarming, although methodological differences affect reported rates of recovery, many people are not recovering from eating disorders (D'Abundo & Chally 2004:1095). A 'cure' or complete re-instatement of health is rare in cases of anorexia nervosa (Ramjan 2004:496). This trend is apparent in patients who discontinue destructive behaviour, but continue to exhibit psychiatric problems and impairments in social and occupational functioning. Even those who receive extensive medical monitoring, medication and psychiatric treatment are not 'cured' within the framework of the medical model (D'Abundo & Chally 2004:1095), as was evident in the prologue to this study.

The aim of modern diagnosis is to be descriptive and non-judgemental, including only criteria that are based on firm scientific evidence. In this regard, Fairburn and Harrison (2003:414) admit that the existing standard for classifying eating disorders is unsatisfactory and anomalous, in that approximately half the cases seen in clinical practice are relegated to an atypical or not otherwise specified group. Another problem that affects treatment and recovery is that, as Hebebrand et al (2004:827) argue, the current DSM-IV criteria do not describe the principal symptoms of the eating disorders adequately. That is, the DSM-IV criteria reflect a 'paternalistic attitude' because the clinician imposes his or her interpretation on the patient's behaviour, instead of merely describing the behaviour. Hebebrand et al (2004) base their reasoning on the lack of empirical evidence supporting the terminology relating to some of the criteria which underlie the current conceptualization of the eating disorders. The same authors concluded that persons people struggling with an eating disorder have an energy intake too low to maintain a body weight within the normal range. In their opinion, the disorder is not due to a lack of appetite as the term anorexia would seem to suggest, as no central or peripheral regulatory system has been found to be specifically compromised (Hebebrand et al 2004:827). They also suggest that research would benefit if each patient's symptoms were more accurately and reliably assessed (Hebebrand et al 2004:835).

3.4.2 Diagnosis and its impact on recovery

A distinction between mental and physical illness is still made, both by the lay public and by many doctors, and the terms 'mental disorder' and 'mental behavioural disorder' are still employed in the two most widely-used official nomenclatures, the World Health

Organization's (WHO's) International Classification of Diseases (ICD) and the American Psychiatric Association's (APA's) Diagnostic and Statistical Manual (DSM) (Kendell 2001:491). The classification of the eating disorders as a mental illness has the unfortunate effect of perpetuating two assumptions, namely that mental disorders are disorders of the mind, rather than the body, and that these disorders are fundamentally different from other illnesses (Kendell 2001:491). It is not possible to identify any characteristic features of either the symptomatology or the aetiology of so-called mental illnesses that consistently distinguish them from physical illnesses. Nor do the so-called physical illnesses have any characteristics that distinguish them reliably from mental illnesses (Kendell 2001:491).

Given the above concerns, why do we still refer to illness as either 'mental' or 'physical'? Kendell (2001:491) believes that the answer is provided in the introduction to the current (1994) edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV):

The term mental disorder unfortunately implies a distinction between 'mental' disorders and 'physical' disorders, that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much 'physical' in 'mental' disorders. The problem raised by the term 'mental disorders' has been much clearer than its solution, and unfortunately, the term persists in the title of DSM-IV because we have not found an appropriate substitute.

The linguistic distinction between mental and physical illness, given the mind/body dualism from where it was originally derived, strengthens the assumption amongst health professionals and the public alike that the terms are fundamentally different. It is often assumed that developing a 'mental illness' is evidence of a lack of moral fibre and that people with this kind of illness ought to control their anxieties. Not only does the distinction between mental and physical illness have no factual basis, it is also damaging to the long-term interests of patients, because of the label of a 'flawed' identity and the stigma created by the diagnosis (Kendell 2001:492).

3.4.3 What do we know about coercion – does it work?

There are potentially many benefits to admitting a severely ill young person to hospital. These include physical health monitoring, the introduction of normal eating habits leading to weight restoration, together with therapeutic assistance and support. However, the extent to

which admission improves these areas, particularly when treatment is perceived as coercive or where the emphasis is on the service taking control, has not been adequately studied.

A number of academic bodies have published guidelines. Two deal specifically with the medical management of children and adolescents; National clinical practice guideline, London (NICE 2004) and the American Psychological Association (APA 2000). These guidelines draw attention to the additional medical risks pertaining to this age group, particularly where there are medical complications without significant weight loss, the management of re-feeding, a lack of agreement of the rates and types of refeeding procedures and a lack of consensus concerning in-hospital weight goals (Lock & Gowers 2005:600). At the same time, engaging with a young person who may not regard herself as ill (but is still unwilling to gain weight) challenges the therapeutic alliance for both clinician and patient, particularly when the patient is regarded as resistant to treatment, causing ethical dilemmas due to her deteriorating health. Neither clinicians nor the law can entirely make up their minds about whether coercion has a place in clinical practice for those suffering from anorexia nervosa (Carney et al 2006:7).

Despite the methodological challenges, some research has been undertaken on the clinical efficacy of various types of coercion within treatment (Carney et al 2006 67-79; Ramjan 2004:495-503). In a study done by Ramjan (2004:495-503), the central dilemmas of coercion in all its various guises, and fraught with ethical challenges, were explored, highlighting the management of re-feeding and nutrition from the perspectives of the patient struggling with anorexia nervosa, and that of the clinical teams charged with this management.

Nursing participants in Ramjan's study (Ramjan 2004:498-500) regarded their work with anorexia/bulimia patients 'as a waste of time', because they believed that the patients had caused the harm to themselves and were therefore responsible for 'fixing' it themselves too. Other ('normal') patients were considered to be more in need of care. However, nurses followed the programme even when they were not convinced of its value. The extremely controlling nature of the programme led to rebellion by the patients, who were then perceived as 'manipulative'. As a result of the power play between the nurses and the patients, both groups felt they were continually struggling for control, which led to mistrust, something which severely hampered the therapeutic alliance. The main arena for conflict was food. On the one hand, patients regarded nasogastric feeding as 'punitive'. They attempted to 'sabotage' it – the patients fighting 'tooth and nail' to regain control over their predicament. Nurses, on the other hand, saw themselves as 'jailers', casting patients metaphorically as

'criminals' who 'did their time', and who had to 'eat to get out of prison', or who were 'repeat offenders', returning to 'prison' with 'suspended sentences'.

Ramjan (2004:501) comments on the lack of mental health education for nurses, using Geanello's description of the 'displacement of emotionally disturbed adolescents into services that are not age appropriate and whose staff are inadequately prepared to work with them'. Placing adolescents struggling with anorexia nervosa in institutionalized care is one of the problems inherent in a hospital system. A person entering a coercive environment such as a psychiatric hospital undergoes a transition from being an ordinary citizen to becoming an in-patient. Drawing on Goffman and his description of a mental hospital of the 1950s, Carney et al (2006:124) observe the evidence of patient transition when new patients give up one role and take on another by adopting what Goffman calls the 'patient role', together with an acceptance of the diagnosis if they wish to survive, with enforced adjustment to the rules of the new environment.

Coercive treatment has a number of physical and psychological management problems at ward level. Staff can feel disconcerted by an imminent death situation in the ward, whilst patients feel violated by enforced nutritional rehabilitation. Wanting to help patients and patients resisting treatment constitutes a powerful and negative barrier to the therapeutic alliance. Treating adolescents with anorexia nervosa in acute care situations with behavioural and medication programmes clearly creates difficulties for nurses, and is not conducive to the establishment of therapeutic relationships (Ramjan 2004:501).

It is an impediment to the treatment of patients that most hospital staff have had no training in anorexia nervosa management. There are also no guidelines to practical treatment management in nursing worldwide, although specific courses in eating disorders are now being delivered for nurses in the United Kingdom (Carney et al 2006:118). Consistent nursing strategies in consultation with management are required. Clinical supervision is vital for staff to review their own projections, transferences and counter-transferences. Yet most units administering care to eating disorder patients lack formal supervision (Carney et al 2006:120). There also appears to be limited evidence available regarding the mental health literacy of primary care clinicians dealing with eating disorder patients (Currin, Waller & Schmidt 2009:453).

3.4.4 Seeking collaborative interaction

According to Currin et al (2009:453), Jorm and colleagues define 'mental health literacy' as 'knowledge and beliefs about mental disorders which aid their recognition, management and prevention'. Little is known about the beliefs and attitudes of people administering primary health care, particularly about how such knowledge and attitudes influence clinical practice. It is well recognized that society in general has little sympathy for those suffering from any eating disorder, regarding such patients as responsible for their own problems. These negative sentiments are also evident among health care professionals (Currin et al 2009:453).

Although the legal framework of 'coercive' powers has a place in the management of patients with anorexia nervosa, clinical and other interventions or services will have an optimal impact if there is a full appreciation of the social, political and spiritual dimensions of this illness (Matusek & Knudson 2009:700; Patching & Lawler 2009:20; Weaver et al 2005:203). It is considered vital for patients to be empowered and consulted throughout the duration of treatment. Patients interviewed after recovering from an eating disorder regarded one of the most helpful factors in aiding their recovery to be the opportunity to talk to someone who tried to understand them (Patching & Lawler 2009:17). Therapeutic alliances are essential in treatment if recovery is to be achieved (Gadow 2004:377; Griffith & Griffith 2002:106; Patching & Lawler 2009:20; Wright 2002:129).

Although clinicians believe in collaboration, there appears to be a discrepancy between professionals' and patients' perceptions of how this is to be achieved. Practitioners need to reflect on how best to continue collaborative engagement with patients to promote fair, reputable treatment (Carney et al 2006:119; Matusek & Knudson 2009:705).

3.5 THE NEED FOR NEW STRATEGIES

Our concern with physical health is understandable, given the influence of seventeenth century Cartesian dualism, separating mind and body. The subsequent development of physical medicine and the emergence of the public health and health education professions that primarily target the prevention of physical illness was perhaps foreseeable (Hawks 2004:12). However, despite firm evidence that mind and body, far from being separate, are intimately connected, our knowledge of what constitutes long-term recovery from these life

threatening disorders remains largely inconclusive (Matusek & Knudson 2009:697; Carney et al 2006:66).

Clearly we need to rethink our current strategies for treating the eating disorders. Recovery rates leave us with a superficial account of the actual experience of recovery. Few people recover fully; and most (between half and 70 per cent) do not show any significant improvement (Matusek & Knudson 2009:698). Overall, even the 'best' evidence-based therapy interventions are hardly producing good clinical outcomes with only 30 to 50 per cent experiencing relief from their symptoms and/or recovery (Matusek & Knudson 2009:697-698).

The methodological approaches typically used in an effort to understand the eating disorders may get in the way of the materialization of new insights into the phenomenon (Fox, Larkin & Leung 2011:117; Patching & Lawler 2009:10). There is an urgent need for a more open investigation, in which the methodology does not impose a pre-existing format on cause and effect in order to arrive at a treatment or cure, as in the medical model (Patching & Lawler 2009:10). No holistic theory of recovery has yet been put forward, with present treatment strategies having uncertain outcomes (Weaver et al 2005:188). Furthermore, understanding the risk factors that pertain to any particular individual requires assessment of the uniqueness of each individual, rather than a pre-determined treatment plan, at the same time recognizing commonalities underlying eating disorder behaviour in those who have experienced the illness (Carney et al 2006:120; Patching & Lawler 2009:10).

In the section below, I discuss a postmodern narrative approach to treating anorexia/bulimia which explores and attempts to understand more holistically the condition from the perspective of the individual (Fox et al 2011:120; Patching & Lawler 2009:11). By looking at the broader picture, common themes and life patterns can be identified. This information can lead to collaboration on treatment goals for the eating disorders. Accordingly, research and clinical practice would be improved by removing the boundaries that exist between patients and those administering care. The gulf between research evidence and service provision also needs to be investigated and bridged; too few patients receive evidence-based treatment and too many receive inappropriate therapy.

3.6 POST MODERN APPROACHES IN THE TREATMENT OF EATING DISORDERS

Postmodern approaches to illness regard lived experiences as happening in a social context, so that knowledge about life and the self is constructed by means of social interaction. The individual is not viewed as being separate from his or her immediate surroundings, but as intimately engaged with them. Hence, postmodern theory corrects the image of a disembodied and disengaged self, and is summarized in the narrative metaphor (Jankowski 2003:243; White 2004:119-147).

Postmodern, narrative ways of working are not about categorization. Instead, they emphasise a lack of boundaries between the clinician and the client in order to make room for collaborative engagement, where the ill person's context-related experiences living with an eating disorder can be investigated (Maisel et al 2004:81; White 2004:127).

3.6.1 The narrative metaphor

Anorexia/bulimia is classified in Western culture as a mental illness within the framework of the medical model (Klump et al 2009:97). The diagnosis itself constructs a flawed identity, as the illness is viewed as inherent of the person's individuality, causing stigmatization and resulting in the patient's feeling hopeless. Furthermore, through diagnosis, the patient is marginalized, her knowledge devalued, as examination also means being subjugated to the examiner and the norm (White 2004:152-157).

Unfortunately, traditional psychiatric approaches and many family therapies reinforce the claims of anorexia/bulimia, because the very tactics the eating disorder uses to disempower women are re-enacted, instilling feelings of guilt, feelings of inadequacy and low self-worth, hospitalization (resulting in isolation of the person), ongoing evaluations (of the person and body weight) and the removal of the person's entitlement to her own experience (disregarding the patient's knowledge and refusing to give her a voice in the treatment). These acts of power are justified by the person's 'underlying weakness', as seen through the objective methodology of science, rather than acknowledged to be produced by this methodology (Zimmerman & Dickerson 1994:296).

A narrative approach to the treatment of eating disorders is very different from that of traditional psychiatric and family therapy practices, based on a different understanding of the problem/illness. The central theme of the narrative approach is summed up in the motto 'the

person is not the problem, the problem is the problem', which suggests that the problem is not inherent in the person, that it is not part of her identity, but has become problematic due to her relationship with the problem. Instead of using a metaphor (physical), in which the individual is seen as a machine with weaknesses and defects, a narrative metaphor (White & Epston 1990:2) situates the problem(s) (the eating disorder) in the discourses that, culturally and personally, have become an influence in the person's life. This means that people are situated in discourse through which meaning is constructed; and it is the meaning that individuals attribute to themselves and their experiences that constitute both identity and the development of resources for living life (Neuger 2001:86). Hence, one of the key contributions of narrative therapy, and thus the focus of this project, is the determination not to locate problems as inherent in people, but instead to understand that the ways in which problems are constructed and experienced are related to matters of culture and history (Russel & Carey 2004:115).

Whereas the scientific approach is founded on an objective view of any personal problem, narrative therapists consider the client to have privileged knowledge in this regard. They are concerned with how people living with an eating disorder make sense of their situation – how they give effect to the problem by means of the self-limiting narrative. Narrative therapists place much emphasis on the work of Foucault and discourse, how Foucauldian theory suggests that the circumstances people find themselves in arise through their being situated in discourse, and that the power involved in discourse determines how people make sense of their lives (Lock et al 2005:321). According to Foucault, power not only positions people in discourse, it also creates them, with some forms of power considered to be positive and constitutive, and others negative and repressive (Lock et al 2005:317).

When the ill person is labelled as 'having' anorexia/bulimia and is considered mentally ill and 'flawed,' conversations about life are seriously hampered, contributing to the process of marginalization (Launer 1999:119). Contextualising the 'problem' narrative means that the sources of the dominant narrative are explored, not only lived experiences, but also the larger social processes and cultural narratives that may have contributed, and therefore have become part of the 'problem' or dominant story (Jankowski 2003:244; White 1995:112-153, 2004:152-174). Narrative interaction seeks the help of the client to articulate how the situation has been constructed through unseen technologies of self that have become integral in ordering the client's everyday life. In order to assist recovery, narrative ways of working aim at bringing into full view these practices and their effect on the life of the client,

particularly how these practices have become part of the 'problem' story causing the individual to seek therapeutic assistance (Russell & Carey 2004: 3-43; White 2004:119-147).

When a person has been discursively positioned as a person 'having' anorexia/bulimia, narrative ways of working focus on linguistically separating the person from the problem, enabling the individual to reflect on her relationship with the illness. The emphasis is on her discovering that she is not what the eating disorder proclaims and would like her to believe, that she has the power to change events. By making use of a particular way of languaging, termed externalizing conversations, the client is assisted to view the problem differently, not as inherent of her identity, but as separate from her, diverting her attention to the choices she has with regard to the illness situation.

Instead of referring to the client as 'bulimic', for example, attention is focused on the relationship she has with bulimia: 'How is bulimia affecting the plans you have for your life?' An opening is created which enables her to consider the effect the problem has on her life, whilst assisting her to seek ways to stand against the problem as it has now been re-constructed. The problem is further explored by means of deconstructive listening, whereby the sources of the dominant narrative are explored, and situated in the larger social context, practices being geared towards increasing client agency and empowerment (Jankowski 2003:244; Lock et al 2005: 323,324; White 2004:119-147). As described by White (1993:53), externalizing conversation and deconstructive listening enable people to appreciate the degree to which they have succumbed to the plans of anorexia/bulimia for their lives by policing their own lives and acknowledging the extent to which these practices have impoverished their world.

In the framework of modernist medicine, the client's voice, already silenced by the dominant discourse of anorexia/bulimia, is further silenced when she experiences the marginalisation of her knowledge by the diagnostic, therapeutic model. Herein lies the difference between postmodern and modernist approaches to the treatment of anorexia/bulimia. Narrative therapy attempts, through its practices, to open up space for the client to articulate her experiences, perceptions and understandings of living with an eating disorder. The focus is on women's narratives rather than on a diagnostic therapeutic model. This stance creates collaborative interaction comprised of actions and behaviours which contribute to improving the ill person's feelings of self-worth and empowerment. Whereas the client was previously subjugated by the effect of the medical diagnosis and the power of the illness, through this

approach, she regains her voice and self-agency to take a stand against the eating disorder and the issues that affect her life.

3.6.2 Shortcomings of the narrative metaphor

Carney et al (2006:102) observe that, according to Surgenor, Plumridge and Horn, the narrative paradigm is incomplete when it comes to dealing with the eating disorders. The study by Surgenor et al concluded that not enough focus was placed on the 'embodiment' of the anorexia nervosa condition. I am of the opinion that a narrative approach alone is not sufficient to bring about healing, because the narrative metaphor does not place adequate emphasis on the reality of situated 'internal logic' (Harris 2000:171), applied by the individual in the development, maintenance and ultimate recovery from anorexia/bulimia.

Narrative therapists are concerned with how the person who lives with an eating disorder makes meaning of her situation, that is, how she constructs the problem by means of language. Much emphasis is placed on Foucault and the invisible effects of power-in-discourse, so that attention is only given to the body insofar as anorexia/bulimia is understood in terms of a body subjugated by the power of discourse. Cultural pressures may be necessary for the development of eating disorders, but are clearly not sufficient (Tozzi et al 2003:144) to explain it. Virtually all young women are exposed to the cultural risk factors, but only a small percentage develops an eating disorder. The social and cultural discourse is used to explain individual behaviour, but the processes whereby the individual engages and exchanges with the social realm are largely unexplored.

In order to make clear my own positioning, this thesis makes no distinction between subjective experiences, emotions and spirituality, as these are argued as emanating from the spirit, with the spirit giving effect to the felt sense of embodied meaning through the body-spirit or body-self relation through the medium of spirituality.

Postmodern narrative approaches have the potential to free individuals from socially constructed labels, by giving clients the opportunity to reconstruct their identities and re-author stories for themselves. Although this view of self is very liberating, what is missing from most postmodern approaches is the role of *spirit* in promoting and shaping a multitude of identities, towards embracing the 'transformational qualities of transcendent reality' in human beings (Damianakis 2001:30). Ironically, although the postmodern challenge claims to embrace a holistic approach to human life and has been fuelled by the individual's

subjective experiences drawing on an embodied and embedded self (Jankowski 2003:243), very few narrative studies consider the human being as mind, body and spirit. Only indirect reference is made to the self, conceptualized within the narrative metaphor as the story a person constructs of his or her lived experience (Jankowski 2003:243). The emphasis is on words and sentences and not on the phenomenological experiences of the lived body, or how the condition of the body structures meaning in daily life.

I am of the opinion that the processes whereby people struggling with anorexia/bulimia identify with and incorporate media messages into lived experience are both individual and social (Gleeson & Frith 2006:88). Here it is important to understand the role of metaphor and imagination in the construction of reality. Rather than representing the world, image schemas provide the basis for patterns of sensorimotor experiences that underlie a person's dynamic, action-oriented engagement with the world. In emphasising individual situatedness in discourse, there is little focus on the human element, on freedom of choice; what comes to the fore are disembodied ideas, divorced from agents and situations, providing a decontextualised view of the individual. Meaning is derived from both cognitive and perceptual capacities, together with the felt qualities of embodied experiences arising in the interface between the body and social practice. To suggest that embodied meaning is distinct or separable from social conditioning is inadvertently to reintroduce Cartesian dualism, which narrative rejects, but the argument is not convincing.

However, recovery is not only about language, but also about the *felt* reality of embodied emotions, intrinsic to the process of healing. The narrative metaphor largely ignores the way in which emotions compel thought and action. A critique of the narrative metaphor and its theory of change centre on the lack of a clear conceptualization of the role of emotions, not only in the storying process, but also in the constitution of the problem and in influencing outcomes. Postmodern approaches, claiming a holistic view of health and illness, allude only indirectly to terms such as healing and love. The question of how postmodern narrative ways of working see human wholeness is absent, with wholeness conveyed by words such as 'connectedness', 'unity', 'harmony', 'peace' and 'centredness'. This wholeness extends to the body, in the sense of both awareness of the body and its needs, and awareness of an embodied self that feels, hears, sees, touches, smells and experiences. The dimension of spiritual well-being as an important element in 'holistic health' is not acknowledged; and the primacy of the body is downplayed in terms of felt sense, emotion and feeling, failing to pay attention to *embodiment* of meaning. The emphasis is on the role of language and context to bring about change in the relationship with the eating disorder. Hence, although postmodern

narrative approaches claim to incorporate spirituality as an important dimension, an assessment of *how* spirituality functions in health and healing by means of the narrative metaphor continues to be elusive.

Clarification of the meaning and concept of spirituality is complicated when using the narrative metaphor, because of inadequate definition and the absence of a conceptual framework in defining the self. Frank (1995:181) states: 'The body-self is also a spiritual being....and exists in moments of immanence'. Roof (1998:217) observes that

...the spiritual self as an entity in the process of becoming...arouses the existential concerns of an increasingly reflexive self concerned with the moral meaning of existence. To speak of a reflexive self is to acknowledge that we are not what tradition or family or even our ascriptive social characteristics simply tell us we are, but what we make of ourselves in interaction with our cultural heritage

Spiritual experiences refer to something 'more internal than external, more individual than institutional, more experiential than scriptural' (Roof 1998:213), and cannot be reduced to individual situatedness in discourse. In support of my argument for spirituality, emotional processes are now widely recognized as a capacity of the embodied self (Kirmayer 1992:330). A close relationship exists between a person's physical state of being and what is possible for that person to know and experience.

Hazzouri (2008:5) examines the construct of subjective well-being (understood to be spiritual well-being) as cognitive and affective, stating that subjective well-being is determined by a person's own evaluation of life. We accept that we are all governed by our emotions, and that the majority of life's decisions have an emotional grounding. Such a perspective emphasises the fact that the body has the capacity to act on the world outside the self, as well as being vulnerable to the world's influence (Gadow 1982:89). Illness is conceptualised as *vulnerability* and the body of the ill person as the suffering 'other'. Without recognizing the body as the site for the construction of knowledge, the suffering body is subordinated to philosophical and political ideals, determined by discourse, which results in a negative view of the body. This distinction both reflects and perpetuates the dichotomous thinking associated with modernism.

Shifting the lens away from a person's body image as only perceptual, and instead seeing it also as an embodied, social phenomenon, focuses attention on the embodiment of meaning and places the body within a cultural, social and spiritual discourse, to make room for understanding anorexia/bulimia within the framework of a wounded self.

3.7 UNDERSTANDING THE WOUNDED SELF

There is great uncertainty about what needs to occur for an individual woman to recover from an eating disorder (Weaver et al 2005:188). Clinical research, by its own admission, has offered little hope to sufferers and therapists alike (Patching 2009:10; Matusek & Knudson 2009:705). This I attribute to a focus on the empirical measurement of recovery instead of its phenomenology, thereby overlooking the life lived in the individual body of someone suffering from anorexia/bulimia (Garrett 1996:1489). Moreover, qualitative studies also tend to emphasise recovery, rather than provide insight regarding the chronological pattern of eating disorders – of developing the illness, living with the problem, recovery and regaining life. I am of the opinion that these entities are inseparable if we are to gain a better understanding of the condition and ultimately work towards improving the theory, diagnosis and practice.

Gadow (1982:87) posits that the body which a patient experiences and the one which a practitioner treats are seldom the same. Moreover, barriers that hinder the progress of understanding and treating eating disorders can be ascribed to the apathy of public health systems, which have focused mainly on physical health as the definitive objective (Hawks 2004). However, in a study done by Garrett (1996:1493), participants regarded anorexia nervosa as a distorted form of spirituality and a misguided way of life. Some of those participating in qualitative studies have indicated that the development of their own spirituality provided a resource in their recovery. Although participants in these studies have indicated the importance of being understood as central to the process of recovery, not many studies have considered patient opinions about the illness (Tozzi et al 2003:145). It is crucial to understand how an individual experiences and relates to her body, because such experiences construct a particular reality; and ongoing censure of these experiences often leads to other forms of self-harm, given the prevailing conflict situation.

3.7.1 Introducing the wounded self

In order to access processes that restore our capacity to address the whole person, I focus on the role of individual experiences occurring in the interface of mind, body and spirit;

structuring reality and conceptions of self, with the person living that reality. Given the many contingent factors that might precipitate an eating disorder, emphasis is placed on the vulnerability of the self, seeking self-acceptance by exerting control over food intake and body weight as a means of gaining self-agency and empowerment. At the same time, the influence of culture is highlighted, where social body imaging and adherence to external standards of beauty determine subject positioning in cultural and social discourse.

Although cultural pressures may be responsible for developing an eating disorder, they are clearly not the only casual factor. As I have indicated above, all women are exposed to these pressures, but only a relatively small percentage develop an eating disorder. Given that dieting is also an important behavioural precursor, it is worth noting that only a small proportion of women who diet develop clinically diagnosable eating disorders (Tozzi et al 2003:144,145). I would like to emphasise the concept of meaning as arising primarily from the felt experiences of situations and events, and only subsequently developing from subject positioning in discourse, suggesting an inherent vulnerability for certain individuals to develop anorexia/bulimia.

This position is explored and argued based on the knowledge and lived experiences of the three women in this study, as they have been subjected by, lived with and regained their lives from the tyranny of anorexia/bulimia. The illness follows a chronological pattern and has an identity-related component (Patching & Lawler 2009:19). Having given primary consideration to the chronology of processes involved, this study exposes facets of the condition not previously identified.

Given the ongoing abuse and injury to the body, anorexia/bulimia is shown to be a severe form of self-injury, little different to other forms of self-mutilation. Furthermore, the disorder is viewed as an obsession, with underlying idiosyncrasies of addiction, a constant quest for continued weight loss, or an abnormal craving for food in the case of bulimia nervosa, accompanied by spiritual enigmas suggesting a diminishing of the self, or a narrowing of existence. Juxtaposing modern medicine and its classification of anorexia/bulimia as mental illness, disordered eating behaviour, coupled with social isolation and withdrawal, is explored in this thesis as a deficit of the human spirit, a loss of self. The ill person gradually loses control of the self, only to be controlled by the illness and by health professionals. In a sense, anorexia/bulimia becomes a 'god', a cult leader, whose prescribed rituals give it power and control over its followers, leaving them lost in existential and spiritual bondage.

A radical makeover in this important area of investigation is now well overdue, because most approaches dealing with eating disorders overlook the crucial dimension of embodiment, embraced physically in the substance of the body and in the social context of the person's dilemma (Kirmayer 1992:328). It is the premise of this thesis that the biomedical approach, which views the body as being in need of 'fixing' by concentrating on feeding the patient, monitoring food intake and body weight, seems largely unhelpful. Healing of anorexia/bulimia involves more than just mechanical repair – it requires participation of mind and spirit as well (Montgomery 1993:126). At the same time, the postmodern, narrative approaches do not give recognition to the lived, embodied realities of anorexia/bulimia, omitting the mind-body-spirit relation and its role in structuring spirituality and hence lived experience.

3.7.2 The body and meaning

In seeking to overcome Cartesian dualism, this thesis understands the body as constructing the basis of all meaning, providing form to all of our experiences. The underlying concept of embodiment is important here, particularly how the 'lived body' of the person suffering from anorexia/bulimia announces itself in forms of social withdrawal and disconnection, a meaning-making strategy, socially constructed, a reality which grounds the psycho-social-spiritual life of the individual. Aspects of bodily sensation and movement, our lived experiences, contribute to meaning – individual spirituality. It is the further premise of this thesis that spirituality, and spirit or self are embodied, structuring a lived reality based on emotion and feeling in the interface between mind, body and spirit. This becomes the body-self relationship evident in the existential interface between body and society. I submit that these embodied responses, contained in practices and 'existential crisis states' (Griffith & Griffith 2002:265) of anorexia/bulimia, are markers of meaning from which the theory, research and practice can learn.

The behaviour manifested in the maintenance of an eating disorder may best be understood in relation to the wider practices of which they form a part. It therefore calls for an understanding of the context within which the disordered eating is taking place, and the relevance of this context to the individual (Mielewczyk & Willig 2007:828). The significance of what is termed 'context' does not refer only to the individual situated in discourse: it is the 'embodiment' of the condition that is its main feature, becoming a more concrete and tangible presence than the mere discursive pattern that is revealed (Carney et al 2006:102). Accordingly, much emphasis is placed on the felt, phenomenological experience of the body, how the quality and structure of the body already contributes, pre-reflectively, to the

meanings made in the daily life of the ill person, structuring individual spirituality as existence.

Following on the above, it is the felt, bodily sense of the problem, the embodied feelings, which determine meaning and thus the basis for logical argument. This argument contrasts dualistic notions of mind and body, as well as a disembodied, information processing account of cognition (Kirmayer 1992:334) in order to demonstrate that the processes are social and embodied. It is the embodied feelings that constitute the raw ingredients that pre-reflectively make up the flow of experience and meaning, with our discursive conceptualization already dependent upon them for determining subject positioning in discourse.

In order to understand the eating disorders, we need to acknowledge that 'behaviour is only understandable given the circumstances in which it is produced' (Harris 2000:72). If we accept this notion, we need to move away from an attempt to predict and de-contextualize eating disorder-related behaviour, in an attempt to understand the motivations which underpin an individual's decision to engage in a particular behaviour pattern, within a specific context, as part of an overall strategy. Finally, this focus on context and meaning may also help us to understand why it is easier to maintain behaviour change in some situations rather than others (Mielewczyk & Willig 2007:828).

3.7.3 Trauma and the body: anorexia nervosa/bulimia as human vulnerability

In a study conducted with women who had recovered from an eating disorder, they often described a strong sense of being misunderstood and of not belonging during childhood, adolescence or adulthood. They saw self-acceptance and a sense of belonging as evolving from feeling valued by others (Patching & Lawler 2009:17).

In another study by Weaver et al (2005:191), women claimed to have experienced states of 'perilous self-soothing', characterized by unhealthy behaviours in an attempt to feel better about themselves, as part of a learning path to negotiate developmental and situational issues in their lives. Perilous self-soothing was considered to involve two sub-stages: not knowing the self and losing the self to the anorexia nervosa obsession. Not knowing the self was characterized by conflict, giving up on the self in order to maintain relationships with others, pleasing others instead of determining their own needs. Personal worth was measured by comparison to external standards, based on physical appearance and popularity. Interaction with others was centred upon seeking approval, which made it difficult

to differentiate between the women's own needs and the perceived expectations of others. These stages of subjective (spiritual) conflict, situated in a social context and embodied in the relation of body and self, marked the onset of anorexia/bulimia.

Research and clinical practice suggests that for women struggling with an eating disorder, there is a complex relationship between trauma, the illness and spirituality (Berrett et al 2007:373; Richards et al 2009:173). The eating disorder becomes a source of trauma itself as women relentlessly punish their bodies through self-starvation, bingeing, self-induced vomiting and laxative abuse (Richards et al 2009:182). Anorexia/bulimia introduces behaviour that causes a severe disruption of bodily functioning, so that the relationship between the body and the self (spirit) is one of enmity (Maisel et al 2004:39).

The experience of a serious illness, whether medical or psychiatric, causes suffering that affects not only the body, but the life lived in that body, so that meaning-making is threatened by the experience of serious illness (Frank 1995:50). Mitchell (2007:129) suggests that serious illness brings a loss of equilibrium, experienced as not feeling whole, with the perspective of health no longer regarded as just a medical-biological state, but also what Gadamer calls a 'life-historical and social process'.

Etherington (2005:302) observes that trauma, as in prolonged illness and vulnerability, disrupts our sense of having a continuous existence. Because trauma is a subjective experience, often related to childhood experiences of loss, abuse, abandonment and neglect, trauma is often held in the body in different ways. It may be experienced through physical illness, addiction or chronic pain, leaving victims helplessly trying to find their own way out of the dilemma. Trauma creates chaos in people's lives and can leave them voiceless and isolated, with little awareness of the body as a physical state, particularly when emotions cannot be adequately expressed.

Given this situation, trauma can cause disruption at many levels of being, but particularly in the realm of the spirit (Barrett 1999:196). It follows that a woman struggling with an eating disorder is displaced from her normal life, bringing about changes in identity; she is not the person she was before her life was interrupted by the illness. When a person does not have language or a frame of reference for her experience, no verbal link can exist between 'disconnected' parts. Without any way of verbally representing the trauma, a woman may look to other ways of communicating the felt sense of separation experienced in the body-self relationship (Etherington 2005:302).

The premise of this research project is that anorexia/bulimia is a form of human vulnerability, an existential given where the illness is 'socially defined and subjectively lived as vulnerability' (Gadow 2000:89). My argument for situating a wounded self or a disabling spirituality in the context of anorexia/bulimia is rooted in the 'ontological assault' orchestrated by the eating disorder, 'on the unity of being' of the one who is ill (Pellegrino 1982:158). This phenomenon can be described using the metaphor of a 'wound', a vulnerability in the human condition, producing both a dilemma and a potential gift (Pellegrino 1982:158; Todres 2006:12). A positive or enabling spirituality is undermined as the illness itself sets the woman apart from the fullness of life, with anorexia/bulimia interposing between the body, the self (spirit) and reality, causing distress, pain and anxiety, leaving her wounded in specific ways (Berrett et al 2007:377). Manipulation and abuse of the body, together with the power manifested in the illness relationship, silence personal expression and become a breeding ground for symptoms (Griffith & Griffith 1994:42). Although those suffering from anorexia/bulimia may become chronically ill and in need of medical care, I am of the opinion that they are essentially individuals lacking the fullness of relationship, isolated, wounded in spirit and in need of healing.

3.7.4 Culture and meaning: the social body of symbolic representation

The self (spirit) is fundamentally social in nature, developed and maintained through relationships with others, nature and God. Because of the social nature of the self, socialization is a lifelong process, a key to understanding the self (Charmaz 1983:170). However, thus far, although the social context is sometimes used to explain the individual's behaviour, in the literature, the processes by which the person engages and exchanges with the social realm are largely unexplored. Garrett (1996:1489) observes that studies undertaken to provide a descriptive disclosure of the inner world of the person struggling with an eating disorder fail to throw light on theory which might explain how these women transformed themselves, in order to claim recovery.

Assuming that a body image 'exists', we need to question how this construct comes into being and how it is deployed and given meaning in everyday health-related behaviour. In considering body imaging as one of the aspects that feature in disordered eating patterns, treatment approaches need to address and capture the individual's active engagement with and the interplay between embodied experiences (spirituality), identity and display (Gleeson & Frith 2006:88). Wright et al (1996:55) point out that how people experience an illness depends on the beliefs they have embraced prior to the illness experience, as well as the

beliefs that evolve through their living with the illness. Through the process of objectification, an object body is created against which the individual compares herself, something which can lead to constant self-criticism, culminating in obsessive dieting and body management routines (Dignon et al 2006:943).

Assuming that body image is a static, internal and individual representation, measured in terms of the appearance of the body is to ignore the dialogical engagement of the body in the social context in which it is understood, to overlook the inherent, socially embedded nature of embodiment (Gleeson & Frith 2006:86). Instead of viewing the body image construct in terms of a perceptual distortion by those who struggle with anorexia/bulimia, I propose that a woman's body image is affected by numerous contextual factors, shifting the interest away from the perceptual distortion of the individual to subjective dissatisfaction within a cultural and social context (Gleeson & Frith 2006:82). Only by ceasing to treat the body of the person struggling with an eating disorder as something to be measured and objectively recorded can we attain observation of the body's discursive production (that is to investigate how the individual uses her body image to achieve certain ends and how body image features in identity projects).

The illness experience is articulated through metaphors that are grounded in and constrained by both bodily experience and social interaction (Kirmayer 1992:323). Meaning emerges from the capacity to use bodily experiences to think metaphorically (Kirmayer 1992:334). Therefore, an understanding of anorexia/bulimia and the behaviour attached to the illness experience must be sought not only in personal history, but in the social contexts that also serve to ground the body image metaphorically for the person. 'Because of their embodied nature, metaphors create meaning not only through representation, but through enactment or presentation' (Kirmayer 1992:339). Metaphors are not derived from sensorimotor structures only, but are embodied in experience, in the pragmatics of language, where context and intention are inseparable from meaning. Metaphors allow for creative construction, despite the dual constraints of both society and the body, so that although metaphors embody a situational knowledge that constitutes culture, individual metaphoric constructions are local contributions to the cultural and social situation.

Each individual retains the potential to create new meaning from his or her unique perspective. The meaning of metaphors is then to be found not in representation but in presentation, modes of action or ways of life (Kirmayer 1992:339). In this regard, Gleeson and Frith (2006:86) use Merleau-Ponty's notion that body image has relevance 'in proportion

to their value to the organism's projects'. They agree with Weis's comment that these identity projects 'derive their significance not merely from an individual's intentions, but from the situation out of which they have emerged and in which they are expressed'. Rather than 'representing' the world, as in the cognitive approach, these schemas give us the world, they are how we come to have the very world that we experience. It is the uniqueness of presentation of body image metaphor that also suggests a vulnerability, a local contribution to the cultural situation, which is the focus of this research project.

Given that culture constitutes a way of life, cultural meaning cannot be reduced to metaphors only, because cultural discourse depends on the existence of people who take up particular ways of life within a given culture. It follows that bodies are experienced in context-specific ways, attached to individual meaning-making strategies, so that treatment approaches which take the body out of these contexts in order to examine and measure it objectively overlook the complex process by which individuals perceive and evaluate their bodies (Gleeson & Frith 2006:86).

The argument holds that body image is a 'process, an activity, rather than a product', as opposed to modernistic conceptions regarding it as an 'internal and individual possession' (Gleeson & Frith 2006:79). This viewpoint contradicts the Western notion of dualism, in which the activity of the mind is valued above the life of the body, thereby minimizing the role of emotion in compelling thought, choice and action, emphasizing a 'disembodied, de-contextualized' view of knowledge construction and value (Kirmayer 1992:323,324).

The body cannot be limited by a theory of representation, because the body's influence on thought and emotion is more presentation than representation (Kirmayer 1992:325); the body is not the means through which acting takes place, it *is* our acting (Gadow 1982:87). A rational approach which objectively views and measures the condition of anorexia/bulimia as due to 'mental, irrational and individual constructions' (Kirmayer 1992:328) not only underrates the dominance of the body in constructing emotions, but also adopts modes of thinking whereby the suffering body is subordinated to philosophical and political ideals (Kirmayer 1992:324). However, as Kirmayer (1992:330) says, 'to be irrational is not a defective category but a category with distinct qualities' – it represents the role of the body in thought, in being sensuous and emotional. These emotions do not determine what is logical, but what is considered most pressing in a given situation, so that the urgency and power of emotions take on a subjectively persuasive quality (Kirmayer 1992:331), derived from the

individual's 'internally situated logic' not understood by applying rational thought (Harris 2000:169).

It follows then that states of embodiment determine who we are (Corbin 2003:258). Given that anorexia/bulimia transforms the body of the ill person into an alien presence, the body language of the individual becomes very important in the study of this illness.

3.7.5 Existential posturing

Pellegrino (1982:157-158) claims the following:

Illness forces a change in existential states, it may mean the loss of personal image, identity or existence itself. It is the perception of change in existential states that forms the central experience of illness – the perception of impairment and the need to be made whole again – to be cured, healed or cared for.

Existential crises states are considered to be a universal human response to loss or trauma. Marked by a state of demoralization, they constitute states of vulnerability to the illness (Griffith & Griffith 2002:265).

3.7.5.1 Other relatedness

For an individual suffering from anorexia/bulimia, the body-self relationship is 'metaphorically' paralleled to her relationship with her emotions, her spiritual life, and most significantly, knowledge and understanding of others and the natural world (Garrett 1998:147). The outer body expresses the inner self, as if others could read the meaning of her person from her bodily appearance (Garrett 1998:151). Disunity within the body-self and disunity between the self and the community reflect the life of a person whose relation to the world has become 'broken and dysfunctional' (May et al 1958:56). This alienation is evidenced by a lack of emotional involvement, a critical detachment and even estrangement (D'Abundo & Chally 2004:1099). Furthermore, being alienated from emotions and relationships, the crisis situation exists at two levels, both conceptual and experiential. At the first level, the conceptualization of self can be described as a 'disengaged subjectivity' (Jankowski 2003:241), whereby the self views itself as an object, or reflects on itself from the position of an outside observer. Jankowski (2003:242) points out that conceptualizing the mind as separate from the body structures experiences of a 'disembodied self'. Fogarty (1976:4-5) summarizes the condition as emptiness and loneliness, with 'something' gone wrong in the

life of the person, her emotional responses to the illness highlighting her basic need for connection.

Pre-occupation with food and other obsessions related to anorexia/bulimia do not leave the ill person time to pursue a normal life and contributes to increased periods of isolation (D'Abundo & Chally 2004:1099). When a person is so immersed in the illness, she frequently remains unaware of the strain her behaviour imposes on others, resulting in further withdrawal as the ill person overburdens family and friends. Often significant others regard the sufferer as having brought the illness upon herself. 'Discrediting definitions of the self' (Charmaz 1983:181) are met with feelings of disillusion because of unmet expectations which developed from the illness situation. Discreditation and stigmatized identity marginalizes social interaction in the world. Charmaz (1983:185) comments that being regarded as a 'valid' person necessitates a continual struggle, as discrediting her often causes the ill person to feel disempowered.

Since the self (spirit) is social in nature, social isolation typically fosters a loss of self. A circumscribed life leads to fewer opportunities for developing a valued self within the context of social organisation (Charmaz 1983:176). Most importantly, a restricted life fosters an all-consuming retreat into illness, causing further concerns for family and friends. With her life story disrupted by the illness, suffering increases as she experiences difficulty in accessing some larger context or higher meaning in which to situate her difficulties (O'Hanlon 2006:28). Stories do not simply describe the self, they are the self's medium of being (Frank 1995:53). By taking pain into their bodies, making it too much part of themselves, the sufferer becomes isolated in her body, with 'isolation bring(ing) incoherence', as mind, body and spirit no longer 'operate in concert' and in harmony with their environment. Instead, the disunity experienced in the body-self relationship produces a 'monadic' body, with the self experiencing itself as existentially separate and alone (Frank 1995:31). In these circumstances, anorexia/bulimia structures the person's world and concept of self, giving effect to a disabling spirituality.

3.7.5.2 Control

Suffering a loss of self (spirit), leading to social withdrawal, is a condition experienced by virtually all who have struggled with anorexia/bulimia. Those suffering come to define themselves by the demands of the eating disorder, feeling good when they attain their goals for self-starvation and exercise. The illness becomes central to the individual's well-being, as it becomes their primary source of identity, comfort and companionship. They do not see the

eating disorder as having taken control of their minds and bodies. They take pride and satisfaction in doing what others cannot do, namely resisting food, equating self-worth with their ability to achieve and maintain weight loss (Weaver et al 2005:194). The emphasis is on control and accomplishment, which is linked to achieving total mastery of the body. A sense of achievement is derived from overcoming physical obstacles by pushing the body to extremes to attain pre-determined goals. Controlling the shape of the body appears to provide a sense of security and feelings of independence (Bordo 1993:152).

However, although the dominant experience of the individual throughout the illness is, or seems to be one of invulnerability, it is a subjective stance which becomes eventually more prominent in forms of disconnection, alienation and withdrawal (Bordo 1993:152). As the sufferers experience the spiralling problems caused by the condition, they suffer a loss of control over their lives. The ways in which they had understood themselves in the past become increasingly remote, as their former experiences differ from those of the present, particularly when the present is characterized by dependency (Charmaz 1983:173; Rao 2006:48). The unpredictable course of the illness fosters uncertainty and fear, with consequent psychological and spiritual dysfunctioning, causing extreme physical discomfort (Rao 2006:48).

Frank (1995:40) states that selves act in ways that choose bodies. He warns that the emphasis on choice is ultimately a moral problem, perhaps the moral problem the ill person has to address. The fact remains that, in adhering to the demands of anorexia/bulimia, together with acts of self-mutilation, the individual is causing self-inflicted pain which takes on a repetitive cycle (Rao 2006:51). Acts of self-mutilation can occur alongside the eating disorder in an attempt to express a measure of control, when control cannot be found in their world – the act itself serves as a mechanism to prevent the person from being emotionally overwhelmed (Harris 2000:172; Rao 2006:51).

Moreover, anorexia/bulimia demands severe discipline of the body through acts of 'self-regimentation' which transform the body into an 'it' (Frank 1995:40). Taking the form of the 'mirroring body-self', the ill person becomes compulsively 'associated' with the body, putting the body on display, with visual presentation becoming essential. What the mirroring body-self wants or desires for itself, emanates mostly from culture, where the image is the reality. What is important for the ill person is sustaining the image. Eventually, the disciplined and mirrored body turns on itself and barely seeks association with 'other'. Rao (2006:50) accepts Straus's metaphor of the body as 'a field of contact with the world', but argues that

the body in pain is no longer a site of possibilities (Rao 2006:47). Pain interrupts living and relatedness (Rao 2006:51). Spiritual dysfunctioning, due to a disassociation between the body and the self (spirit), causes the ill person to withdraw from social activity, with the unpredictability of the illness placing further restrictions on her life. As already indicated in Section 3.7.5.1 above, the body becomes monadic and isolated (Frank 1995:48).

3.7.5.3 Body-relatedness

In my attempt to understand the bodily politics between the ill person and her body, I am indebted to the work of nursing theorist Sally Gadow (1982:86-100, 2000:89-97, 2004:375-384) and Pellegrino (1982:157-166). These authors provided me with much insight into the rupture caused by anorexia/bulimia of the unity ordinarily experienced between the self and the body, when the ill person, in her interaction with the world and with others, no longer experiences herself as one being. The body in its present state is in pain, malfunctioning and disabled, so that it is no longer the willing instrument of the self (Pellegrino 1982:158). Body and self are then experienced as acting upon one another, just as the lived body and the world interact under normal circumstances (Gadow 1980:88).

Hence, when the focus turns inward (when the self-body experiences itself as acting upon or being acted upon, not by the world but by part of itself), the lived body gives way to peculiarity and restraint. It impedes choices and actions; it is no longer the willing servant of 'transbodily purposes' found in work, amusement and pleasure (Pellegrino 1982:162). The primary unit divides into self/spirit and body. The body stands opposed to the self, while it is still partially inseparable from the self (Pellegrino (1982:158).

In contrast to the lived body unity, experienced as occupying an enabling spirituality, the body at the present level of struggle and subjugation is the 'object' body, referred to as the 'existential otherness' of the self, or a concrete otherness of the self for itself (Gadow 1980:89), giving form to a wounded or disabling spirituality. This dualist relationship indicates the alienation of the self from the body, the alienation of the subjective self from the objective world, the subjective retreat of the individual alienated from social community, tradition and shared meaning (Cushman 1990: 599-611; Jankowski 2003:242).

An eating disorder encourages blotting out the body's messages, in the form of hunger and emotion, and if this is successful, it is regarded as a form of moral victory and control (Bordo 1993:145). However, when food is denied, irrespective of the body's needs, it becomes a

profoundly spiritual issue. Food, as a 'symbol of life' provides 'spiritual nourishment' to the body (Garrett 1998:183), sustaining life and upholding a spiritual connection to existence. Food ensures ongoing participation between the body and the world at large. In forgoing food, we not only cut ourselves off from sensual experience and the social world, we also deny life, which is the materiality of our living bodies. In this sense, the body is not merely a symbol of spirituality, it is itself sacred (Garrett 1998:182).

With spirituality providing connection between the body and social practice, responsibility towards self and 'other' is made possible through the body. The body constitutes the means whereby humans communicate through the web of social interaction, so ceasing to think of oneself as being in a body constricts thinking of oneself as existing for the 'other' (Frank 1995:37). It is through the body, and its passionate relation to the world in which spirituality is experienced and lived, that our being is constituted (Garrett 1998:164).

Having to embody – having to attend to the body intimately on a daily basis (taking the body seriously) – poses problems for those struggling with an eating disorder. Failure to live closely with her body, her feelings and perceptions, causes the ill person to lose her connectedness and ability to relate. Cognitive schemata provide the source of images and metaphorical reference in constructing reality or meaning. Positioning within discourse is not determined by situatedness in discourse, rather it is our bodily experiences, our meaning-making strategies involving language, cognition and emotion which give rise to linguistic metaphors and images through which we make sense of existence. Understanding provides the knowledge of what it means to exist in the world, and this depends on language arising from bodily experiences (Griffith & Griffith 2002:56-57).

The decision not to eat, carried to its extreme, denies any choice over life and death and makes a mockery of existence (Garrett 1998:1493). When the self and the body are in conflict, locked in a relationship of bondage (as opposed to a relationship of unity and mutuality), freedom is compromised. Focus is on the power structure that has lent itself so easily to violating the body, with this form of violence considered an attack on life (Pellegrino 1982:158).

The climax of the illness is identified by extreme anxiety and irrational behaviour, the disorder controlling nearly all aspects of life, with both mental and physical symptoms threatening the health of the individual (D'Abundo & Chally 2004:1099).

3.7.5.4 Desire and love

Those suffering from an eating disorder seem to have fallen out of love with themselves. No longer desiring or caring for the self diminishes the self (spirit). This non-acceptance becomes visible in the body. Those who suffer from an eating disorder consider their bodies to be unlovable or undesirable. Trapped by the demands of the illness, their ultimate aim is 'to kill off its desires and hungers, to cease to experience hunger and desire' (Bordo 1993:145-146).

The unfortunate effect of this process is that anorexia/bulimia would appear to develop a vitality or spirituality of its own, seemingly beyond the will and control of the ill person. She experiences a shift in her sense of identity, a feeling of separation between the body and self, causing aspects of physical or sensory experience to become disengaged from the self. This might result in her dissociating herself from her own sexuality, experiencing memory lapses or being estranged from her own body (O'Hanlon 2006:42). As a natural response to the trauma carried in her body, she senses this disconnection, with the self feeling disowned and devalued. This conflict and anxiety in terms of selfhood not only affects the care of the body, but also causes the ill person to be cautious of other people, given her feelings of indifference and otherness. Frank (1995:49) argues that when the body is not fully associated with itself, the body-self cannot exist as a unity with its two parts 'interdependent but inextricable'. Association and contingency of bodily functions are contextualized by the body's producing desire, a feeling that crystallizes the body's ethical capacity. Accordingly, when the body is a desiring body, the person wants and needs to reach out to others, meaning that the body never belongs to itself alone, but is instrumental in creating its humanity in relation to other bodies.

It follows that illness often causes the body to lack desire (Frank 1995:39). In caring for the needs of the body, one would ask what the body wants and how this desire would be expressed for the body, with the body and through the body. It has been suggested that the absence of love is a major cause of mental illness and that the presence of love, a self-enlarging experience, is consequently the essential healing element in therapy. Love for ourselves and others is the source of all energy to create and connect (Denton 2005:758). Connecting to the self or spirit is connection to the deepest level within and involves having a connection with oneself that is beyond the rational, logical or even emotional (O'Hanlon 2006:12). The core ethical questions concern what the ill person should want for herself and

for others. Frank (1995:156) observes that as ethical questions, desires become responsibilities: '[W]hat is it good to want for oneself and others?'

O'Hanlon (2006:10) regards the components of an enabling spirituality to be connection, compassion and making a contribution to the welfare of the 'other'. If the ill person could feel being connected to something more, within and beyond the self and the demands of anorexia/bulimia, she may be inspired to seek out and contribute to the lives of others. Anything that gives one an experience of the 'bigger self', or what is beyond the limited personality, is a component of spirituality. Compassion then becomes a sense of 'feeling with' rather than being against the self, others and the world (O'Hanlon 2006:10).

In the act of contributing to the lives of others, the ill person moves beyond what she wants for the self, as dictated by external standards and discourses in which the illness is situated, to bring about an 'inward turn', feeling compassion and love for others. Compassion is not just a means of spiritual transformation, but an end in itself. 'It is the central ethical value of the Jesus tradition, as well as the central quality of God' (Borg 1997:113). Beginning with presence (for it flows out of being present for others), compassion is being moved in the heart, at a level of the spirit. Borg (1997) observes that, for the ancient Hebrews, the heart was not associated only with feelings of love and courage; rather it constituted the totality of the human psyche, involving not only emotion, but also intellect and perception.

People suffering from anorexia/bulimia feel estranged, disconnected and disempowered, which can be ascribed to the domination of the body, a body lacking desire and love. Living an enabling spirituality begins with reversing these experiences, because connecting to something bigger, within or beyond the self evokes a sense of wholeness. What is important is the condition of the heart. What is needed is an open heart, a soft heart. The prophet Ezekiel associated this with spirit: a new spirit turns a heart of stone into a heart of flesh (Ezk 36:26). A new heart, a new spirit and knowing the sacred all go together (Borg 1997:113). This directs attention to the spiritual world as lived in the context of anorexia/bulimia.

3.8 UNDERSTANDING THE SPIRITUAL WORLD OF ANOREXIA NERVOSA/BULIMIA

Investigating anorexia/bulimia in the context of a wounded spirituality, calls for an understanding of the power inherent in the illness, resulting in sacrificing the self and body for a relationship of enslavement. Drawing on early proponents of the Existential approach to psychotherapy, Kierkegaard and Nietzsche, May et al (1958:23) write that these thinkers

were concerned with understanding the individual person 'as the being who represses', a being who surrenders self-awareness as protection against reality. They questioned the reasons for a normal person, conscious of her existence, to deliberately block off consciousness (avoiding reality) and 'as a result suffer compulsions, anxiety and despair'. They were of the opinion that these forms of behaviour surfaced because of the individual's relation to the self, that the individual had become fundamentally problematic to herself (May et al 1958:23). As the Existential therapists point out, the fundamental condition becomes 'subjectivity', simultaneously constituting a form of power that can be experienced as unthinking or uncontrolled dependency (embodied in a wounded spirituality). The focus should be on the 'subjective stance' employed by the person struggling with an eating disorder, who, despite appearing to be exercising control over eating, takes little pleasure in the experience of embodiment with a concomitant disintegration of inner emotional and spiritual life becoming evident (Bordo 1993:151).

Anorexia/bulimia strikes the sufferer with a double blow. Not only does the illness cause a disassociation between the self and the body, it also disenables the most effective mechanisms for coping with illness and stress: a person's relationship with God, communion with others, a sense of control over destiny and having a sense of purpose in life. For this reason, the illness most commonly 'violates' and 'attacks' the relatedness upon which spirituality rests (Griffith & Griffith 2002:16).

The mental health profession has generally had an ambivalent relationship with spirituality and religion. However, although the reasons for this omission are multiple and complex, shifting the focus from the psychological to the spiritual world opens up possibilities for recovery not evidenced by other approaches in the treatment of anorexia/bulimia. In this thesis, spirituality implies relationship, and places relationships at the centre of awareness, with relatedness as the essential constituent of our humanity (Griffith & Griffith 2002:16). However, spirituality may develop an anti-spiritual character which surfaces when practices in the interface between the body and the self harbour a dependency fixated in a source outside the self. This stands against employing spiritual practices which stimulate individual transcendence and growth by an acceptance of the self within.

Eating disorders are characterized by 'dependency' on self-induced vomiting (in the case of bulimia), obsession with food and calories, rigid adherence to a diet, excessive exercise, together with continuous monitoring of body weight. Not only do these practices provide a metaphorical connection between the eating disorders and addictive behaviour (Garrett

1998:51), but the repetitive behaviour associated with the condition has an urgency and compulsion that is 'uncomfortable', given the normal spiritual rituals of our culture. Dominated by fear, even the ill person often perceives her behaviour as mindless and irrational, other than providing relief for her anxiety. However, the expression of spiritual experiences is harmful when they violate the relatedness on which spirituality is based (Griffith & Griffith 2002:219). Hence my argument that anorexia/bulimia should be investigated in the context of a wounded self and disempowering spirituality, which produces the grounding from which illness symptoms develop and are maintained.

When a person describes her spiritual experiences, she tends to do so in terms of particular relationships, using a specific language that shapes those relationships. In therapy, the relationships and language of spiritual experiences can provide a means for understanding anorexia/bulimia in order to improve the theory, research and practice. Spiritual experiences are expressed through metaphors, beliefs, rituals and spiritual practices (Griffith & Griffith 2002:59). These provide powerful images by which people struggling with an eating disorder create and express meaning in their lives (Griffith & Griffith 2002: 62).

3.8.1 Beliefs and spirituality

The discourse of anorexia/bulimia not only constructs knowledge about what is virtuous and acceptable, it also encourages practices that give effect to the power that operates through discourse, structuring individual spirituality through the link between beliefs and emotional states of the body. Beliefs employ metaphors and stories which are embedded in the form of emotions in the physical state of the body (Griffith & Griffith 2002:145). Some beliefs can foster emotions that are conducive to relatedness with the self, others and God, whilst others have the ability to violate relational interdependence (Griffith & Griffith 2002:146). Beliefs provide a sense of 'how the world is' and exist in prejudices and biases, so that beliefs are instrumental in the ways in which discourses construct the life world in which people exist (Griffith & Griffith 2002:151). By eliciting specific postures, beliefs position us in relation to society and the physical environment (Griffith & Griffith 2002:142). Beliefs, structured through discourse, are highly politicized (Griffith & Griffith 2002:50) because some ways of communication appear to have been acknowledged, whilst alternative ways of speaking and relating have been barred. The ill person's positioning, based on her relatedness with her self and her world, give form to a disempowering spirituality, when stories and metaphors of 'thinness' are being lived and illness symptoms are being maintained.

In what follows, I situate experiences and emotions so profoundly encountered through ritual and spiritual practices in the context of anorexia/bulimia within the framework of discourse and beliefs. Through the manipulation of the body, these experiences structure a disabling spirituality, creating conflict and a subjugation of the body-self, placing the individual in a position of vulnerability and dependency.

In my attempt to understand and unpack the reality of a disabling spirituality, I was indebted to Vaughan (1991:105-118) and Griffith and Griffith (2002), who opened up the world of anti-spiritual realities to me. This enabled me to connect to and write about what was so powerfully portrayed whilst working with the eating disorders in support of my situating anorexia/bulimia as a woundedness of the spirit, giving effect to and hopefully initiating investigation into the realities of a disabling spirituality threatening the existence of those living with the illness.

3.8.2 The eating disorder: an idol

I am of the opinion that when people, and particularly adolescents, experience a 'change in world design', there is often a conflict between the desire for inner growth and maturity on the one hand and the demands placed on the individual by the 'real world' on the other. This change in the world may be circumstantial and may occur at any time, but is always present in the metamorphosis from childhood to adulthood. In many instances, the body develops too quickly for the self (spirit); the self is 'left behind'. It is at this time that the self is particularly vulnerable and problematic, and release is often sought in substitute gratification which might take many different forms, including alcohol, drugs or becoming entrapped by an eating disorder.

Behaving like a false teacher (in a sense, a cult leader), anorexia/bulimia promotes itself by promising adherents a sense of 'spiritual exclusiveness', constituted in a journey which promises escape from the pain of existential realities (Vaughan 1991:108). The eating disorder becomes a god, almost in the religious sense of the word, appearing to be 'authentic', providing answers to life's challenges. The 'convert' is 'lured' into the false promises of anorexia/bulimia, with the relationship becoming both pleasurable and seductive; her anxieties are calmed. Abdicating her life and her own feelings of worth to the spiritual demands of anorexia/bulimia may be comforting to her, because she perceives obedience to be a desirable characteristic. Furthermore, power and control operate on two levels. The ill person experiences personal empowerment, particularly when weight loss is acknowledged,

and she receives compliments from others about looking good; finally, she has been noticed by others. However, the real danger involved is the subtle form of power and control by the eating disorder, causing manipulation and abuse of the body, leaving the body subjugated and marginalized, with the ill person becoming 'disengaged' and 'disembodied' (Jankowski 2003:241).

Moreover, because of the secrecy involved in the disorder, anorexia/bulimia takes on a spirituality of its own, constituting a particular reality lived by the ill person, signalling the message 'to whom I belong' (Griffith & Griffith 2002:165) often identified with a member of a particular religion, culture or cult. Power and control over the body is further paralleled in ways the illness isolates its 'followers', creating 'exclusivity' in a world where 'it' rules, dominates and controls by unquestioned obedience, whilst disparaging interference from 'outsiders'.

Regrettably, the problems inherent in the relationship with an eating disorder are not noticed or accepted at first, due to a restlessness within the self or spirit, which is comforted by a 'blind devotion' to the spiritual practices involved in the ritual of anorexia/bulimia. Herein lies the real danger, as these practices soon take on an 'urgency and compulsion' fuelled by this 'devotion', giving rise to abnormal practices and experiences, referred to in this thesis as anti-spiritual and portrayed in existential postures which are manifested as a disabling spirituality. Vaughan (1991:108) states that whenever a person is obsessed with or pursues anything that sacrifices a healthy spirituality, internal deprivation ensues, with the individual no longer free, but caught in a kind of spiritual bondage. As the ill person becomes 'lured' into a false sense of reality, feelings of euphoria provide a welcome relief from her initial sense of isolation and separation, as she is drawn into the protective 'bubble', a spiritual world created by the illness, from which she will find it very difficult to escape.

Griffith and Griffith (2002:165), explain rituals as being prominent, with the same stereotyped actions repeated sequentially, over and over, at regularly prescribed times. These behavioural characteristics are evident in the ways in which the illness manifests itself in the lives of those living with an eating disorder. Griffith and Griffith (2002:165) state:

Rituals, ceremonies, and spiritual practices share some other similarities. To perform each of them, a person must participate with body as well as mind. Each of the three goes beyond language to engage the body through physical action and bodily experience – specific posturing, gesturing, speaking, hearing, eating, drinking, touching, smelling

In defining ritual, Griffith and Griffith (2002:167) use Turner's words to provide more insight into ritual as 'prescribed formal behavior for occasions not given over to technological routine, having reference to beliefs in invisible beings or powers regarded as the first and final causes of all effects'. From Turner's perspective, ritual always has reference in transcendent experience. Also significant is the dimension of power involved in ritual. In my opinion, both transcendence and power as dimensions of ritual play a crucial role in situating anorexia/bulimia in the context of a wounded spirituality.

Given the above definitions, ritual is emphasised in the ill person's symbolic expression of a spiritual practice. 'A spiritual practice is a method for transforming one's being – mind and body – to expand its openness to spiritual experiences' (Griffiths & Griffiths 2002:172), which is important insofar as the enacted behaviours bring about a change in consciousness.

This poses a serious danger because, as Vaughan (1991:112) explains, when humans are elevated to 'spiritual specialness', when spirituality becomes self-centred in the human quest for personal growth, there is a real risk of losing the immanence and meaning of spirituality, because a psychologically healthy spirituality does not presume that there is only one truth. Harboring a desire for 'spiritual specialness', sufferers of anorexia/bulimia open up the body and self to manipulation and control, particularly when 'hierarchies are esoteric, secret and hidden from the view of ordinary mortals'.

3.8.3 Spirituality, guilt and purification

Individual spirituality becomes destructive or disempowering when spiritual practices of anorexia/bulimia are employed to escape from reality or life's challenges (Vaughan 1991:107). These challenges include self-deception, self-doubt, fear, guilt and anger. The spirituality motivated by guilt or fear is psychologically constraining, because spiritual development and growth are vested in sources outside the self, which makes growth from within and transcendence of the self or spirit impossible to achieve. Reactions that follow initiation into these experiences can be detrimental, as unconscious projections of power and allegiance to anorexia/bulimia can eventually contribute to inappropriate feelings of helplessness, because dependency is reinforced and self-reliance is undermined.

Fear of punishment is commonly associated with feelings of guilt and unworthiness, and these emotions sometimes contribute to the practice of purification rituals, evidenced in self-starvation (manifested as self-harm and abuse of the body by anorexia/bulimia), in burning and cutting the skin, as well as repeated self-induced vomiting (Harris 2000:172). However, a

dependency is created because these purification rituals may also contribute to building a sense of loyalty and specialness in 'group members'. By belonging to a 'special group' which creates dichotomies of 'us' and 'them', those who struggle with eating disorders develop a spiritual awareness – 'specialness thus becomes an egocentric investment in self-righteousness' (Vaughan 1991:114).

The risk involved in purification rituals arises from this investment in self-righteousness, if the rituals have the desired effect of relieving burdens of guilt. Whether the investment is in seeing oneself as especially pure and good, or especially guilty, the specialness is an obstacle to recognizing our ordinary humanity which provides sustenance to authentic spirituality (Vaughan 1991:115). A healthy spirituality is not achieved in isolation, but in living in harmony in mind, body and spirit, with others, with nature and with our Creator. For anyone suffering from an eating disorder, wholeness at the point of intersection between mind, body and spirit becomes crucial, given the state of disassociation between mind and body so typical of the illness.

3.8.4 No longer free: in human bondage to the spiritual power, domination and control of anorexia nervosa/bulimia

The false promises of anorexia/bulimia become evident to the ill person when she realizes that something is seriously wrong, that all her efforts toward achieving perfection and gaining acceptance and admiration have impaired her own sense of well-being. She is left helpless and fearful, enslaved by the illness and unable to escape from its control. Subjugation to the eating disorder, following ritualistic and purgation practices, establish a disabling spirituality of its own, creating altered states of consciousness in order to escape reality, breeding dependency, leaving the ill person addicted to the powers of anorexia/bulimia.

Obsession with the demands of the eating disorder, in pursuit of unattainable goals, violates relatedness and hinders the growth of a healthy spirituality, anchored in connectedness with the self and the body, others and God. Having been immersed in the spiritual practices upholding anorexia/bulimia for some time, held captive in a 'bubble' (a world created by anorexia/bulimia), unable to (and also fearful of) participating in any 'strange' and 'challenging' new reality is evidenced by existential bodily posturing of disconnectedness, isolation and withdrawal.

It is the needs arising from the experience of illness in this person that provide the source of the professional morality of those who profess to heal. Even in what is presumed to be 'only' bodily illness, these oppositions of body, self, mind and external world attack the 'fundamental unity of being' associated with the state we perceive as health (Pellegrino 1982:158,159). I submit that it is this addictive, disabling form of spirituality which is responsible for the intractable nature of this illness. This spirituality is unknown or foreign to most professionals in health care, who continue to adopt a Cartesian dualism that has led them to a diagnosis of pathology, a pathology of the mind, rather than to investigate the inner realm of spiritual entrapment. Herein lies the challenge, a world unknown, to be discovered if we have the boldness to investigate, in order to try to understand the power and control what I would describe as 'fiercely' encountered in the spiritual realities of living with anorexia/bulimia.

3.9 RECLAIMING THE SPIRITUAL WORLD

Loveland et al (2004:49) argue that healing calls on a client's own resources to assist the process, so that healing comes from within, notwithstanding outside intervention by the therapist. In the case of anorexia/bulimia, medical science focuses on the objective condition, and ignores the patient's subjective experience of the illness. It throws light on the pre-occupation with 'curing' without addressing the problem of human suffering and the related concept of healing. Importantly, the locus of healing is centred within the client, suggesting that all healing is, without exception, self-healing (Shield & Carlson 1989:140). This concept of healing is synonymous to 'finding me' (Weaver et al 2005:195), involving not only a turning point but a process, a journey where the individual begins to distance herself from the eating disorder, when she begins to 'think outside the little bubble', at the same time beginning to look at and relate to the body differently.

Central to the therapeutic task is the challenge to help those struggling with an eating disorder to have faith in God or a higher power, their own strength and ability to recover and in the love and support of family and friends, rather than in the false promises of anorexia/bulimia (Berrett et al 2007:378). The process of healing does not suggest a simple return to some prior level of being: for true recovery to take place, there is always new life arising. Healing can be thought of as a 'birthing process', bringing forth new life and new relationships, 'a creative process that brings forth patterns and connections that did not exist before' (Shield & Carlson 1989:140). People struggling with anorexia/bulimia often refer to themselves as being caught up in a bubble from which they cannot escape. The bubble both

protects (from the outside world) and constrains (like being in a cage). The 'birthing process' referred to here can be interpreted as the client's safe exit from the confines of the bubble. In a very real sense, the therapist assists in the birthing process through her relationship with the ill person, with the spirituality of therapist and client in synergy to create a new beginning. (This point is further discussed in Chapter Eight, where I unpack my own model of practice.)

In this regard, Scotti (2009:846), herself a former sufferer of psychiatric illness writes:

Recovery is knowing oneself under new circumstances, redefining one's role, and re-evaluating oneself to develop a new sense of respect of oneself. After living in darkness for many years and having died to my old self, thinking that my life was over and futile, a new birth emerged from within me that has made my life more meaningful and purposeful than before. Whereas before I was a 'thing' person, I now discovered a part of me that is a 'people' person. I treasure relationships, everything from my relationship with our Creator, family, service, users, co-workers, fellow peers, and friends...

3.9.1 Healing as facilitating wholeness

In the previous section, I discussed the woundedness of the self or spirit coupled with the rupture or distortion of the ill person's sense of reality, in essence, her being-in-the world. Although a woundedness of self or spirit, coupled with self-limiting behaviours, suggests an affliction of the spirit, treatment by modernist medicine is predominantly biophysical, where every effort on behalf of the patient is directed to regaining the weight lost.

Holistic healing brings about major shifts in how we think about health and illness. Wholeness of life can only be achieved by facilitating the right relationships. For Shield and Carlson (1989:139), the golden thread in all healing is relationships: '[W]hen we talk about wholeness, we talk about relationship.' The opposite of this relatedness is found in alienation, isolation insulation (the bubble syndrome) and estrangement, feelings typically experienced by women suffering from an eating disorder.

Given the above, healing would be seen in a renewed capacity to re-embodiment, to become at one, with her body, her self, with others and with life in the broadest sense. It suggests an awareness of the whole, a right relationship with self and all beyond the self, with a positive, life-affirming attitude opening the door to all healing (Ralph 2005:132).

3.9.2 Love : the common denominator underlying all healing

People moving toward healing cannot be seen as being separate from those with whom they interact. Healing does not happen in a vacuum, but goes far beyond the recovery of the body. All problems hindering the body's capacity for self-healing must be addressed; and opportunities that would stimulate and promote the body's capacity to heal must be sought (Shield & Carlson 1989:142).

In order for the body to heal, the self or spirit also needs to heal. There must be some stimulus, some source of strength and encouragement for it to take place (Ralph 2005:133-134). Therefore, effective healing stems as much from a changed perception as from a changed body (Shield & Carlson 1989:21). The process of healing also requires the recognition and identification of attitudes and emotions experienced in a disabling spirituality. Denial of the relational consequences of anorexia/bulimia was evidenced in attempts to avoid dealing with the problem.

Healing not only suggests a body no longer under the rule of anorexia/bulimia, but requires a sense of self-forgiveness, of belonging and caring. For a person struggling with the illness, a changed attitude about her self and her body, her being in the world and her relationship with God or a higher power allows for healing to take place. Reflection on belief systems and their impact on the body and the self becomes an important part of recovery.

3.9.3 Healing is re-awakening of hope

People struggling with an eating disorder hold the belief that they are 'other', and not competent to make their own decisions (White 1995:113), particularly because of the stigma attached to mental illness. The relational nature of the self means that there are many contradictory influences affecting the self, constituted in and through relationships, from the past and by society. Because these influences cannot be integrated, they are felt as alien or other: 'Otherness is more than just the presence of difference, it is the presence of difference that cannot be reduced or eliminated' (Poling 1991:111).

Poling (1991:111) suggests that three patterns of ambiguity need to be addressed in order for the resilience of hope to become available:

- the ambiguity of otherness in the self;
- the ambiguous tension of transition – dissolution in the self; and
- the ambiguous tension of good and evil, love and hate, life and death.

The re-awakening of hope, after hopelessness, does not mean that all doubt or suffering is overcome. People in healing come to endure suffering as part of the process of self-transcendence and transformation (Ridgway 2001:337). In the process they can invite the Divine into their lives as a supportive presence, in helping them to 'let go' by taking responsibility without self-judgement and self-contempt, crucial factors in gaining a voice and standing up against the eating disorder (Berrett et al 2007:381).

In this regard, Leete (1989:200), who suffered from schizophrenia herself explains:

We conquer stigma from within. As a first step – and a crucial one – it is imperative for us as clients to look within ourselves for our strengths. These strengths are the tools for rebuilding our self-image and thus our self-esteem.....To do this, we must change the image of who we are and who we can become, first for ourselves and then for the public

Scotti (2009:846) also comments:

They also say that the goal of recovery is to be more human. All pain and suffering of the past was not a waste because it has helped me to be more human, in that now I feel I am a more compassionate and emphatic person, and I can use that new enlightenment to help others. Thus, my recovery has been a precious discovery for me...

3.9.4 Healing as active coping

By taking responsibility for her own well-being, the client gains a sense of mastery over a condition, which was previously perceived as being beyond her control. In order to heal, she must grow in her understanding of herself and the illness. She must overcome the power of the illness, subjugating her body and maintaining the cycle of pain, she must discover new ways of coping and living, and must make innovative changes to facilitate her own growth and discovery (Ralph 2005:133-134).

Of crucial importance to the healing process is that the client should want to get well. As part of the recovery journey, clients, like the participants in this study, have to learn to make decisions and choices that were real, take risks and assume responsibility for their own healing (Ridgway 2001:338). Active coping requires a high degree of self-awareness,

including attentiveness to the sources of stress, as well as all positive resources in her life world. The participants learned to monitor their thoughts and feelings in order to overcome difficulties as they emerged. Ultimately, they learned dynamic and personalized skills and strategies which helped them to cope against the power of the illness.

Scotti (2009:845) recalls:

Recovery was not some magic wave that swept over me. I had to learn to live life all over again, and it occurred in painstakingly small, tiny steps over long periods of time. In and out of my own, each step may have seemed insignificant, but with steady reinforcement of incremental growth, progress was miraculously achieved.

Leete (1989:197) states that 'taking responsibility for my life and developing coping mechanisms has been crucial to my recovery'. For her, growth meant changing her priorities and taking better care of herself. In the process she had to examine her attitudes in order to become more accommodating of people. In addition, she altered her behaviour and response to everyday problems of life.

Poling (1991:70) observes that striving for relationships that are non-abusive gradually becomes the basis of power in the emerging self. When the client internalizes new relationships that are non-controlling, healing is made possible, as new relational experiences are fundamental in creating a new sense of self. By gradually seeking out new experiences in which to find healing, the client uses her own freedom and strength to re-value the abusive past, and foster reliance on healthier, internalized values, counteracting the power of anorexia/bulimia, leading to a new self.

3.9.5 Healing: moving from withdrawal to engagement

Learning to trust is a process of discovery for patients – not simply a quick fix or therapeutic intervention, but rather an ongoing development of inner understanding, acquiring a sense of purpose and direction for themselves. Social support is dependent on letting others into the circle of life (Berrett et al 2007:381). This turning towards others is crucial in overcoming the isolation and disconnection brought about by the eating disorder.

Spirituality then becomes 'the notion of empathic projection – the ability to feel with the other, to embody imaginatively the experience of all that surrounds us' Denton 2005:765). Such an

'aesthetic' attitude to the world is central to self-nurture, to the caring for others and the ministering to the world itself (Lakoff & Johnson 1999:566). When a client is able to give and receive support from others, it becomes empowering for the self, insofar as such coping mechanisms challenge the distorted view that these clients are flawed and unworthy, and reinforces the truth that they have something valuable inside and worth sharing (Berrett et al 2007:382). Spirituality becomes more than a spiritual experience, rather it constitutes an ethical relationship to the physical world (Denton 2005:765).

The troubling voices, practice of self-mutilation and separation of body and self gives the illness enormous power, which limits self-transcendence and personal freedom. The potential for healing is increased when clients show a willingness to trust a compassionate God or acknowledge a higher power in their lives (Berrett et al 2007:378). It is in the context of these intimate interactions that a person continues to co-create an evolving story with God that is uniquely her own, not dominated by the therapist or counsellor's story, or the story of her particular religious doctrine (Griffith 1995:106).

3.9.6 Healing as self-empowerment

In order for people to achieve healing, they must be given back the power to take charge of their own well-being, a power often taken away by the disability of illness, and also by health care practitioners that tend to create dependence. Healing for the individual means no longer viewing oneself in terms of an identity constructed by diagnosis, but reclaiming a positive sense of self (Patching & Lawler 2009:11; Ridgway 2001:339; Weaver et al 2005:199).

To heal is 'to make whole again' and doing so requires confronting ways in which illness wounds the humanity of the one who is ill. These expectations become promises each time the professional presents himself or herself to the person who is ill and offers to help, 'the act of pro-fession, a promise to be authentic' (Pellegrino 1982:160).

3.9.7 Healing is a non-linear journey

Healing does not suggest a sudden conversion experience, but is made up of a succession of small accomplishments with ongoing commitment (D'Abundo & Chally 2004:1103; Matussek & Knudson 2009:705; Ridgway 2001:337). Healing does not imply a smooth journey of achievement; rather, the course is often erratic with falling back; the ill person has to make a new start again and again. Each person's journey is unique, and setbacks are seen as part

of the healing process. Furthermore, healing holds some chance, some mystery, and involves transpersonal occurrences and spiritual passages.

3.9.8 Healing: reclaiming the problem-saturated story

Griffith and Griffith (2002:119) believe that when a problem becomes chronic and entrenched, conversations between the ill person and those around her, as well as her own 'self-talk', become 'monological, stagnant and devoid of creative ideas'. Griffith and Griffith (1994:133) agree with Bruner, who wrote that 'Narratives are not only structures of meaning, but structures of power as well'. The power of a binding self-narrative resides in the power play between the client, anorexia/bulimia and self-mutilation, and is 'performed' repeatedly, with the illness gaining more control and the client losing her voice and becoming smaller in the process.

For recovery to take place, it is necessary to recognize the power of binding self-narratives, given the way in which stories are enacted through the body. Being involved in the rituals of anorexia/bulimia, the body takes on a specific state of being, a particular emotional posture which not only strengthens the hold of the illness, but also keeps the body in a symptom-producing bind. In these circumstances, the client cannot heal because the problem story is being rehearsed continually, with her losing her own authority and sense of meaning. People are aware of their own suffering, but not of the oppression they suffer under the influence of the binding self-narrative. It is precisely these stories, which are not known or recognized as stories, that are most dangerous for the body, because the client has internalized the story, to the extent that it now becomes a valid account of reality (Griffith & Griffith 1994:120-133).

Narrative re-authoring begins by identifying the dominant narrative that is relevant to the mind-body problem. It is spaces within the bounds of the dominant narrative that open up opportunities for developing an alternative narrative. Counselling would involve listening to the client's story in order to formulate questions, metaphors and stories in the co-construction of an alternative, more hopeful, narrative that would leave the body in a more relaxed state, open to new ways of thinking (Griffith & Griffith 1994:120). New meaning is created by displacing the dominant narrative and loosening the hold the problem story has on the body of the client. These healing narratives open a 'quest narrative' that opens pathways and presents positive trajectories for a life course of discovery and personal growth after the experience of chronic disability (Ridgway 2001:341).

3.10 CHAPTER OVERVIEW

In order to direct attention to the research questions, this chapter centres my approach to the eating disorders by exploring the concept of a wounded self, which gives effect to the lived reality of anorexia/bulimia as a disabling spirituality. In support of my argument that anorexia/bulimia should also be investigated in the context of a wounded spirit, I provide a classification of the eating disorders within the biomedical model and unpack and critically discuss both the modern and postmodern narrative approaches, highlighting the shortcomings in these treatment approaches.

In support of my argument for spirituality as embodied in the lived reality of anorexia/bulimia through existential crises states of social withdrawal and isolation, I argue for the connection between spirituality and the embodied experiences of cognition and social discourse, evolving into the chronology of the lived experiences of the illness. In my argument on how social discourse gives effect to the lived reality of anorexia/bulimia, I emphasise the importance of understanding spirituality as the unfolding of a felt sense of embodied experiences through cognition and social interaction, with such experiences emanating from the spirit.

In order to provide an understanding of the issues of power and control given the eating disorders, I highlight the situatedness of the individual in the context of anorexia/bulimia, as the one being controlled by the illness, rather than having control over the illness. I stress the spiritual connotations of anorexia/bulimia, featured in properties of ritual and addiction, where, unwittingly, such spiritual involvement creates a futile reaching after unattainable goals through cultural discourse, whereby the individual loses self-agency and control over the illness.

I am giving further effect to the research questions when I discuss the process of healing as highly individualized and coming from within. The ill person is challenged to take responsibility for her own condition and grow towards healing with the help of the therapist or caregiver. Healing is presented as an ongoing journey of discovery in search of meaning, finding the self, others and God.

In the next chapter, I discuss and unpack the research process, founded within the framework of a feminist model of pastoral care, given a qualitative research design. The chapter underscores the different methodological stances which structured the interaction

between myself and the participants, with the emphasis on the co-creation of embodied and intuitive ways of knowing. I discuss the semi-structured interview as a method for framing our face-to-face interactions, and the biographical method for portraying and capturing the participants as performing on stage their experiences of living with an eating disorder. The research process is presented as a story of our collaborative journey together, giving effect to the research text with language and emotion as forms of embodied knowledge, tying together the re-authored story of hope and spiritual evolvment.

CHAPTER FOUR

THE RESEARCH PROCESS

It is possible to talk with patients, even those who are most distressed, about the actual experience of illness.Witnessing and helping to order that experience can be of therapeutic value.

Arthur Kleinman, *The Illness Narratives* (1988)

4.1 INTRODUCTION

The three women participants in this research shared their subjective experiences of living with an eating disorder with me, telling of how they tried to make meaning of those experiences, and, by finding their own spirituality, how they managed to heal.

All three initially came to me for therapeutic support and pastoral care, having lost belief in themselves and unable to make rational decisions about their own lives. Recovery (or healing, for the purposes of this inquiry), is defined as a non-static, non-linear, ongoing process of growth, discovery and change (Ralph 2005:132-145; Davidson et al 2005:147-170). This has implications for both practice and research, given that such a definition entails consideration of the ill person's role in her own healing; both within and outside the context of treatment. This consideration signified a break from traditional models of psychiatric/psychological research and practice, by placing the emphasis on the ill person's subjective experiences in the context of the illness. With regard to my practice, this translated to the adoption of less 'illness- deficit-based models' of therapy (Davidson et al 2005:166), in favour of a person-centred approach, an approach which implies a supportive, collaborative, therapeutic alliance (Abma 2005:339; Garrett 1998:264; Liberman & Kopelowicz 2005:114; Ridgway 2001:339; Weaver-Randall & Salem 2005:174).

Within this framework, and in sharing my own experiences of the illness, I told the participants about my involvement with Mariska* and how her life and death had touched my own life. I wanted them to become aware that, in order to overcome feelings of helplessness and to heal, it was important to take personal responsibility for their own recovery by growing in their understanding of the illness and its impact on their lives. It meant discovering new

strategies for coping and living, with their own talents and strengths becoming the focus towards recovery and healing (Adame & Knudson 2007:159; Allen & Hardin 2001:169; Deegan 1996:91-97; Ralph 2005:132; Ridgway 2001:337). During these initial interactions, I engaged with them as clients. Our conversations focused on providing therapy/pastoral care, building trust and establishing relationships.

Therapeutic support and pastoral care were provided to each of them over a period of eight months to a year. When the healing process was under way (as they moved from isolation to active participation in life), I approached them with regard to sharing their stories as experiential knowledge to assist others struggling with the illness and to further theory, research and practice. The research planning was born out of these partnerships, moving from a collaborative therapeutic alliance, to the research process, with all participants becoming (re)searchers in the co-construction of new knowledge. The process of (re)search turns researchers and subjects into co-participants in a common moral project, co-searching for new knowledge about which all participants have a say, thereby constituting a form of participatory action research (Denzin 2003:249; Kotzé et al 2002:25).

In this chapter, I unpack the democratic, empowering and humanizing approach that at all times underpinned both the therapy and research in this project (Stringer 1999: xiii). Ethics and morality were inscribed as essential features of the inquiry – not only as standards to be achieved in the interests of humanity, but also as standards that determined the outcome of the study (Stringer 1999:xiii). The research report is therefore largely a retrospective, reflective account of the methodological process that supported both therapy and research.

When healing was present, I engaged in a research contract with the participants. From this point onward, therapy and research were synthesized: the research process itself becoming therapeutic in the journey of recovery. At all times, the ethical imperatives of therapy were placed before the enquiring demands of research. I am aware that this fusion of therapy and research might cause difficulties for the reader, but I have found it very difficult, if not impossible, to maintain a clear distinction – at times they appear to be the same process, which they were, and at other times not. Insofar as therapy sought new paths to recovery, perhaps even therapy at first contained the seeds of enquiry.

Placing myself openly within the research process as a subjective participant provided the starting point for the study, and highlighted the rationale for a qualitative research strategy, which determined both the nature of the data and the means by which it was collected, as

described by Watts (2006:388). I examine our interactions, founded on a feminist model of pastoral care, drawing on a variety of qualitative-phenomenological methods for the interpretation of spirituality in the context of anorexia/bulimia, with the experience and reality of the illness as it is *lived* becoming an integral part of the spirituality of the ill person.

Set in the context of postmodern positioning, two approaches featured predominantly. The first involved eliciting perspectives, experiences and voices of the participants through qualitative research methods that relied on first-person accounts. Data was generated and documented by means of open-ended, partly structured interviews. Our interaction focused on healing as a spiritual process with no pre-determined ideas regarding the flow of the conversation, the framing narrative, or the face-to-face conversations. The inquiry was informed and guided by a social constructionist approach to reality construction, with narrative as a tool providing the content of existence, interpreted and negotiated through language. This implies a shift away from understanding knowledge as an objective representation of the real world, towards a postmodern perspective which views knowledge as a 'local and inter-subjective phenomenon' (Tanggaard 2007:162), constructed between myself and the participants. Foucault's (1980) analysis of unseen power as it operates in discourse to produce 'technologies of self', whereby persons are recruited into discursive resources available to them, further informed the study. At the same time, the inquiry explored Foucault's (1998a) 'aesthetics of existence', (Peters 2005:387) whereby ways in which individuals come to shape their lives through their capacity to make choices were investigated.

The second approach involved the paradigm of participatory action research. Within the framework of participatory action research, the research methodology is based on the assumption that individuals with chronic illness may have important information, indeed sometimes expertise, to contribute to the process of healing and to the research inquiry itself and should therefore be engaged in the process of investigation (Bochner 2000:269; Davidson et al 2005:148; Denzin 2003:249; Kotzé et al 2002:25). Furthermore, participatory action research as a qualitative approach to inquiry underscores the desire to promote further positive change and growth for the participants through their involvement in the research process (Stringer 1999:11). My own field notes, together with the journals, poetry and letters from the participants were used in the drafting of the field text. I used Van Manen's (1990) thematic analysis, together with Gadamer's 'fusion of horizons' as an approach to qualitative data analysis. This helped to identify the themes, processes and meanings which were both a series of events important to the narrator, and created a story

with a plot, illustrating who the narrator has become. I made use of embodied interpretation as a method to explore the fabric of the story and finalize the research text as a biography, incorporating first person narratives, poetry and my own self-reflections. The participants were challenged to tell their own stories, using language and their own form and style to express their individuality.

In this chapter, I also discuss the reliability and authenticity of the research process within a postmodern, qualitative framework. I close the chapter with a discussion on research ethics, centralizing and making transparent my own researcher-self in the 'doing' of research. Participation as the key ethical commitment is discussed with reference to elements such as power, self-other consciousness, narrative, accountability and responsibility in conducting qualitative research. I round off the chapter by providing an overview, with the purpose of summarizing the key elements and leading the reader into the next chapter.

4.2 ON BECOMING OTHER-WISE: OPENING THE DOOR FOR A QUALITATIVE RESEARCH DESIGN

In the following section, I position myself theoretically in order to anchor the methodological approaches which served to guide the entire therapy/research process during all the interactions between myself and the research participants.

4.2.1 Theoretical and empirical grounding

After my journey with Mariska* I came to realise that the lack of congruency I experienced in my involvement with her stemmed largely from the fact that I was not 'seeing' what the medical profession saw during her hospitalization. I became aware of how the illness came to shape her life, denying her a voice, with her own self or spirit vulnerable to the power of the illness. An underlying premise of this investigation is that a lack of spiritual connection is the variable that predisposes the dissociation between the self and the body, which is evidenced in isolation from others and the world. I also encountered this initially in the lack of a sense of connection and trust in my interaction with all three participants. As a result, counselling with a spiritual focus was geared toward restoring an order which the illness had interrupted.

Enhancing new connections meant establishing an environment open to the creation of many new possibilities for healing to occur (Becvar 1996:153; Combs & Freedman 1990; Griffith &

Griffith 2002:134; Leseho 2007:452; Maisel et al 2004:274-290; White 2004:126). Knowledge cannot be created in a void. Hence, in dealing with human relational processes, it was also essential for me to make sure that the setting we created for interactions was open to expand, to transcend and to free spiritual endeavours. I had to provide the space where the participants could experiment with new attitudes to life, to their own selves and bodies, to the world. The power of the illness, with death ever a possibility, provided the capacity to touch something profoundly spiritual, a pulling on the spirit in order to create opportunities for 're-assessment, forgiveness and reconciliation' (Wright 2002:127). I set out to learn about participant spirituality, how to define it and then create a strategy for spiritual practices. It called for a willingness to enter into these processes with no choice but 'wide awakesness and informed passion' (Watson 2004:415-422).

Given these considerations, the research inquiry necessitated a qualitative research design, founded on different methodological perspectives. Within this framework, there was a constant awareness on my part of how interaction, with a spiritual focus, could be instrumental in the co-creation of knowledge and practices that could become the basis for re-authoring the problem story, such as those of the participants.

The re-establishment of relationships that had become broken due to the disempowering messages of anorexia/bulimia grounded in new forms of connection formed the basis for a holistic approach to healing.

4.2.1.1 People are ill as wholes, not as parts

With its focus on achieving healing for the participants, the research inquiry was founded on the following declaration by Kestenbaum (1982b:33), making the inquiry holistic in its focus:

To heal is not merely to heal the body but to heal the humanity of the person which has been wounded by illness. Illness is a transformation of our being-in-the-world, but not only that; it is an attack upon it, a deformation of it, because it threatens our integrity. This integrity includes that of self and body and that of self and world. With the loss of these forms of integrity we lose our freedom.

Given this affirmation by Kestenbaum, it is fair to say that the clinicalization of anorexia/bulimia takes the form of an over-emphasis on diagnostic representations that do not fully account for the essence and wholeness of people's illness experiences (Adame &

Knudson 2007:168; Cowling 2000:16; Nortvedt 2003:129-136; Weaver-Randall & Salem 2005:175-176; White 1995:112-154). It tells nothing about the real person hidden behind the labels of pathology, nor how to confront and ameliorate the ways in which anorexia/bulimia wounds the humanity of the individual.

Moreover, postmodern deconstructionist proposals have (with rare exceptions), offered no framework for integrating the 'divided self' of a person struggling with an eating disorder (Heshusius 1996:131). The fact that the illness makes sufferers disown their own voice, trading real existence for a delusion, is largely overlooked. Accordingly, my therapeutic efforts were structured to assist the participants to overcome the conceptual, internal divisions of mind, body and spirit, with a focus on the *relational self* coming to know itself through connectedness, community and shared meaning (Bergum 2003:124; Gadow 2004:379; Rawlinson 1982:76).

4.2.1.2 Healing from within: a spiritual process

I recently read an article in the *South African Fruit Journal* which provided guidelines to agriculture on biological farming (Pieterse 2006). The author made a plea for a change in focus – he suggests feeding the soil rather than feeding the tree. He stressed that although the application of fertilizer (which he regards as a treatment from the 'outside') may be necessary, it is caring for the soil that will ultimately ensure the health of the orchard (Pieterse 2006:48).

This journal article provided the illuminative metaphor that shaped the research inquiry. It opened up that which was familiar, the feeding of the body only, to alternative ways of thinking and seeing, the care of the body and spirit, where the body cannot be restored without first healing the spirit. In line with the research question, the focus then turned away from the problem presented for therapy to the person herself – the way in which she positions herself 'inside' the illness. This called for an exploration and understanding of participant spirituality, her meaning-making strategies and level of self-awareness and responsibility, evident in the ways in which she shapes her life through the capacity for making choices (Youngblood-Jackson 2004: 674). Contrary to other treatment approaches for anorexia/bulimia, which marginalize the care of the human spirit (Cowling 2000:16), our research investigation focused on the role of spirituality (of the participants as well as of the researcher), seeking its potential by inviting the spirit or self as 'compassionate witness' to enter the therapeutic relationship (Becvar 1996: 27-49; Schwartz 1999:232).

Moreover, the inquiry lent itself to a qualitative research design because of the underpinning principle that each person deserves respect, and should be understood holistically and in context. At the same time, it was open to the voice of spirituality and the body, mostly marginalized in medical discourse, thereby opening the way towards a 'sacred discourse' (Denton 2005:756). Emphasis on healing the body and spirit recognized the connectedness of the self with the body, and the self with the world, within the framework of a moral epistemology, where being particularly attuned to the body also gave rise to expectations about what it meant to be in the world, in relation to others.

The knowledge of the body and of the other is always interactional. It is best characterized in terms of moral notions, through reception, recognition and obligation; it involves a different way of understanding, of being in the world, rather than a matter of procedural and descriptive terms (Tanggaard 2007:162; Todres 2008:1568-1569).

4.2.1.3 Towards establishing new connections: looking for the I-Thou in relationship

Buber (1937:16-17) states that the realm of Thou has a different basis; when Thou is spoken, the speaker takes a stand in relation. According to Richards and Bergin (1997:92), when Carl Rogers said that he believed in 'other' realities, he came to accept, (as I do), 'that the spirituality of the therapist can help to heal the spirit of the client'. Among the strategies identified during the research investigation, creating a context for changing beliefs was pivotal as the central and enduring foundation of the healing process. This hinged on bringing important relationships into the new narrative, as central to the research inquiry's active and dynamic process of enhancing connection, in order to encourage liberating, empowering and healing directions. As a qualitative researcher, the way in which I positioned myself and the way in which I constructed meaning became closely related issues, based on the consideration that the construction of meaning was more than a measurable quantitative topic (Hermans 2001:323; Heshusius & Ballard 1996a:13-14). An ethics of care model (Montgomery 1993; Noddings 1984) structured my interaction with the participants and emphasised ethical caring as occurring in the relation between the 'one-caring' and the 'cared-for' (Montgomery 1993:52), with the one-caring not following particular abstract rules or principles. Instead, ethical caring emerges from 'the natural sympathy human beings feel for each other and the longing to maintain, recapture, or enhance our most caring and tender moments' (Noddings 1984:104).

Looking for the I-Thou in relationships made the research inquiry person-focused, whilst emphasising a different way of understanding being in the world. As the one who administered the caring, my role was to facilitate healing, with a clear intention of not doing the healing, but to assist the participants in achieving healing from within. Transformation and healing were envisaged as a process in which each participant found her own self, because of new ideas concerning the concept of self, other and God (Loveland et al 2005:27; Vella 2000:7; Walsh 1999a:33). Theologically, the standpoint affirmed the place of the Creator and the importance of human relations as central to all life (Neuger 2001:193). Methodologically, it responded to both the religious and non-religious needs of the participants by being there, in meeting, listening and witnessing.

Establishing the I-Thou in our relationship not only addressed the epistemological and ethical aspects which served as the foundation for the research inquiry, but introduced a form of interaction that enters the mystery of spirit with another in a way that imposes nothing, but acknowledge mutuality and the uniqueness of each individual, setting the stage for healing to begin (McGoldrick 1999:16). Such a stance encouraged awareness on the part of the participants of their own spirituality, within their experiences of the illness, in order to make and find new patterns of meaning. It suggested involvement at the level of the spirit, sharing a meditative state with the 'other' which transcended the boundaries of you and me (Schwartz 1999:236). Hence, the desired level of caring was not considered a relationship between a knower and known, but a relation between 'two knowing subjects' who both contributed knowledge to the relationship (Gunzenhauser 2006:627). The depiction of roles of myself (as researcher) and the participants (to be researched) created a platform for a dialogical relationship between two parties, who, each from her specific expertise, collaborated as a co-investigator in a research inquiry on the meaning given to the illness experiences (Hermans 2001:342; Kotzé 2002:17).

With a focus on the body as occupying space and creating a presence, I was drawn into an awareness of my own body, the awareness of how I embodied the relationship with the participants. The space occupied differently by my body asks the question: '[W]hat harm could come from using the self to display what might be therapeutic?' (Pelias 2004:8). My actions shaped the behaviour of the ill person, and my body shared the potential of illness (Frank 1991:71). The process required of me to be a sensitive instrument of awareness at all times, not just in terms of active engagement, to identify the potential or actual impact of my own personal values and positions on the research process (Kingdon 2005:622), but also what the process meant for the participants, particularly the effect on their bodies. This

positioning meant placing the lived, gendered body central to the process and the product of the research inquiry (Finlay 2005:271-292; 2006:19-30).

The methodological stance which underpinned this project is based on the premise that experiences of the spiritual necessarily occur in the body as sensations, perceptions and feelings, in thoughts of the inner world and in the lived events of everyday life (Denton 2005:754). In place of the enquiring gaze centred on the individual and her pathology, a new attitude in helping the participants would involve occupying space differently as relational beings, in order to achieve agency against the demands of anorexia/bulimia. It meant relinquishing 'precision and control' (Guba 1996:125) for 'uncertainty and complexity' (Bochner 2000:267), considering intuition and creativity to be the main components structuring the research inquiry (Janesick 2001:532).

Through a participatory mode of knowing, the body became the centre of discovery for all knowing and learning, emphasising connectedness through somatic and emotional involvement (Finlay 2005:271-292; 2006:19-30). Within this model of caring, objective verification was questioned to make room for a more 'enhanced subjectivity' (Gunzenhauser 2006:628), a participatory form of consciousness that abandoned the position of value neutrality.

4.2.1.4 Interpretivism as methodological stance

The research inquiry framework – variously called qualitative or ethnographic, rooted in postmodernism – was interpretive at every stage. From framing the research question to choosing the participants, deciding what to ask them, transcribing their narratives to text, interpreting what they said, deciding on what to include and emphasise, made the work interpretive at every point, as Josselson (2006:4) shows. The description of the study as interpretive underscores one of the central premises of the study, namely that 'in the world of human experience, there is only interpretation' (Denzin 1989:8). According to Gubrium and Holstein (2000:487-508) and Schwandt (2000:189-205), based on the philosophical hermeneutics of Gadamer and inspired by Heidegger, it may be argued that understanding is the very condition of being human, so that understanding is interpretation. Gadamer (1970:87) explains that understanding is not 'an isolated activity of human beings but a basic structure of our experience of life. We are always taking something as something. That is the primordial givenness of our world orientation, and we cannot reduce it to anything simpler or more immediate'.

The process is inevitably hermeneutical, because as investigator, my researcher-self and everyone else, became part of what may be called the circle of interpretation (Schwandt 2000:189-195). Instead of manipulation and control to attach meaning to the participants' lived experiences, the inquiry sought openness and dialogue as a means of gaining knowledge. Reality resides neither in an objective external world nor in the subjective mind of the knower, but in dynamic transactions between the two (Lykkeslet & Gjengedal 2006:79-89). Thus reaching an understanding of participant's worlds did not entail setting aside, escaping or managing my own standpoint, prejudgements and prejudices; rather, understanding required the engagement of my own biases through dialogical encounter with that which I did not understand, opening myself up to risking and testing my own preconceptions and ideas. Moreover, understanding became something that was produced in and through dialogue, instead of something reproduced by myself through an analysis of that which I sought to understand. Within the framework of philosophical hermeneutics, meaning became something negotiated in the context of the inquiry (a matter of coming to terms) and understanding came to be a 'participative, conversational, and dialogic' process (Schwandt 2000:195).

Interpretive inquiry called for courage; its principles required that I face myself and the other in ways that impelled me to account more honestly for the personal use of my own power as researcher: '[H]ow shall I be toward these people I am studying?' (Schwandt 2000:203). It required me to become immersed in the research setting as a 'total person', rather than relying on the skilled use and execution of research methods (Bassett 2008:255; Burns 2003: 230). All interpretations that the participants and I arrived at themselves became constructions and re-interpretations, with no separation of myself as researcher from the researched. Interpretivist inquiry is unashamedly subjectivist (Greene 1994:539). Also, being dialectic, the process of meaning construction transformed me and the participants, so that we became 'other' in the accumulation of new knowledge.

Within the framework of a postmodern paradigm, the research process sought to make room for interpretation as the means by which knowledge was created, replacing 'truth' based on 'expert' knowledge and positivist approaches. Given the spiritual focus to therapy which guided the research process, knowledge became something constructed between myself and the participants, based on active collaboration. Moreover, the knowledge we constructed was at all times open to being challenged by diverse interpretations, setting the stage for the creation of new possibilities.

In this section, I have unpacked the methodological approaches instrumental in the creation of an informal, non-hierarchical atmosphere, the context within which the interaction between myself and the participants was structured. I highlight the difficulties experienced in the early stages of the journey regarding establishing a relationship between myself and the participants; and I discuss therapeutic strategies which emerged from the relationship itself to overcome these barriers. It is clear from the above that some common threads of feminist thought and therapeutic practice inspired the research design. In the section below, I explore how feminist values informed all aspects of practice.

4.3 TOWARDS A PROCESS OF HEALING: A MODEL OF FEMINIST PASTORAL CARE

In the context of this research project, healing is considered as a process from within. I show how, in contrast to scientific models which hold that distance and objectivity are prerequisites for healing and personal growth, a feminist model of pastoral care profoundly affected how I approached, engaged with and assisted the participants in the healing process.

4.3.1 Practice-based considerations in a feminist model of pastoral care

In establishing a model for the pastoral care and counselling of women, I gained much insight through the work of pastoral counsellors Neuger (2001) and Poling (1991), feminist practical theologians Bons-Storm (2002), Ackermann (1997) and Ackerman & Bons-Storm (1998) and from Watts (2006) and Reinharz (1992) for feminist methods in social research.

Quoting Parsons, Bons-Storm (2002:34) states “A feminist is one who takes seriously the practical course of women’s lives, the analysis and critique of these conditions of life, and the ways in which women’s lives may become more fulfilling”. To this effect Ackermann (1997:65, 66) states that critical feminist theologies are compelled to grapple theologically with the effect of contextual issues in the lives of women, so that issues such as sexist practices, sexual violence, disempowerment and poverty, to name but a few, are no longer merely contextual but profoundly pastoral and theological, making feminist praxis the link between passion and justice.

Furthermore, doing research based on feminist principles requires a particular theoretical position on my part as researcher, and insists on certain approaches in respect of my method and process to inform ethical practice in qualitative research. To this effect Bons-

Storm (2002:34) stresses the importance of different forms of listening to a narrator. The author suggests that an open way of listening would embrace embodied presence, attitude, non-verbal communication and narrative, whilst critical listening would require hearing and determining which beliefs interfere with the development of an individual in terms of their God-given potential. Watts (2006:385) calls for an awareness on my part as researcher of the dimension of power between myself and the participants, the foregrounding of participants' or subjects' viewpoints, a commitment to the participants as the researched and purposing to use the research to improve the lives of women.

The research inquiry moved through the following three stages, starting with our field experiences and leading to the writing of the field and research texts. Firstly, we established rapport and developed trusting relationships. Secondly, there was an opening up of participants' worlds to fresh relational possibilities. Finally, we worked on freeing the body and transforming symptoms with the focus on the process of healing from within.

4.3.2 First things first: establishing rapport and developing trusting relationships

The qualitative research inquiry evolved from a relationship between the participants and myself, based on collaboration, asking questions, and a sharing of ideas, advice and opinions. Feminist research advocates the integrity of the self, recognizing personal involvement as the essential condition under which individuals come to know each other and admit others into their lives (Clough & Nutbrown 2007:80; Fontana & Frey 2000: 655; Reinharz 1992:27). If spirituality was considered as happening between us, as embodied in relationship, this meant that the information shared and the process of meaning-making was dependent on my relationship with the research participants. Therefore, as the most important 'ingredient' in the research process, it was the nature of the research relationship that established the epistemological framework and ensured the trustworthiness of the study (Gunzenhauser 2006:622).

4.3.3 Uneasy beginnings

However, relationships needed to be 'worked at', not just on entering the field but throughout the inquiry process (Clandinin & Connelly 2000:73). We were off to a bumpy start. My journey with each of the three participants commenced at a time when she was very vulnerable. In focusing on their conscious experiences of themselves-in-relation, we found that anorexia/bulimia was very much in control, with the client 'religiously' following what 'it'

prescribed. They were experiencing profound hurt and an underlying anger, as they did not understand what was happening to them; only that something was dreadfully wrong. But so subtle were the lies and tactics of anorexia/bulimia, that at the same time they were not ready to give up 'their secret'; nor were they willing to talk openly about the problem. They were both fearful and uncertain; their worlds had changed, the tide had gone out and left them stranded. They were now in an alien world, and I did not sense from them any feeling of connection or shared emotion.

Having been a witness to Mariska's* life and death under the tyranny of anorexia/bulimia gave me the motivation to explore the spiritual dimensions of the illness and the resolve to 'stay the distance', something which would have proved very difficult had I not had this experience. With the advantage of 'insider knowledge', identification with the inner struggle experienced by the participants served to aid ethical insight, rather than a forsaking of objective analysis (Reinharz 1992:26).

4.3.4 Seeking help

During our early conversations, I sought direction and inspiration from the literature on the illness, but with few exceptions found this literature to be unhelpful. Most studies on anorexia/bulimia are conducted within the framework of the medical model (Bryant-Waugh 2006; Fairburn & Harrison 2003; Lock & Fitzpatrick 2009; Lock & Gowers 2005; Steinhausen 2002), employing quantitative methods which provide no room for the individual to describe the illness experience. Qualitative studies (Maisel et al 2004; Morgan 2000; Zimmerman & Dickenson 1996), whilst offering the reflections and views of clients, focus largely on strategies invented by a clinician or therapist to subvert the illness, and constitutes what the participants in this study came to interpret as 'help from the outside'. Furthermore, research writing and practice has contributed to the marginalization of the voice of the person diagnosed with anorexia/bulimia; and knowledge of her inner experiences, the individuality of her suffering, is sadly lacking. Positioning theory aims at deconstructing subject positioning in discourse, in order to re-negotiate their relationship and identity conclusions, but leaves gaps in the knowledge. Little attention has been paid to the processes by which persons shift and change positions in identity projects (Winslade 2005:362). Information as to *how* people make changes in identity projects is therefore still lacking, providing a focus to this inquiry.

4.3.5 Observed barriers

In the early stages of our journey together, I often left the interviews and our discussions unsettled or open-ended. I was moved by what the participants were experiencing, but I was also surprised by how difficult it was for me to gain a sense of connection and how many questions I found unanswered. Although they never missed appointments, their body language was stiff and withdrawn. During our early interactions, the participants would take up a seat as far away from me as possible and found it hard to look me in the eye. I never got a spontaneous hug upon their leaving, often they were happy to walk past me without even looking back. There were days when they admitted that they had not wanted to come, and they were not keen to talk about their relationship with the illness. Without any input from me, the participants would have remained largely silent. Based on the writings of Michael White (2004:124) and Freedman and Combs (1996:118) I pursued questions such as:

- 'How is the session going for you today?'
- 'What would have been different for you if you had not come today?'
- 'Who do you think would benefit most if you chose not to come for our discussions?'
- 'What is there we should be doing differently?'
- 'Have any of my responses in this conversation put limits on what you feel you can talk about here?'
- 'Do you have any thoughts about other directions for our conversations that might be relevant?'
- 'Do you think you could reflect on our conversation and put me in touch with what seems more helpful to you?'
- 'What plans does anorexia/bulimia have for your relationship with other people?'
- 'Is this something you want?'

Sometimes I felt that our conversations were of little value to them and I often came away from our discussions feeling emotionally drained. However, this feeling of a 'barrier' between us was inevitably my subjective experience; what I may have perceived as an obstacle was not necessarily perceived in that way by the participants (Watts 2006:392). This later became evident in their stories when they revealed the emotional and psychological uncertainty they felt in the beginning, which was evidenced by a need to distance themselves from a perspective that positioned them as 'other'.

4.3.6 Feeling 'other'

This concept of 'otherness' developed within the framework of modernistic medicine and technology, which treats the body objectively, reducing individuals to objects. With the diagnosis of mental illness, the illness becomes intrinsically part of the patient, providing her with an identity that is fixed and also flawed. Moreover, the patient is lifted out of her immediate experience of self and illness and labelled as a problem or category of disease (Bishop & Scudder 2003:108; Watson 2007:1283). Coming from an 'expert', the practice of modernist medicine contributes to marginalising and subjugating the ill person and contributes to her experience of 'otherness'. At the same time, given the complex nature of the eating disorders, patients/clients often receive little empathy from professionals and family, as they are being seen as 'courting' the illness. At the same time, they do not like to be labelled 'anorexics' or 'bulimics' and express suspicion when their suffering is reduced to medicine's general unifying view. As a result, the ill person remains stuck, experiencing a lack of freedom to explore other ways of being in the world, vulnerable to the power of anorexia/bulimia and increasing the likelihood of future acute episodes (White 1995:115).

4.3.7 Bridging the divide

In working towards gaining their trust, I realized that even when and if I could gain it, this trust would remain fragile. At the same time, the importance of reducing the divide between the therapist and the client, between researcher and participant, is now widely accepted across various disciplines as a precondition for thorough comprehension and practice (Beveridge 2002:102; Watson 2007:1285). In this regard, Fontana and Frey (2000:647) argue that as social scientists, we should recognize that interviews are 'interactional encounters and that the nature of the social dynamic of the interview can shape the nature of knowledge generated'. White, Boyle and Loveland (2005:240), in opening the window on 'stigma-shaped' practices within treatment systems, explain that these practices have served to de-personalize and de-humanize people. In a similar vein, and in common with the current research project, Deegan (1997:353) has identified these practices as 'spirit-breaking', explaining that this may be happening to people in any environment of chronic illness, where they are being disempowered, prevented from making their own choices and directing their own lives.

So as not to impose the preconceptions of academic thinking on the participants, I regarded 'close rapport' to be essential (Fontana & Frey 2000:655), something crucial to the fluidity of

building trust and establishing relationships. Early on in our discussions, whilst providing pastoral therapy and care, and as a means of building bridges, I told them of my involvement with Mariska* and how her struggle with an eating disorder inspired me to seek new perspectives in therapy and practice, with continued research towards helping those living with this illness. As a feminist researcher, my own personal experiences in the context of anorexia/bulimia became a source of entitlement, where objectivity and subjectivity were not seen as incompatible opposites, but rather as opposites that served each other (Reinharz 1992:263). It was a strategy not only to make myself more visible in the process, but also to introduce the 'world' of the eating disorder from another perspective. I presented myself as a 'learner' and wanted them to know that I was sincere and committed. I shared with them how the knowledge I had gained during my interactions with Mariska* had been invaluable in giving me insight into the power of the illness, and how I had developed new awareness about healing, rather than curing the illness.

4.3.8 Positioning

These experiences conflicted with modern expectations that as a therapist and researcher I should be detached, impassive and value neutral. In front of me I saw human beings, not objects to be acted upon, or illnesses to be treated. Each one of them could take a stand against the illness and not be a passive victim, could overcome her particular situation and all of them could become 'experts in their own journey of recovery' (Deegan 1996:91-92). I sought to attend to each one individually, through descriptively focused interpretations, to clarify her meaning-world with her, thereby providing her with the experience of being heard – and hearing herself – in a manner that was non-judgemental and accepting of the struggle she was experiencing.

Given my existential-phenomenological approach, I argue that it is through the relationship itself which sought 'to be *with* and be *for*' the client (Spinelli 2004:5), that the client's issues were manifested or 'brought forth' for examination. I had to position myself in relationship with the participants in a manner whereby the encounter not only acknowledged our 'co-constitutionality', but also emphasised *doing* as an extension of, and not a substitute for, my *being in relation*. What I 'do' as therapist becomes an expression of my attempts to acknowledge and enter into the client's world-view, rather than being considered the 'expert taking charge' of the therapeutic encounter.

In being with and being for the client, my 'doing' was not based on a specific technique or a set of committed skills; instead, I maintained a flexible attitude and approach towards my own 'therapeutic style', which emphasised my own personal or 'being' qualities as an essential part of our interaction. This interaction, underpinned by a collaborative therapeutic approach, provided the foundation upon which the qualitative research inquiry was built. Much later in our discussion (after about eight months to a year), I approached Mare-Lee, Mariska and Heidi for their full participation in the research project. All three had by that time made significant progress in standing against the illness, their core narrative having shifted from one of chronic disability to a much more fulfilling, dynamic life story, best understood as an ongoing journey (Ridgway 2001:335). This journey meant placing the participant at the centre, with the stages of healing as part of the growth process in her recovery. Hence, healing meant not only transcending the stigma of a 'mental illness', but also becoming involved in all dimensions of life, embracing connection and re-establishing relationships, with recovery becoming an 'attitude, a stance, and a way of approaching the day's challenges' (Deegan 1988:15).

4.3.9 Participatory action research

Kemmis and McTaggart (2000:573) explain that participatory action research emerges in situations where people want to think 'realistically' about where they are now – how things came to be that way, and from these starting points, how things might change in practice. I approached them about sharing their new-found knowledge in the research project as a means of helping others struggling with an eating disorder. I explained that I was registered for a doctoral study, and that my research interests stemmed from my heartfelt desire to include the experiences of those suffering from the illness in the 'not-yet-said' and the 'language of the unsayable'. I provided them with a typed information sheet which outlined the scope of the project. (See Appendix A for the Information Sheet inviting them to participate and Appendix B for a sample of a Consent Form for participation. Note that the title of the project given in the appendices was the original title of the study).

We discussed how the classification of the illness and the 'labels' attached to them created barriers that left no room for their voices to be heard. I suggested that the research project had the potential to create new perspectives and that I wanted them to share in the challenge that together – we had the ability to make a difference, to promote change and further their own development and growth. I provided an agenda for our sessions with parameters regarding the duration and scope of the research relationship.

I explained that the notes I had taken during our interactions would be included in the research text, and asked if they would be willing and interested in sharing their stories in the published text; not as mere data providers but as co-researchers, thereby honouring and acknowledging their contribution to the research endeavour. I made certain that they understood what such a position would entail in terms of their involvement (ethical considerations are discussed in more detail in Section 4.9).

A factor that I believe was crucial to the fluidity of the process was the issue of gender. Inquiry into the lives of the three women became fundamentally participatory, where 'listening and talking from a woman's standpoint' (Devault 1990:96) was deeply valued. Anyone with no personal experience of the illness might have been regarded with suspicion by the participants, and as an outsider might not have gained their acceptance and confidence. As a woman doing research with women, I could be considered 'on their side'; our gender enabled at least some measure of 'sameness' or 'connectedness' in the complex dynamic of the researcher/participant relationship. I spoke their 'language', I believed them when they told me about voices they heard, and how this made them fearful. I could not simply dismiss as delusional what for them was real. Such an understanding, from the perspective of the participants, stands in opposition to the medical meta-narrative which trivialized their actions and thoughts, or interpreted these experiences from a male standpoint (Neuger 2001:128; Reinharz 1992:87).

Above, I have looked at the interactional context in which the relationship between myself and the participants was structured, within the framework of a feminist model of pastoral care. I have unpacked how this model inevitably influenced the research context by inviting an openness into my thinking and a flexibility into my ways of working, in order to practise in a self-reflective, interpretive manner. I discussed how the value of the endeavour was founded less on the strategies employed and more on the quality of our collaborative relationship, seeking to be with and for the participants in ways that were open and respectful, in order to strengthen connection and foster the process of transformation and growth.

Having established the basis for our research participation, the research process then required that we unpack their relational standing with anorexia/bulimia and undertake the construction of meaning in the context of the illness.

4.4 OPENING UP THE PARTICIPANTS' WORLD TO FRESH RELATIONAL POSSIBILITIES

Meaning construction and reconstruction required serious attention to be paid to the stories the participants told about their lives and to the ways in which they organised events that became part of the problem story (Freedman & Combs 1996:42-76; Morgan 2000:11-16; White 1995:41-59). This meant that the concept of 'voice' became central to the method of the qualitative research. Hence, the words used by the participants in recounting the events in their everyday life are reported *verbatim*, as they wanted their stories to be heard (Hermans 2001:324). Research is essentially political, in that whatever evidence I present embodies a particular position when I try to interpret the meanings implied by the research participants, within their particular social frameworks (Clough & Nutbrown 2008:95; Schwandt 1994:128).

In a qualitative approach, I am seen as an expert in theory and methodology, because I have experience and knowledge of people and communities. However, the participants were considered experts in the circumstantial meanings that they gave to the events in their lives, and to be knowledgeable about the particular circumstances and events that played a major role in their personal stories (Hermans 2001:342).

A widely used method for creating field texts in qualitative research is the interview (Clandinin & Connelly 1994:420). The kinds of question I asked and the ways in which these questions were structured provided the framework within which the participants shaped their stories.

4.4.1 The interview as a framework for data collection

As I had a very flexible approach to data gathering, our face-to-face conversations took the form of open-ended or unstructured interviews, intended as a type of therapeutic interviewing, where we shared experiences in a context of 'conversational intimacy' (Corbin & Morse 2003:338). Kvale (2006:483) defines the research interview as 'a meeting with another person to achieve a specific goal, and more generally, as a conversation with a purpose'. From the outset the participants took part as co-authors and not mere subjects, with the purpose of inviting them to question 'known' knowledge of the illness with regard to the diagnosis, and to generate new knowledge that would empower them to stand against anorexia/bulimia. My aim was to create an inclusive inter-view model that would be open and

exploratory, based on the sharing of ideas so that our conversations were loosely structured and informal; and the participants were free to interview me too, as recommended by Watts (2006:387). This model generated the following questions proposed by Roux and Steyn (2002:166): What do we need to be able to co-ordinate with each other? What kinds of skills are needed? And what do we need to learn from each other in order to co-ordinate our knowledge?

Interviews served as the tool which enabled an exploration of the participants' situatedness within the context of anorexia/bulimia, making it possible for them to language what they felt and experienced, turning their lived experiences into narratives. Thus interviews provided the method by which the personal was made public (Denzin 2001:28). Several open questions were asked that referred to the temporal dimension of a participant's self-narrative, that is, to the past, present and future (Hermans 2001:342). Asking many questions opened up possibilities which generated and brought about new ideas and knowledge as each question became generative action in itself (Roux & Kotzé 2002:149). Collaboration entailed seeking to understand what was of interest to the participants and how the journey was affecting them (Morgan 2000:3). Probing was done gently, from a position of mutual trust, listening and caring for the experience described by the other (Clandinin & Connelly 2000:109). This loosely structured approach proved very useful as a method for generating qualitative data, because I considered it appropriate for exploring the subjective experiences of the participants, and because I valued the collaborative exchange as essential in establishing rapport and trust in the negotiation of our ongoing relationship. My actions, the questions that I asked and how they were structured shaped our relationship and provided a frame within which the participants responded and gave accounts of their experiences (Clandinin & Connelly 2000:164).

At the same time, a specific use of language became critical, because language constructs meaning and creates social reality. Language is powerful in that it either closes down possibilities for action or doing, or is reflexive and responsible and invites an 'ethics of participation' (Roux & Kotzé 2002:149). A question such as 'what do you think are the plans bulimia has for your life?' not only highlights the participant's relational standing with bulimia, but invites critical reflection and dialogue in considering this relationship, which in turn opens up new possibilities for growth and change. Roux and Kotzé (2002:149) suggest that 'when language creates and invents, it generates new possibilities for alternative actions, impossible before'. The statement 'I am a bulimic' suggests that the illness is inherent to the client's identity, causing the illness to be fixed and irreversible. However, asking questions

and using language that created new possibilities for alternative actions invited cogency and openness into our conversations, rather than relying on my own 'superior' knowledge and training as a therapist. Ultimately, our discussions developed into what Waldegrave (1990:24) calls a form of 'energized conversation'.

The qualitative research interview provided a personal alternative to the objectifying, positivist quantification of questionnaires and allowed a 'gentle, unassuming, non-directive' approach into exploring authentic personal relationships with the participants, as suggested by Kvale (2006:481). Used in this way, the interview was simultaneously a site for conversation, a discursive method and a communicative tool that produced knowledge about the self and its relationship with anorexia/bulimia (Denzin 2001:28).

The capacity to be a witness to their illness stories became central to providing care and constituted the genesis of healing. As trust was established, gradually more information was shared, so that the interviews became 'reality-constructing', 'meaning-making occasions' (Corbin & Morse 2003:338), which are essential in the re-authoring of problem stories. Meaning-making was pursued with the help of patterned narrative linkages which provided 'horizons of meaning' (Gubrium & Holstein 2000:501), as the participants and I shared in an event of understanding in which we were both transformed (Freeman 2007:941). Although I played an active role in assisting the process, the participants remained the leading players on the stage. I responded, probed or asked for clarification during the course of a loosely structured interview (given my research interests) to ensure that focus was maintained and that direction and relevance were not lost (Corbin & Morse 2003:397).

Most of the interviews were conducted privately, but some included participants' mothers (by participant invitation). Our conversations lasted for approximately one to one and a half hours, at negotiated intervals (on average twice per month), depending on the participants' school or university commitments. Furthermore, our conversations took place at different times on weekdays and weekends, and were not confined to my office. In a move to help them re-connect to the outside world and to establish new relationships outside the 'prison' created by anorexia/bulimia, we sometimes took a walk on the beach or enjoyed coffee in the garden restaurant of a local wine estate.

In our conversations, I identified some phenomena as interesting and worthy of annotation. I used my own discretion in deciding what should be documented, so that the process became highly subjective and dependent on the happenings of any particular day (Wolfinger

2002:87). My notes had a dual quality: there were the notes that captured experiences during my interactions with the participants, as well as the notes to myself reflecting on these experiences (Clandinin & Connelly 2000:88).

Composing texts required being alert to what the participants did and said during our discussions. It also necessitated keeping records on how they were coping with the experience of being part of the inquiry. In recording our interactions, I divided my page into two sections. In one section, I noted what they told me and tried to stay close to the actual words they used. In the other, I recorded my own 'reflective notes' (Clandinin & Connelly 2000:128). Their stories were important, but I also observed body posture, facial expression, the tempo and rhythm of their speech, and their chosen seating arrangements; and I recorded these as data for understanding the phenomenon in question (spirituality). I made notes of events as they unfolded and summarized my notes after every occasion on which we met. This provided me with the advantage of being able to reflect on the events of each day and recall detail that might otherwise have been forgotten (Wolfinger 2002:87). These preliminary notes generally formed a comprehensive outline for the compilation of a more complete report.

Overall, these interim texts supported me in detailing the richness, nuances and the complexity of landscape, returning me to a richer and more complex synopsis than memory alone was likely to construct, as Clandinin and Connelly (2000:82) point out. These texts not only accommodated the problem story, but opened up space for the development of a more hopeful re-authored story.

4.4.2 Exploring the problem: the role of stories

Making meaning is basic to being human, and being human entails actively constructing meaning. In order to create a context for change, it was important for me to understand what meanings the participants constructed about anorexia/bulimia, and how they languaged their experiences and made meaning of their relationship with the illness. As a tool for the exploration of the problem-dominated story, narrative provided a focus on language, discourse and power. I take the position that all meanings constructed as self-knowledge are the effect of interrelations between power, discourse and truth. In this, I agree with Youngblood-Jackson (2004:676), who in turn drew on Haraway, that no knowledge can escape being compliant with meta-narratives, those so-called taken for granted truths that circulate in society and count for accumulated wisdom.

Our conversations were structured as a form of narrative therapy, based on the work of Freedman and Combs (1996), Kotzé (2000), Maisel et al (2004), Morgan (2000), Russell and Carey (2004), White (2004) and White and Epston (1990). Narrative inquiry can be regarded as a playful form of communication, interpretive at every stage, and implying a firm belief that persons are greater than the problems they present for therapy. This approach to therapy seeks to reposition people as the experts in their own lives, and is therefore a respectful, non-blaming approach to counselling (Morgan 2000:2; White 1995:15). Narrative inquiry is essentially a linguistic form of inquiry, with conversations grounded in communication (Clandinin & Connelly 2000:77), based on the assumption that people tell stories, that many stories occur at the same time, and that the events as they occur will be interpreted according to the meanings (plot) dominant at that time. This implies that the act of living requires an engagement in the mediation between the dominant stories and the alternative stories of our lives (Morgan 2000:9; White 1995:19, 2004:124).

Using narrative inquiry allowed me to create a research text that illuminated the participants' experiences as they lived 'inside the illness', but also how the discourses of social and cultural contexts shaped their relationship with anorexia/bulimia. These discourses are voices and perspectives confronting and contributing to meaning negotiation and a widening of horizons, in the context of the research inquiry (Tanggaard 2007:161). In telling their stories, the research participants made visible (also to themselves) the 'lived border' constitutive of the relationship between the personal and the social, where their lives were lived (Saukko 2000:301). There is always a context in which stories are formed. For the research participants, it was the 'lived border' that constituted reality and ways of living with the illness. The participants presented themselves as being intensely focused on the problem-dominated situation, and being out of touch with their capacity to be successful in the face of their difficulties. I regarded these problems as stories, as ideas with a 'history and a future – as being directional, as having a lifestyle support system, and as being progressive, i.e. they are located in a sequence of events across time' (Kamsler 1998:59).

The participants constructed meaning by interpreting events through the lens of the dominant story, which resulted in a particular reality being lived. This reality, strengthened by the discourse of anorexia/bulimia, developed a truth status, almost a spiritual truth, which they religiously adhered to and followed. Because no truth is constructed outside relationship, and with spirituality constituting the relation between body and self, anorexia/bulimia developed its own spirituality determining what was real for the participants.

I used narrative or story, not only as a method for gathering information, but also to inform me on how the participants were positioned in talk. '[T]he self is being made present in the construction of a narrative' (Miehls & Moffatt 2000:343), when participants take up positions in relation to discourse in the very moment of making an utterance in conversation. That is, 'as we speak, we create and exchange pieces of discourse' (Winslade 2005:353). As Lock et al (2005:317) point out, Foucault spoke about unseen power which operates in discourse to construct what he referred to as 'practices of discipline' and 'technologies of self'. Therefore the problematic situation the participants found themselves in resulted from their positioning in and through discourses available to them.

In order for me to understand how the participants were constituted by, and were recruited into reproducing discursive practices, it was important to view their account of the illness experience, not as a direct result of how things were 'out there', but as a consequence of the meaning it carries within society, with implications for identity construction as 'an artefact of communal interchange' (Gergen 1985:266). The participants were not only recipients of the influence of social discourse, but, given that each utterance in social interaction calls on discursive material (words and meaning) in order to make sense, they constantly produced and reproduced discourse through participation in social interchange made up of patterns of meaning (Winslade 2005:354). The participants came to live the reality of pathology constructed within the medical framework of anorexia/bulimia. Diagnosis silenced them, they became implicated in the production of narratives by doubting themselves, thereby giving the illness immense power. Coming from an 'expert' and spoken out over them, these knowledge took on a truth status that informed their beliefs about themselves. They were recruited into social discourses that subscribed to the Western cultural demand for slimness in women's bodies, which became prescriptive and inscriptive with standards of beauty and acceptance achievable only by severe manipulation of the body.

4.4.3 Unsettling the problem story through discourse analysis

Wang (1999:193), informed by the teachings of Foucault, suggests that we should not focus on a self that 'appears' to be fixed, but should rather on the work of discourse and its inscription of the self. Again drawing on Foucault and the social constructionist paradigm, Speedy (2005:284) argues that a narrative approach to counselling positions personal agency within social and political discourse, and emphasises identity as a 'social, historical, and relational achievement'. For example, some meanings came to dominate the participants' self-understanding, and constructed ideas about the self because of general

consensus. A statement such as 'I am a bulimic' suggests a self/identity that is fixed, something inherent in the participant's self, rather than the influence of the discourse that 'as a woman you need to be thin to be beautiful, and it is acceptable to use self-induced vomiting as a means of weight control, everybody does it'. These discourses operate in society and legitimize meanings as to how things are, thereby obscuring the possibility that other meanings exist (Winslade 2005:354).

However, given that relationships are always open and evolving, and that the participants' selves were constructed in and through relationships, these selves are also open and shifting and are not determined by discourse. In other words, the self is not static, without agency (Youngblood-Jackson 2004:674). Rather, because of the notion of multiple selves and possible self-agency, the same discourses that produced what in a narrative approach is referred to as 'thin' descriptions of participant lives have openings where the self can exercise freedom of choice, whether to subscribe to certain discourses or not (Youngblood-Jackson 2004:675). This meant that the research participants had the ability to re-position themselves, and to act as agents, actively involved in re-shaping their world.

At the heart of narrative inquiry is the conviction that the problems presented by the participants were taking place in language and conversation, so that the main concern became the participant's story and the way in which this story embodied and sustained anorexia/bulimia (White & Epston 1990). The ultimate aim of the research inquiry was to transform the narrative constructions so as to enhance participants' well-being.

4.4.4 Re-authoring the problem story

In order to create self-agency and empowerment in their struggle against anorexia/bulimia, participants' positioning in discourse became the key concern in our inquiry. The methodology calls into question how narratives are interwoven within relational plays of power, and how subjects re-negotiate their own positions within discourse (Allen & Hardin 2001:174). I was committed to exposing the discourses that kept anorexia/bulimia alive, with the power to hurt and even kill those it entraps.

As a therapist I moved from empathic listening, central to the process of coming to voice, to deconstructive/radical listening (Neuger 2001:139). Deconstructive listening provided a critical and interpretive method through which I became aware of different voices, enabling me to unsettle subject positioning in discourse. This implies a research methodology different

to merely hearing: it is a form of listening which pays attention to all the voices to be heard in the context of inquiry. The research act was therefore both political and positional. It was political, in that radical listening and focused attention exposed discourses and so-called 'truths', thereby balancing negative stories of 'damage' and 'pathology'. It was positional in that the aim was to discover openings or spaces within the discourses in order to re-position the participants in the re-authoring of stories of resilience and resourcefulness (Clough & Nutbrown 2008:25).

The processes of deconstruction and externalization are the pillars of narrative inquiry and provided the methodological tools to unsettle the problem story, so that the influence of the story in the participant's life became evident and opened up possibilities for new narratives to arise (Sakalys 2003:235). White (1991:27) explains that

deconstruction has to do with procedures that subvert taken-for-granted realities and practices: those so-called 'truths' that are split off from the conditions and the context of their production; those disembodied ways of speaking that hide their biases and prejudices; and those familiar practices of self and of relationship that are subjugating of person's lives.

For instance, I asked Mariska: 'Are the voices in your head different from the voices of those who pinned all the labels on you? What are the tricks these voices use to become so demanding of your life? What gives these voices the authority? What about your own voice, your own power?'

Externalization is a process that linguistically separates problems from persons. This is a helpful practice, because problems are often internalized; participants referred to the illness as if it was part of them: 'I am a bulimic.' Through externalizing conversations, the effect labelling and diagnosis had on their lives was diminished. For example, I could ask: 'Do you think you have a problem with bulimia? What has bulimia talked you into about yourself? Do you think bulimia has any good plans for your life?'

Participants were assisted to move from being a 'bulimic', to someone who struggles with bulimia. The problem is then objectified and moved outside the person's body, the problem is 'de-stigmatized' (Weingarten 2003:77). This linguistic separation created an emotional distance which allowed for an opening in the problem narrative through which participants' were able to reflect on and review their relationship with the illness.

This way of speaking about problems is profoundly different, because it uses non-blaming or non-pathological language (Neuger 2001:138.). Speaking in this way, it is these distinctions that provided structures for knowing, structures that contributed to participants' being acknowledged as individuals and provided with opportunities to reflect on taken-for-granted attitudes about their lives, and who they were as people (White 1997:137). In these re-authoring conversations, little events and acts that stood against the dominant plot took on a special significance, and in so doing provided options for the identification and thick description of alternative stories of the participants' lives.

Above, I suggest how the loosely structured, open-ended interview complemented a flexible approach to collecting qualitative data by means of narrative, face-to-face conversations. These conversations not only aided in structuring our ongoing relationship, but also provided the context underlying the participants' construction of meaning, as evident in the subject positioning within discourse. The ultimate aim of our narrative conversations was to create an awareness of 'truths' constructed in and through discourse, so that the participants would appreciate how the language they used constructed meaning and reality. This was evidenced in living the problem story, resulting in the body's remaining subjugated by the power of the illness.

Introducing a postmodern narrative approach which externalized the problem served to separate the pathology constructed by the medical diagnosis from the participant's identity, but that process alone could not transform or heal the extreme emotions and beliefs that generated the problem in the first place. In the section below, I emphasise healing, understood as a spiritual process from *within*. It focuses the lens away from anorexia/bulimia as situated in taken-for-granted narratives in discourse to an illness manifested in the interface between mind, body and spirit, and evident in the lived reality of a wounded self.

4.5 THE PROCESS OF HEALING FROM WITHIN: RECONNECTING MIND, BODY AND SPIRIT

Given the abuse and neglect suffered by the body, Foucault's teaching on the 'aesthetics of existence' became relevant, particularly with reference to anorexia/bulimia. Peters (2005:392) draws on Foucault in suggesting that care of the self, that is, finding self-agency through voice in discourse, means a process of *self*-transformation, an ethical and political project, and above all, a matter of the *self* (spirit) understanding the relationship to *itself*. Externalizing anorexia/bulimia as the 'problem' does not deal with the core issue of what

constitutes reality for the ill person, or why the discourse of anorexia/bulimia has left her self and body vulnerable to the power of the illness.

Any form of violence or abuse to the body not only affects the personal integrity of the participants, but also their feelings of self-worth, as the illness compromises their ability to relate and connect with others. Because the human spirit or self is embodied (Denton 2005:755), self-inflicted injury or harsh treatment of the body is indicative of a broken relationship between self and body. If the self or spirit is considered to have the embodied capacity of healing (Denton 2005:755; Schwartz 1999:227), healing can be seen as a spiritual process, a self-witnessing act, with the self or spirit being able to attest fully to the stories of *how* the self became burdened by the illness (Schwartz 1999:227).

The relational positioning of the participant within the context of anorexia/bulimia (evidenced by the self turning on itself at the expense of the body, as well as the brokenness in her relationships with 'all' around her) became the focus of our interaction.

4.5.1 Existence within the framework of relational positioning

Much research and literature has focused on anorexia/bulimia's having cultural and social significance (Dignon et al 2006:942-956; Gremillion 2001:135-149; Maisel et al 2004; ; Morgan 2000: 151-157; White 2004:152-173). Although I am of the opinion that culture does play a role, very little reference is made in the literature to anorexia/bulimia as a deliberate, indirect form of *self-harm*, through abuse of the body, sometimes also occurring with direct self-mutilation in the form of cutting or burning the skin. Deiter, Nicholls and Pearlman (2000:1174) draw on the work of Favazza and colleagues in suggesting that self-injury is present in as many as 40% of individuals with bulimia, suggesting that it is the relationship the self has with itself that has become problematic.

The term 'self-injury' refers to deliberate acts resulting in damage to one's own body and bodily tissue, when these acts are not intended to bring about death (Deiter et al 2000:1174; Harris 2000:169). When I was confronted with the physical consequences of such behaviour, the focus of my therapeutic support was to try to understand the meanings and functions of self-injury within the framework of anorexia/bulimia. This meant an exploration of the meanings and purposes of the behaviour and assisting the client in developing strategies around interpersonal connection, affect and self-esteem, which often underlie self-injury (Deiter et al 2000:1180). It was through the processes of *self-appreciation* and *self-healing*

that the participants came to understand the real effects of anorexia/bulimia on the body, how acts of self-injury were wounding not only the body, but their very existence (Rao 2006:50).

It became important for the participants to understand their own spirituality in order to reflect on forms of relating – between the self, the body and all else. If the participants were to heal from within, they needed to become aware of the spirituality or reality they were subscribing to and the impact of this ‘truth’ on all forms of *relational engagement*, directly assaulting all dimensions of spiritual existence. Moreover, a reflection of her own spirituality placed participant agency alongside choice, where the power to act or not to act was attached to her own performance. It called for an awareness of daily patterns of association, interrupting patterns of disconnection and actively seeking to expand patterns of connection. It meant actively thinking ‘in other categories’ (Barrett 1999:198), that is, actively adopting and holding onto strategies to discipline the mind, to bring about a positive mental attitude towards the self and the other. Our interactions were directed to helping them look *within* for alternative outcomes, becoming aware of their own healing potential, with the self or spirit as the embodiment of that capacity.

Metaphorically, the journey of recovery was envisaged as ‘a journey of the heart’ (Deegan 1996: 91-97). As such, it is both a journey inward and a journey outward. It is by learning to discern and listen to feelings and emotions of the spirit, experienced in the ‘heart’, that growth occurs, bringing understanding with a sense of direction and purpose, leading the way to healing. In order for me to be able to enter into the participants’ reality, I had to understand their behaviour in terms of its existential significance for them. I had to grasp the magnitude of what it was I was asking them to risk when I invited them to start caring for themselves and start living again (Deegan 1996:92). I had to be respectful of and honour their interpretation of ‘the truth’ in terms of what made sense for them. It required a move beyond the mere recognition of the illness to wholeheartedly encountering the *person* in front of me.

From a postmodern perspective, to live is to participate in the construction of our reality. As human beings, we are continuously involved with others in mutual processes of feedback and response, with new knowledge being re-created in each moment of perception and interaction. This meant that the participants’ worlds, their lived reality, was not fixed, but open to constant change and transformation (Becvar 1996:152). Healing from within was conceptualised as necessitating changing and growing from within, closely connected to

ways of making meaning and constructing reality. It also meant that the participants were challenged in terms of the reality they wished to create.

In view of the above, our interactions focused on creating participant awareness in the process of creating reality, their role in helping to create the world that it was possible for them to experience (Griffith & Griffith 2002:64). They were invited to change previous meaning-making strategies which had inadvertently kept the illness symptoms flourishing. The participants were encouraged to learn to 'think differently' about the illness relationship. It meant (re)introducing the participants to new ways of connecting, drawing them into unexplored territories which would expand their perceptual capacities about the illness, the world and their place in it (Frank 1995:37; Watson 2004:25).

4.5.2 The role of story, symbol, metaphor and imagination

The research process relied heavily on story, with its elements of metaphor, symbol and imagination, as a technique to access and use participants' inner resources in pursuit of healing, and also to pursue my therapeutic goal, that of investigating their spirituality in the context of the illness (Combs & Freedman 1990:53; Griffith & Griffith 2002:59). Because language both expresses and constitutes spiritual experiences, as a tool, the telling of stories can open up healing possibilities when these experiences become embodied through metaphor, story and symbol (Griffith & Griffith 2002:57). Whatever the immediate, felt presence of spiritual experience, it is given form, transformed, shaped and constrained by symbolic language and action. Therefore metaphor, symbol and story were the means by which participant spirituality could be accessed, expanded on and expressed. This strategy implied that the participants already had inner resources in the form of personal knowledge, perceptual positions, attitudes and behavioural patterns that were already part of their experiences, and that they could draw on to resolve their difficulties in the problem situation (Combs & Freedman 1990:53).

The stories we shared served as a metaphor for the ideas they expressed. Furthermore, story and metaphor brought about shifts in thinking that released and tapped into spiritual energy to expand awareness and responsibility (Maturana & Varela 1992:17). Through the sharing of stories, and a simultaneous flow of new information, the participants were challenged to focus on the nature of the reality they wished to help to create (Becvar 1996:137). These stories embedded useful ideas that altered, modified or challenged constraining beliefs when approached from an 'offering' and 'inviting' stance (Wright et al

1996:220). The conversational flow changed from asking questions to telling stories, so that this form of conversational behaviour invited the participants into a listening mode (Wright et al 1996:220). At the same time, the participants were invited to open space to this sharing of information, something which avoided my imposing my own views, keeping our discussions a dialogue rather than allowing them to become a soliloquy.

Through the sharing of stories, the participants were given a choice whereby they selected the information that fitted their experiences and discarded what did not. It was a respectful way of offering the option of receiving or rejecting learned information, the most effective way to help participants open up space for and be receptive to new perspectives (Wright, Watson & Bell 1996:216). I shared with the participants verses from *The Holy Bible*, the diaries of Ellen West (Binswanger 1958:237) (which detail the life of a woman struggling with an eating disorder during the time of the Third Reich), *The Devil's Advocate* by Morris West (which explores the difficulty of finding and knowing God), *The Prophet* by Kalil Gibran, and the story of *Corvus the Crow* (a story which captures metaphorically the 'prison' created by anorexia/bulimia (see Chapter Five, 'Mariska's story'). Change took place when participants' curiosity was aroused and opportunities to evolve and grow were made possible.

4.5.3 Towards imagining the Divine

Spirituality, as defined in this research project, involves an awareness that at the heart of human existence and all creation there is profound interconnectedness, an intricate interdependence, making all life forms dependent and interrelated (Becvar 1996:77-101; Bergum 2003:126). The lens of spirituality brings into focus the reality of a sacred power, energy or life force that infuses and connects all that is.

The eating disorder undermined participants' spirituality as the illness became the sole focus of their lives, replacing God and significant others as a source of support, love and comfort. In believing that anorexia/bulimia would provide a solution to their relationship and spiritual problems, the eating disorder effectively became a false idol or a god, creating its own spirituality. All three participants were initially extremely aloof and withdrawn, they had difficulty showing any emotion and deliberately avoided situations where they were called upon to participate or socialize.

Griffith and Griffith (2002:215) argue that spiritual practices that are not God-centred can become harmful, as they encourage an escape from the world and separate people from

reality, at the same time disempowering processes that may lead to change. These authors are also of the opinion that when human relationships are absent or distant, relationships with a personal God can often provide a primary venue for therapeutic change. Similarly, Remen (1993:363) believes that healing happens only in the context of an imminent awareness of something greater than the self.

In this regard, Neuger (2001:13) writes: 'How God is named, imagined, and conceptualized, significantly affects how we understand ourselves, how we understand our purpose, how we order our social and familial relationships and how we structure our culture.' McFague (1982:32) comments that we will not find religious language relevant unless we are freed from the myth that, in order for images to be meaningful, they must be traditional. My interaction with the participants was further guided by the following comment from McFague (1982:32):

Metaphorical theology, as is true of the parables, demands that our understanding and speech in religious matters be open-ended, tentative, secular, indirect, iconoclastic, and revolutionary. It demands that the central model in Christianity for human and divine life – the model of personal, relational existence as found in the story of Jesus – be allowed to guide us both in form and in content.

In addition to the metaphorical language used by McFague, my interaction with the participants was further guided by the writing of Borg (1997:61), who emphasises two primary 'models' of God found in Christian life today. The first is a 'monarchical model' which clusters images of God as king, lord and father and which leads to a 'performance model' of Christian life. The second model groups images of God which point to intimate relationship and belonging. This 'Spirit model' leads to a 'relational model' of Christian life. It was only when Christianity became the dominant religion of Western culture that the monarchical model took precedence. Yet alongside it, as an alternative voice, the Spirit model persists. Interestingly, the images aroused by these two models are, first, an image of a distant, powerful Being, and, second, an image stressing relationship and belonging. The human condition looks very different according to the lens through which we view creation.

In line with feminist theology, it was important that only the participants' *experiences* of God could alter or renew God images and perhaps the interpretation of religious doctrine (Denton 2005:755). Accordingly, it was important for me to understand something about the participants' spiritual beliefs, practices and experiences, particularly how these factors were

related to what brought them to therapy, or what might be helpful in the healing process (Miller & Thoresen 1999:12). I struggled with the rhetoric of religious dogma, which sometimes tended to solidify the experiences of the sacred into a system of prescribed practices, attitudes and values (Denton 2005:755). These 'stories of certainty' which circulate in society suggest an 'already knowingness', which closes possibilities for curiosity and creativity and in the process constrain possibilities for conversations with God in therapy (Andrews & Kotzé 2000:325; Griffith & Griffith 2002:50). These authors are of the opinion that therapeutic change usually requires an infusion of creativity – fresh ideas and innovative behaviour.

In order to share the lived insights of sacred experience in a way that was not prescriptive, the research process sought an agenda that would provide fresh, but transforming theological and spiritual concepts, remaining cautious not to promote any particular spirituality or any one image of God; attempting rather to understand and support the process of how spirituality and the Divine were conceived, and how these images might affect their lives. I was challenged to interpret their stories through which they came to understand spirituality, and to remain open to the creative and healing possibilities inherent in the spirituality of each participant, guarding against a disabling spirituality that could destroy or cripple the process of healing (Griffith & Griffith 2002:62). Our quest was to awaken an experiencing of the heart, where knowledge was constructed empathically, placing them in a position of participation, as opposed to a life of subordination, as experienced in the illness relationship. Different images and ways of thinking about God were introduced to inspire creativity and the construction of hopeful realities and purpose to life. Furthermore, the participants were invited to reflect on constraining beliefs that were increasing the power of the illness, and that through these reflections they could begin to entertain alternative, more facilitative ways of being.

As we entered the territory of spiritual inquiry, metaphors and images, rather than definitions, became our guide to understanding (Denton 2005:761; Griffith & Griffith 2002:66). Inquiring into their spirituality as embodied, lived experience, our interactions sought metaphors that would allow them to express and encourage new practices of spiritual life, images that would have a direct impact on and enrich lived experience (Denton 2005:761). The new metaphors we introduced were intended to stand in juxtaposition to the limitations of the dominant stories which influenced the participants' way of thinking, affecting how they constructed reality and thus life (Griffith & Griffith 2002:66). Like McFague (1982), Andrews and Kotzé (2000:325) argue that a plurality of metaphors and perspectives open up different ways of

viewing the Divine relationship, something which inspires alternative beliefs, possibilities and opportunities for change and growth, together with an openness and responsiveness to God's presence. The participants were encouraged to reconsider their ideas about how God felt about them, in order to see God in more positive ways and to welcome Divine love, and the love of others into their experience (Berrett et al 2007:380). In order to foster increased intimacy and new ways of imagining and relating to God, the Divine was conceptualized as a member of the relationship, becoming a 'partner' in their lives. This relational engagement with the Divine served as a place of safety, from which to take risks or reach out and receive love from others (Berrett et al 2007:380; Griffith & Griffith 2002:124-125).

Spiritual talk included finding a sense of direction, meaning and purpose – encouraging a connectedness with self, with others and with God or a higher power, reflecting on what is truly important in life, fostering love and compassion and the creation of a sacred space, within which a bond was formed for further growth and self-discovery (Miller & Thoresen 1999:13).

4.5.4 Making the ordinary spiritual

Within the framework of modernist science, the feeling body has become estranged, something to be disciplined, restrained and contained. Science has excluded the body rather than embracing it as a site of knowledge construction. Because eating disorders 'violate' and 'attack' the relatedness on which spirituality rests, the therapeutic challenge was to help the participants to access their spiritual resources to assist them in the process of healing and recovery. Hence, for healing to occur, 'an inward turn' was sought and relied on, which led to the (re)awakening of the spirit, replacing the body/self dualism with the intimacy of contact and connection. This implies a metaphoric shift from movement out of and away from the body, to a movement within and toward the body (Denton 2005:759; Griffith & Griffith 2002:42).

According to Griffith & Griffith (1994:30), Heidegger was convinced that it was in understanding plain and simple moments of everyday life, so close that one might even disregard them as experiences, that the secret of human existence would be found. Introducing the ordinary as spiritual meant bringing about a consciousness that allowed for finding and paying close attention to extraordinary occurrences in life that are usually taken for granted. It meant actively looking for a more 'lived experience' in the stories that the participants told about themselves. Thus, we were looking for what White (2000:145) refers

to as 'little sacraments, events that have everything to do with the maintenance of a life, with the continuity of a life, often in the face of circumstances that would otherwise deny this'. Hudson (2000:10) describes this as 'experiencing God in the everyday and ordinary'. Although such experiences are 'unstable', as they are never found in the same place twice, and they are not found when we 'look' for them, these moments, more than others, usually offer an opportunity to be transported somewhere else, 'to belong differently to the world for a while' (Neumann 1992:197). From this position, the participants were invited to embrace the paradox of an 'embodied transcendence' (Denton 2005:759), a condition of ecstatic participation in the mystery and wonder of this immediate and material world. Denton (2005:759) characterizes this as a moment when, as Merleau-Ponty would put it, 'transcendence no longer hangs over' us: we become 'strangely, its privileged bearer'.

Although spiritual experiences are often expressed by way of language, these experiences extend beyond language to involve the body directly. They often deepen and soften the heart, so that this form of embodied knowing extends boundaries to embrace the body of others, a sharing of community by all (Denton 2005:767; Griffith & Griffith 2002:135). What was important, given the context of the illness, was for the participants to connect to spiritual practices and experiences which directly engaged the physiological processes of the body. This understanding of emotion allowed for an acknowledgement of feelings as part of the healing process, incorporating the values of reflexivity and reciprocity. It takes into account both the 'thinking' and the 'feeling' aspects of emotion and the ways in which these emotions are experienced and displayed, in and through the body (Dickson-Swift et al 2009:62). A 'relaxed' body also meant a body that was not manipulated, making room for a reconnection of mind, body and spirit and thus the (re)establishment of harmony of relationship.

Listening for extraordinary spiritual experiences, as well as creating an environment in which participants could access these experiences, the therapeutic process sought to create counter-practices or stories that would disable the dominant story's destructive hold over the body. New behavioural patterns and experiences had to be discovered in order to provide an adequate basis and credibility for creating the re-authored story, at the same time anchoring a new and rediscovered understanding of the participants' spirituality. Sperry and Shafranske (2005:17-18), influenced by Wuthnow, characterize this development as a change from

...[a] spirituality of dwelling to spirituality of seeking where a spirituality of seeking emphasises *negotiation*: individuals search for sacred moments that reinforce their conviction that the Divine exists, but these moments are fleeting; rather than knowing the territory, people explore new spiritual vistas,

and they may have to negotiate among complex and confusing meanings of spirituality.

The participants were encouraged to practise a number of spiritual disciplines such as solitude and silence, prayer, reading and studying the Bible. Suggesting participation in spiritual disciplines was done from a not-knowing stance in which the participants had the final say as to whether they wanted to engage in these disciplines or not. For instance, becoming involved in a life of prayer meant opening up the self and body to different aspects of experience, so that healing properties of prayer restored health and wholeness to the body. Fosarelli is of the opinion that prayer is the ultimate act of intentional connectedness (2002:212). Each participant's journey was unique; each one had to discover what worked best for her.

Books also proved to be a source of inspiration against the power of the illness. Kalil Gibran's *The Prophet* was a source of inspiration for one participant, as was Kim McMillen's *When I loved myself enough*, which I bought for another. All were encouraged to initiate a process of self-reflection, and to establish points of reference so as to recognize their own spiritual strength and growth. When they focused on the 'now', they also came to live a life of retrospection (Leseho 2007:448). When such spiritual practices have a conscious effect on the physical state of the body, they play an important role, not only in mediating the relationship between the self and the body, but also in preparing the body to be resourceful in the face of illness (Griffith & Griffith 2002:173).

By introducing the ordinary as spiritual, the research process focused on creating new information which could assist in the construction of more hopeful realities. Introducing feelings of connection, warmth and acceptance, the self and the body became conscious of the 'suffering body' under the tyranny of the eating disorder. This kind of knowing counters isolation, with self-acceptance bringing about a healing of the self and, ultimately, change (Remen 1993:362). Our emphasis was on how the body could once again become the most important vehicle of interaction between self and all else, being involved in the wholeness of life, where care for the body becomes care for the other.

4.5.5 Self-care: when caring for the body and spirit becomes care for the other

In the context of the eating disorders, the participants experienced the self and the body as being in opposition; overcoming this perception was necessary for healing to be achieved. On my part as a researcher, it constituted a methodological move, seeking to achieve a new unity between the self and the body, with the self living more articulately in and through the body (instead of evaluating or separating from it), 'to recognize that this body is me' (Frank 1991:61), where 'the self recognizes the body as another manifestation of selfness and sets the means of recovery at a new level' (Gadow 1982:94).

For the participants to heal, they had to learn to connect, not just with their own bodies, but with 'all' around them. Berrett et al (2007:381) propose that the most significant intervention for healing (eating disordered patients) lies in helping the individual to learn to let love into her life and heart. It is emotion that connects us to our selves and others and puts us in touch with reality. Being emotionally involved, feeling or showing emotion, cannot take place without using the body (Dickson-Swift et al 2009:63; Finlay 2005:272). Therefore, in order to reclaim the self, the reclaiming begins with the body, as the self is formed through using the body (Griffith & Griffith 2002:42; Frank 1995:49).

The body fulfils two separate roles, one personal and the other social. The body-self unity is considered a spiritual being, with ongoing responsibility to give effect to the choices we make in our everyday lives (Frank 1995:50). There is no other part of life experience more intimate than the experience of one's body, and the security of its well-being holds a higher priority than nearly any other concern in life (Frank 1995:27-43). Furthermore, the body-self is not a 'secularized' private domain of the individual person, but an 'organic part of a sacred, socio-centric world a communication system involving exchanges with others' (Kleinman 1988:26). Human communication with the world and the exchange of information this interaction rests on begin with the body. The self is understood as coming to be human in relation to others and the self can only continue to be human by living for the other (Frank 1995:36,37). Hence, behaving as embodied beings becomes a profoundly spiritual experience; people discover themselves not as separate or alienated, but as essentially connected and engaged (Perry & Rolland 1999:274).

Being subject to the power of anorexia/bulimia, the participants' ability to relate, as well as their bodily experiences of affection and emotion, was severely compromised by the illness. Choices that the body-self acted out became orderly and austere, the body-self defining itself

primarily in actions of 'self-regimentation' (Maisel et al 2004:41), where the body is manipulated in pursuit of ideals which transform the body into 'it'; with the self or person becoming disassociated from this 'it'. When a person regards the body as an object, the client becomes, in essence, a disembodied being (Bergum 2003:122). A self or spirit disassociated from its body will rarely seek and discover terms of association with others, turning itself into a monadic body (Frank 1995:41), understanding itself as existentially separate and alone.

Trauma and stress caused by the illness have a profound effect on the ill person's being, her world and the wholeness of life. Healing and becoming whole required a shift in power, a process by which the participants reclaimed their self-agency, reconnecting with themselves, others and with their environment, while developing a new sense of meaning and purpose to life. This challenge could only be taken up with careful attention to the *relationship* between the body and self, in essence individual spirituality. To become re-embodied, the participants had to open themselves to touch, to staying close, hearing and smelling – not just seeing – to becoming actively involved in their life-world again. Encouraging attention and development of all the senses, which is the wholeness of embodiment, is not just aesthetically pleasing, but vital to developing close relationships with others (Bergum 2003:124).

The aim was to seek knowledge that had been systematically excluded from the participants' consciousness, so that these might be restored to their human condition (Watson 2004:419). It meant exploring the lived space between the self and body, between self and other, where such knowledge 'resounds bodily' and is always under construction. These forms of embodiment also emphasise the essentiality of attending to one's own experiences in order to live ethically and with moral sensibility, as well as the necessity of relationship (Bergum 2003:121). Knowledge becomes understanding of what it means to be human, going beyond the 'physicalist, material orientation and fixation of the modern era' (Watson 2004:419), an opportunity to discover new sources of value in familiar things too often ignored (Frank 1991:79).

Given this scenario, how is the space created that is necessary for relationships to develop? Bergum (2003:121) states that the relational space (not the space where one or the other lives, but the space that occurs in the in-between), sustained by spontaneous interplay, is where personal meaning is awakened and where inherent knowledge is developed, so that living reciprocally, recognizing our interdependence, is now acknowledged as the reality of human existence (Becvar 1996:24; Gadow 2000:89; Miner-Williams 2006:815). Experience,

apart from being merely personal, is also located in the world, so that all experience is affected by the interaction that occurs between the individual and her 'world'.

In discussing self-care, we spoke about the clients' extending themselves to new possibilities, putting aside old ideas and coming to understand how each created her own reality (Leseho 2007:450). During our interactions, the participants and I unpacked established habits that had constrained their relational experiences; and opportunities to transform future relational practices were explored. In therapeutic practice, there is great concern regarding the power of anorexia/bulimia, and how it is experienced and expressed through manipulation and abuse of the body, within the relational space between body and self. However, when the participants became consciously aware of and began to incorporate changes in all forms of their relational engagement, anorexia/bulimia lost its power, with listening, initiative, creativity, letting be, respect and responsibility becoming part of the relational space of interdependence. Regardless of the relationships the participants entered into, it was the relational space in-between that needed much care, together with the practical development of skills and techniques in order to become effectively involved in their life-world again. In this interplay of relational space, moral consciousness and compassion was awakened that moved from an epicentre outward towards self-care, to caring for others, to caring for and being part of nature, an evolving world that people are co-creating (Watson 2004:419).

Hence, self-care was understood as caring for the spirit as if for the body; so self-care became self-growth, opening the way for these young women to care for others. It was not important what activities or roles they chose to become involved in, rather, it was necessary for them to participate in personally meaningful and gratifying activities that afforded them a sense of making worthwhile contributions to their community, thereby counteracting the isolation they had experienced, as well as coming to understand this isolation as the main factor which impeded their own healing (Davidson et al 2005:152).

Our discussions provided avenues for exploring the obstacles they perceived to living a life that replenishes, rather than depletes (Davidson et al 2005:152). In these discussions, the importance of their own voices through journal, poetry and autobiographical writing was emphasised.

4.5.6 Acknowledging the special role of language in constructing reality and healing

All the participants were keen writers. In order to foster 'growth' in their lives and to create new perspectives around the illness, I invited them to keep a journal, and if they felt inclined to do so, to express their ideas and feelings in poetry. Their journals and poetry often became ways in which they organised and expressed their 'situated experiences' (Kingdon 2005:627) in new configurations that enabled them and the reader to see and feel new dimensions to their world (Richardson 2000:933). It was an endeavour towards using the mind exclusively to alter the state of the body, a move that sought harmony with the world and with the self in order to undermine the symptoms of the illness (Ornish 1993:105). The power of poetry and personal journalling was acknowledged in order to promote a sense of intimacy, community and connection that contributed to healing. It was Romantic poet William Wordsworth (Stewart 1999:22) who suggested that the metre of poetry makes pain bearable – we can face or apprehend forces of evil or suffering, and even endure pain as something almost pleasurable, once we can give it form. In giving 'voice to the unsayable' (Merwin 1999:22), and reconnecting us to the act of 'dreaming ourselves into existence' (Komunyakaa 1999:22), writing is about authentic experiences and the ability to give life to those experiences for oneself and for others.

Conversely, the journals also took on an 'intimately reflective puzzling quality' when participants tried to make sense of their lives in terms of what was happening to them (Clandinin & Connelly 2000:103). Their journals and poetry provided me with insight into their illness experiences, something which strengthened meaningful participation. Reading their work often provided me with new insights and brought to light certain aspects of their experiences that were perhaps not shared during face-to-face interactions, or that might have been missed or misunderstood (Kendall & Murray 2005:748).

These writings became invaluable parts of the field text that brought participants' illness experiences to life, inviting the reader into their worlds. Given the importance of emotion as embodied knowledge, it was crucial for the research investigation that the poetry and journals, in capturing the participants' 'felt' experiences, also aroused an emotional response from the reader (Kendall & Murray 2005:746).

The foregoing section goes to the heart of this project, underscoring its thesis that the person struggling with an eating disorder is in need of healing, a healing that must come from within. Anorexia/bulimia created a 'prison world' for the participants. Stepping into this world

involved taking risks, the risk of relationship, intimacy and connection. This brought an awareness of the 'other' as the crucial element in finding self within relationship, an awareness that restored feelings of love and desire in the participants, long missing because of a body neglected and in pain.

4.6 THE WRITING PROCESS: FROM FIELD TO FIELD TEXT TO RESEARCH TEXT

With our focus now on structuring the research text, the participants and I moved away from our frequent meetings and close contact, to start working more independently to create the first field texts. The field texts represented all aspects of our experiences in the field and were based on notes taken during our face-to-face conversations, together with all journals and autobiographical writing we gathered as we journeyed together. Composed of 'experience near' events that were emotively descriptive, the field texts provided the basis for asking questions of meaning and social significance and as such defined and set the terms for the inquiry. For instance, we asked 'which practices provide relevance and meaning to participant spirituality and why does it make a difference to understand the meaning-making strategies that inform these practices?' Furthermore, our relationship and shared interest in the project, based on ongoing collaborative interaction, embedded meaning in the texts compiled, and ultimately shaped the epistemological framework within which the research text developed (Clandinin & Connelly 2000:162).

4.6.1 From field experience to field text

Because there is no consensus regarding the analysis of qualitative data (Clandinin & Connelly 2000:140), I read and re-read all the data to familiarize myself with the content of each story, as well as to formulate an overall picture of the data in front of me, bearing in mind 'what...I want to know in this study' as the critical starting point (Janesick 1994:210).

Subsequently, I followed the thematic analysis suggested by Van Manen (1990). I arranged the data in a holistic, thematic manner which involved my notes, transcripts and all relative information, in their entirety. I made notes in the margins as I proceeded in order to capture points of importance and to formulate the overall significance in the texts. Secondly, a selective approach was used to highlight phrases and statements by the participants, particularly those which provided meaning and understanding of participant spirituality. This procedure entailed a process of bracketing, which made it possible to manage all the data in all its forms equally, whilst the phenomenon under study (participant spirituality) was held up

for serious inspection (Janesick 1994:216). I interpreted the meaning of these phrases and statements and also obtained the participants' interpretation of these observations. Next, I inspected and reflected upon these meanings and what they revealed about the essential, recurring features of participant spirituality. Finally, I conducted a detailed reading of the transcripts and all relevant notes, line by line (Gramling 2004:386).

I then proceeded writing the first drafts of the text co-created during our interaction and passed these to the participants for their perusal and comments. The participants and I consulted on an ongoing basis to thicken plot lines and to continue the development of points of importance. I looked especially for knowledge that would provide further insight into the eating disorders, seeking that not already said or written, and ongoing progression of participant's spiritual experiences that stood against the power of the illness. I also searched for some of the greater organising ideas presented in the data from which to form initial themes. Inevitably, my foregrounding played a role in making certain aspects more or less visible (Clandinin & Connelly 2000:144). Together, the participants and I wrote a few interim texts.

Finally, the collection of data was structured into an interpretive, contextualized text. It was interpretive because it was shaped by my own interpretations and those of the participants. It was contextualized because of the particular circumstances and contexts that shaped the inquiry process (Clandinin & Connelly 2000:144). Our next action was to reconstruct these texts as research texts. Research texts grow out of the asking of repeated questions concerning the meaning and significance of the phenomenon under study (Clandinin & Connelly 2000:144).

4.6.2 From field text to research text: situating the research text in the context of the research process

The research text, presented as a research story, came to fruition after having been crafted from early drafts of the field texts and edited by myself and the participants. In the next few sections, I unpack the flow of experiences and thoughts which assisted my own positioning in compiling the research text.

As individuals, we are always engaged in narrative processes which provide storied accounts of our lives. The research process, conceptualized as a story of inquiry, involved inquiry experiences in a storied form at several levels, as the participants and I began to live and tell

the story of our collaborative journey together, as recommended by Clandinin and Connelly (1994:418).

The consideration of the research text, at the end of the research process, brought the research inquiry full circle. Having made personal experience methods central to the research, my own storied version of the research process became central in structuring the research text. Furthermore, because of my relationship with the participants, I cared about the ways in which the research text would ultimately influence their lives, so that our involvement also influenced the way in which the research text was ultimately composed (Clandinin & Connelly 1994:423).

As a researcher, I set out to tell or represent the story of the research project, crafted into a biography which captured the lived experiences of the participants, describing turning-point moments in their lives (Denzin 1989:13). In essence, the research text represented the transformative nature of our work together, illuminating the alternative and preferred stories of the participant's lives, with the participants being the co-authors privileged in the collaboration of the re-authored stories of their lives. These stories represent the articulation and experience of other ways of being and thinking, with the participants moving from being captives in a 'problem-dominated' story, to a more hopeful scenario, with their own spirituality and strength becoming the media which assisted them to stand against the voice of the problem (White1995:20), in this case, anorexia/bulimia.

Situated within a postmodern framework, all the knowledge constructed in the course of the research process formed part of a continual flow of interpretation; understanding the illness relationship called for the act of interpretation as a means of knowledge construction (Kotzé 2002:15).

4.6.3 The research text within the interpretivist paradigm

Moving from the field text to the reader constituted a complex, reflexive process. I set out to construct the research text based on my experiences with the participants, searching for patterns, narrative threads, tensions and themes that would shape the field text into the research text, with reading and writing becoming central to interpretation. Interpretivism is about contextualised meaning (Greene 1994:536) so that good interpretation, according to Geertz (1973:18), takes the reader to the centre of the experiences being described. Denzin (2000:261-262), drawing on Lévi-Strauss, regards the practice of interpretation as an art

which allows the field-worker-as-*bricoleur* to translate research findings into a body of textual work that communicates these understandings to the reader. The process of interpretation is inevitably hermeneutical, based on openness and dialogue between the participants and myself, rather than manipulation and control, with myself as researcher becoming part of the circle of interpretation (Schwandt 2000:227).

After the finalization of the interim research texts, I set out to craft the 'published' text in the form of a biography, making use of the interpretive biographical method proposed by Denzin (1989).

4.6.4 Interpretive biography

The biographical method has its origins in the qualitative, interpretive sociology of Weber and his concept of *Verstehen* or understanding, and method, claiming that people construct meaning about their lives, and that these meanings can take on a truth status with a definitive presence (Denzin 1989:13). In an attempt to understand how the participants created meaning in the context of anorexia/bulimia, I had to interpret the significance they attached to experiences that had shaped their lives. Denzin (1989:28) states:

Interpretation, the act of interpreting and making sense out of something, creates the conditions for understanding, which involves being able to grasp the meanings of an interpreted experience for another individual. Understanding is an inter-subjective, emotional process. Its goal is to build shareable understandings of the life experiences of another.

Given the research question, the biographical method as interpretative lens seemed most appropriate for capturing the lived experiences of the participants, whilst also describing the turning-point moments in their lives (Denzin 1989:13). In using this method, I relied on the subjective, verbal and written expressions of meaning by the participants. This method 'usually, but not always, eulogizes the subjective, the important part of human existence, over the objective, less significant part of life; it blurs the borders of fiction and non-fiction' (Smith 1994:288). By making use of this method, I made the participants and their experiences 'real', shaped along guidelines suggested by Denzin (1989:18-22):

- **The Other**

I write the texts with an 'other' in mind. The 'other' refers to God, the reader, other women and all who would want to know more about the feelings and emotions of those living with an eating disorder. The presence of an 'other' in the biographical text means that the text

is written with a dual perspective in mind (that of the author and that of others), so that the eye of the other directs the eye of the writer. Language, for both myself and the participants, provided the vehicle through which, and by which, we were able to create a meaningful, biographical reality.

- **Gender and class**

The texts are gendered, reflecting the biases and values of patriarchy. Moreover, they emphasise our stand that the lives of women are important and that their stories should be told.

- **Family beginnings**

These stories are grounded in family or family histories. The biographies highlight the presence or absence of mothers and fathers. These 'others' are seen as having an important structuring effect on the lives of the participants.

- **Knowing authors**

The completed text always presumes the presence of an author or 'outside' observer who is able to record and make sense of the life in question.

- **Textual turning points**

Beginning the biographical text with family suggests that the participants' lives have beginnings or starting points. However, stories are open-ended and evolving – they can never be told completely. The biographical method also supports the idea that the participants' lives were shaped by unique, turning-point events, so that transformation became a central part of the biographical form. I typically set out to structure their stories in the research text around such epiphanies, which brought about permanent change in their relationships with the self and anorexia/bulimia.

- **Objective markers**

The above extracts suggest that participants' lives have both objective and subjective pointers and that these reflect key and/or critical events in their lives. These 'sparkling moments' perhaps form the essence of the narrative fabric. They suggest the existence of 'real' people, whose existence in our world can be mapped, changed, and given meaning.

Our collaboration in terms of what data to include or exclude, the thickening of plot lines and the development of points of importance, imbued all observations and claims to knowledge with moral significance, also making transparent my own position as the researcher. All knowledge constructed became value-laden, context-dependent and context-bound.

Ultimately, the quality of our relationship determined the trustworthiness of the data and established the epistemological framework within which the research text developed.

Having reflected on the development of the research text within an interpretive paradigm and the use of the biographical method as a means of processing data, I now consider the structuring of the research text.

4.7 THE RESEARCH TEXT

Following the guidelines provided by Denzin (1989:18-22), I began the organisation of the research text. I searched the participants' stories for any contributing events preceding the onset of the illness, as well as relevant information about their families, friends and career plans, which I obtained from my database of field notes. I used this information to construct a starting point for the biography and to develop a chronology in each participant's story. Having made use of narrative inquiry, the story is heard through the first-person voice of the narrator, but also through my own voice as researcher in its retelling and reporting (Connolly & Reilly 2007:522).

4.7.1 Language and emotion

I set out to represent the participants in ways that would give reality to their experiences of living with anorexia/bulimia. My approach acknowledged the evocative and poetic power of language, its ability to transport meanings that are neither unique nor shared, but always 'in between'. Pelias (2004:12) writes:

Evocative scholarship has language doing its hardest work, finding its most telling voice, and revealing its deepest secrets. It is literature that makes its writer and readers take notice, not just of its point but also of its aesthetic presentation. Often it relies on the figurative and rests on form. It avoids the cliché, the familiar. It depends upon the creative and finds its force in the imaginative.

I sought words to arouse feelings that would connect with the reader, stirring something within (Todres & Galvin 2008:570). This meant that in the telling of their stories, words were not just spoken, rather life was performed on stage with meaning expressed through the 'feel' of language (Todres & Galvin 2008:570).

4.7.2 Emotion as embodied knowledge

Following on the above, I remained attentive not only to the detail of the story, but also to ways in which we were consciously embodied, emphasising understanding ‘with-the-body’ (Eisner 2001:136) as a ‘bodily attending’ (Cancienne & Snowber 2003:248) or embodied interpretation. This form of embodied interpretation opens up to a ‘body-based, hermeneutical journey’ (Todres & Galvin 2008:576), where I sought to bring qualitative meaning to participant experiences by moving back and forth between words and their felt complexity in the lived body, a way of being open to and responsive to the words of the participants as I read their stories.

An embodied interpretation draws on Gadamer’s (1975) notion of a ‘fusion of horizons’ and on the capacity of phenomenological research to emphasise connectedness. A fusion of horizons suggests an encounter with another, in which one allows one’s deepest convictions and assumptions to be called into question by taking seriously the assumptions that inform the other’s way of life. It is a stance that requires complete openness; that is, giving the ‘other’ the kind of respect necessary in order to understand their perspective from the inside.

It follows that what brought the participants and myself together in dialogue, which was a primary condition for understanding to occur in the context of the research process, was our shared interest, that of co-searching for new knowledge that would enable the participants to grow spiritually in their stand against anorexia/bulimia. This ‘coming together’ allowed me to see what was regarded as familiar or taken-for-granted in new and stimulating ways. It helped me to step into the shoes of the ‘other’ and to use their voices in sensitive and meaningful ways.

4.7.3 Hearing the participants

I stayed close to the words used by the participants during our interactions and, whenever possible, transcribed their journals and poetry *verbatim*. Their poetry was autobiographical and provided a ‘snapshot’ in time of important events in their lives. Their journals provided powerful ways in which the participants gave accounts of their day-to-day lived experiences in the context of the illness (Clandinin & Connelly 2000:103). Through their writing and my own field notes, I set out to convey a physical or real sense of the situation, seeking to highlight aspects of their spirituality that had not been evident before.

Embedded in their stories was a portrayal of the participants' feelings, thoughts and attitudes. They experienced emotions of not being at home in their bodies due to a dissociation between the body and the self. I sought to do justice to the richness of their local experiences whilst capturing the complexity of the social discourses they were embedded in. I positioned myself as an insider witness to the stories I had before me, taking on a participant role and using a particular form of language in order to make known the dark and troublesome secrets of a life controlled by anorexia/bulimia. I wanted to make known the trauma they experienced in their bodies and the resources they chose to deal with their hurt. I searched for words that could adequately communicate those meanings to the reader (Clarke et al 2005:914). In the process I presented the participants like characters in a dialogue, to invite the reader into their experiences in order to encourage a reasoned and open response (Saukko 2003:303). The act of writing became an art-ful process, I paid attention to the nuanced qualities of the particular in order to create a work of aesthetic value (Eisner 2001:136).

4.7.4 Re-authoring the problem story

I regarded the participants' narratives as a source of empowerment and as a centre of resistance to counter the domination of the problem-story. I carefully crafted their stories so as to de-stigmatize the participants' identities, humanizing their experiences and helping them to gain agency through their testimony (Bochner 2000:271). The languaging of these experiences facilitated an emotional 'homecoming', a metaphor for the recognition of their truths that were also deeply personal, meaningful and aesthetic (Todres & Galvin 2008:569). It constituted a re-negotiation of identity that contributed significantly to the thick descriptions of the alternative stories of their lives, and were thus constitutive of new possibilities for life outside the confines of an eating disorder. Their stories were structured around a process of 'rebirthing' (Ben-Ari & Dayan 2008:1439), not just in the therapeutic sense; but also in the political sense. Truth became the gift of telling, a gift that transported lived experiences to others in order to create conversations that transcend suffering (Giorgio 2009:162). In particular, the gift was to be found in the transformative powers of language and reflection (Griffith & Griffith 2002:134-135), to open up new knowledge for the participants, the researcher and the reader in some way.

It became a story of two selves, who they were and who they had become, their lives transformed by the healing experience. I present a drama before an audience, hoping that the story will do the work on its own, as a story (Todres & Galvin 2008:576). At the same time, I wanted to make clear how discourses worked differently in each context, giving rise to

a particular pattern that was repeated across the stories. In the process, I attempted to write a narrative with a good plot, dramatic tension, coherent and logically consistent. The text had to create impressions of real life with surprise endings that will hopefully challenge the readers to see the participants' lives in a new way (Ellis 2000:273). Perhaps more significantly, through the processes of re-authoring and co-responsibility, we have, as White (1995:141) suggests, provided conditions under which it became possible for the participants to break free from the dominant discourse of what is socially acceptable in terms of women's bodies and to experience a freedom to explore other ways of being in the world.

As a social inquirer, I was morally and ethically compelled to be actively engaged in and to assume responsibility for the consequences of the work as I moved between what needed to be conveyed to the reader, and how the written text would ultimately affect the lives of those involved. In essence, the creation and interpretation of meanings in the context of the project became a responsibility shared between myself as the researcher and the participants as stakeholders. Throughout the process, I relied heavily on my own reflexivity, an ongoing process of self-awareness, essential in an attempt to demonstrate the trustworthiness of the findings (Kingdon 2005:622).

4.8 TRUSTWORTHINESS OF FINDINGS

Denzin (2003:245) states that 'in the social sciences today there is no longer a God's view which guarantees absolute methodological certainty'. The narrative or story line is imposed on the details and facts of the situation, for nothing ever tells itself, as nothing stands outside representation. In presenting the text, experiences are offered as they were remembered and observed, with no possibility of 'value-free knowledge' (Denzin 2003:245). Committed to not just describing the world but also changing it, feminist scholars regard ways of knowing (epistemology) as moral and ethical, with researchers and subjects becoming co-participants in a common moral project, when undertaking participatory action research. Given that this research study attaches itself to less certain interpretive criteria, 'the ways in which relationships of difference are textually represented answers to a political and epistemological aesthetic which defines what is good, true, and beautiful' (Denzin 2003:248).

4.8.1 Care versus objectivity

The research investigation was founded on an ethic of care (Gunzenhauser 2006:626), which justified both the epistemological and ethical status of the research project as a whole.

Based on a qualitative research design, the research process called for my intimate involvement in the lives of the participants, so that the caring relationship between myself and the participants transgressed the epistemological position of objectivity (Gunzenhauser 2006:626). In order to make clear my own position as qualitative researcher, I submit that because the knowledge claims presented have emerged from ethically defensible relationships between myself and the participants, the knowledge claims also become epistemologically justified (Gunzenhauser 2006:626).

4.8.2 Interpretive truth as a basis for knowledge construction

Moreover, the aim of the investigation was to capture the richness of participants' spirituality in the context of anorexia/bulimia, rather than to enable a statistical generalization of the phenomenon in question (Ben-Ari & Dayan 2008:1429). As such, the study sought to present a credible picture of the lived experiences of the participants, making known their struggle with the illness by means of a narrative inquiry. The process concerned the meanings they attributed to their relationship with the illness, so that knowledge developed through a hermeneutical understanding between myself and the participants, a discovery of the meaning embedded in the story (Polkinghorne 1988:160). However, knowledge in the realm of meaning cannot be organised into covering laws that seek mathematical and logical certainty. Instead, the research investigation aimed at producing results that were reliable and well-founded (Polkinghorne 1988:161).

4.8.3 Participatory consciousness informing reliability of data

Polkinghorne (1988:176) posits that reliability in a narrative study means 'quality and dependability of data', while validity refers to the integrity with which data have been analysed. As a qualitative researcher, I relate this to the 'trustworthiness' of my field notes and the transcription of interviews or stories, as well as the extent to which the participants became involved in the ongoing review and editing of all the written texts. Although the research text cannot claim to record every event or occurrence, the investigation of how the participants constructed meaning was concerned with plausibility, with the participants at all times qualifying the text, as Polkinghorne (1988:176) recommends.

As a qualitative researcher, I argue my thesis by providing excerpts from the participants' diaries, poetry and journals, highlighting the role of their own spirituality in the context of the illness, whilst also emphasising healing as a spiritual process. I present the conclusions by

means of 'informal reasoning' (Polkinghorne 1988:15), with my arguments reflecting likelihood, rather than certainty. The research inquiry was therefore marked by uncertainty and vulnerability, so that statistical analysis for data verification purposes was not possible. Knowledge construction remained fluid and open, always in the process of evolving, due to many new possibilities, with different interpretations emerging continually. Because the construction of knowledge was at all times subject to interpretation, data were evaluated in terms of my ability to illuminate the participants' spirituality as lived experience. The account of a research text becomes valid if it represents accurately those features of the phenomenon, in this case the participants' spirituality, that it endeavours to describe. All knowledge and claims to knowledge become reflective of the process, the location and the contexts of the knower and the known.

However, if narratives are tools, and if the crafting and sharing of stories involves moral issues, then a discussion of ethics is a necessary and critical component of narrative inquiry (Adams 2008:177). In the next section, I review ethical considerations in research and illustrate how these themes also influenced the whole of my narrative inquiry.

4.9 ETHICAL CONSIDERATIONS

Participatory ethics requires an ethical consciousness which calls for the participation of all, especially those normally excluded or marginalized. In this section, I unpack the ethical considerations which underpinned my interaction with the participants, with the emphasis on moving away from what could be interpreted as prescriptive, to a more participatory form of interchange.

4.9.1 Introduction

Kotzé (2002:13) refers to (primarily modernist) 'prescriptive' research ethics, where researchers make use of standardized guidelines that are considered 'truths' that are universally accepted as the basis for ethical ways of inquiry. Bochner (2000:269) comments that such a desire to authorise one set of standards easily diverts attention away from ethical issues at the heart of the work. Ethics as a prescriptive practice largely ignores the human and creative element in the research process – it fails to render transparent the researcher's self and the role of embodied and intuitive understanding as the basis for knowledge construction.

Because of my commitment to a feminist paradigm, inevitably, feminist-inspired methods informed the research process and assisted me to recognize some of the potential dangers and pitfalls associated with the use of personal experience methods. Reinharz (1992:67) is of the opinion that feminist methodologies challenge particularly the conventional hierarchy of researcher and researched, questioning the ownership and authorship of the research project, in order to create an awareness of possible exploitation of the research subjects. This meant that the three guiding ethical research principles, those of consent, confidentiality and conduct of the research process, had to be constantly weighed against the balance of doing good and causing no harm (Watts 2006:386).

Kotzé (2002:13) explains that participation by everyone with an interest in the research process and results, together with possible effects and consequences, becomes the key ethical commitment for all research. Denzin (2003:250) writes that in the ethical call to action, 'researchers-as-performers' should engage in concrete steps which will ultimately change the research process. In line with these statements, in the sections below, I unpack my researcher self, making it more transparent, highlighting the practices in this study which underpinned the participatory research process as an ethical undertaking.

4.9.2 Participation as ethical undertaking

This research project, with its focus on the re-authoring of participants' stories from a problem-dominated narrative to a more hopeful, empowering narrative, involved the lives of the women participating in the journey of inquiry. The very private nature of the material involved in narrative research is the all-important reason for seeking participants' permission with regard to the gathering of information, its interpretation and the process of writing the report .

Participatory research as an ethical undertaking granted the participants the opportunity, right and responsibility to participate in all aspects of the inquiry as co-researchers, having an equal say in all the events that affected their lives and that of the people close to them. This meant that they participated in all decisions involving the research process. It also meant that they understood my reasons for doing the research, the situatedness of the process within a particular paradigm, my reasons for choosing the paradigm and what the paradigm and research journey entailed. Furthermore, it called for negotiation with the participants in staging their stories in the co-construction of the research report, how research reports are written, prepared and evaluated for presentation towards the fulfilment of the requirements of

a degree. These were all issues to be considered and negotiated with the participants in the research (Kotzé 2002:27). What makes this form of participation ethical is the simultaneous shaping of particular practices which situate each and everyone as being for the other, not just with or about the other, seeking ways of living that will be for the good of all, and will not benefit some at the expense of others. It calls for a mode of 'participatory consciousness' (Heshusius 1994:15), an awareness that, as co-participants, we are in the search for knowledge together. It needed to be pointed out that ultimately such knowledge is being constructed in and through our relational positioning, towards and in each other, within the research context.

4.9.3 Participatory consciousness as ethical commitment

Given the postmodern framework within which the research process was situated, any distance between myself and the participants was replaced by adopting a form of consciousness that did away with boundaries between 'me' and 'them', with all knowledge becoming an open, evolving process of continued negotiation. Information was not just gathered from the participants; rather, it was the confrontation between emerging viewpoints on experiences and activities that became the central union of knowledge production in our discussions. It implied a context where the participants and I were of necessity challenged by the 'crossing discourses' in the interview encounter, so that negotiation of meaning came about when we were confronted by each other's assumptions and discourses of learning and understanding (Tanggaard 2007:164).

Heshusius (1994:15) describes 'participatory consciousness' as freeing of ourselves from the categories imposed by the notions of objectivity and subjectivity; as a re-ordering of the understanding between the self and the other to a deep kinship. This can be best understood as transcending dichotomies of a subject-object distinction evident in positivist research methods, making room for a self-other consciousness (Kotzé 2002:18). It meant not only working and communicating with the participants, but also being continually involved in creating a particular context, sustained by particular ways of being together in that context. The entire research process was therefore characterized by an absence of control; and the goal was being and staying connected with compassionate understanding (Heshusius 1994:15).

A position of 'participatory consciousness' called for ongoing reflection and interpretation as the key to creating knowledge with forms of active listening, witnessing and participating,

becoming practices that shaped the research inquiry. The emphasis was on an embodied form of knowledge, allowing for a continuous and collaborative process of interpretation and re-interpretation between myself and the participants. It enabled a co-searching and co-construction of knowledge towards preferred and negotiated outcomes for all involved in the research process. It also meant being mindful of the type of knowledge that we co-constructed. I therefore requested the participants to keep me advised as to what they found helpful, or less helpful during our interactions. I made sure that the recording of the work in progress was kept up to date, and shared with them, at regular intervals, how the research process was developing. Searching for new knowledge together invited the participants into the research process, and provided me with the privilege of being invited into their lives, and sharing their stories.

4.9.4 Narrative or storytelling as a form of sustaining research ethics

As a narrative counsellor, I did not regard any of the participants as being the problem; I saw anorexia/bulimia as the problem, with narrative ways of working making visible the relationship each of the participants had with the illness. As a pastoral therapist, I could not be neutral in my commitment – I had to take a strong stand with the participant against the eating disorder. Neuger (2001:179) states that a feminist-oriented pastoral counsellor seeks to do three things. Firstly, he or she seeks to empower the telling of the story that the problem is rooted in. Secondly, the counsellor assists in the process of clarifying the issues by seeing them through a variety of cultural lenses, and employing deconstructive frames to illuminate the real problems. Thirdly, the counsellor seeks to empower the counsellee to make choices that work to resist and transform the oppressive forces in her life and world.

When I first met the participants, all three were unable to imagine their lives differently, because of the power inherent in the illness relationship. They had lost themselves in living the lies of the eating disorder, in terms of who they were and their role in society. My first task was to assist the participants in gaining clarity and new perspectives about the illness, with the purpose of developing strategies to resist the beguiling tactics and lies of anorexia/bulimia.

4.9.5 Liberating narratives

Narrative theory was especially useful in assisting the participants to gain insight into their experiences of living with the illness. Storytelling and coming to voice were the key

dimensions of the liberating process (Neuger 2001:179). Therapy suggested that we found ways to deconstruct these diminishing and disempowering messages fed to the participants, because these messages compromised their self-esteem and self-agency, simultaneously crippling spiritual growth and the possibility of an abundant life.

The narrative process of deconstruction and externalization opened up and made visible ways in which their beliefs had taken on a 'truth' status. Thus it moved to diminish the power of anorexia/bulimia in the lives of the participants. If reasons for sacrificing the body and self to the claims of anorexia/bulimia could be explored, such knowledge could also serve to investigate other ways of making meaning out of life experiences. Once other ways of selecting and interpreting life choices became an option, then counter-stories were generated, arising either out of previously unstoried experiences, or out of counter-practices which did not abuse the body.

Counter-stories can also be understood as 'resistance narratives' (Neuger 2001:176), which serve to resist what has become accepted as truth in general, and, in this case, cultural discourses about women's bodies. It is through narrative, and the sharing of stories, that frameworks and opportunities for resistance narratives can be provided (Neuger 2001:177).

4.9.6 Narrative and community

Furthermore, for women struggling with an eating disorder, there is a tendency towards social isolation. In making use of narrative therapy, within the framework of feminist-inspired research methods, I regarded the counselling relationship as constituting an indispensable part of resisting and defeating the threat of isolation and estrangement. A caring relationship, based on collaborative interaction, and witnessing produced ways of doing research which not only countered isolation, but also had a direct impact on the abusive power evident in the illness relationship itself.

Relational positioning within the research context took seriously the writing of Foucault (1979) and his ideas on power and knowledge. According to him, a dimension of power exists in every relationship. Being constantly aware of this power in my interaction with the participants was critical in building relationships of trust.

4.9.7 Sharing of power as a form of research ethics

Foucault exposes power as being destructive when such power is exercised in ways that marginalize and subjugate people, not giving them a say in events that affect their lives. If we do not take into account the opinions, experiences and vulnerabilities of the persons who come for counselling, no real transformation can occur in their lives (Neuger 2001:179).

The extensive use of the participants' stories as the focus of qualitative inquiry rendered the participants more vulnerable to exposure and my interpretive authority as a researcher. In this regard, Heshusius (1996:131) states: 'To live morally requires, in the first instance, not moral discourse, but a relentless awareness of ourselves in the particulars of moment-to-moment living.'

I was careful not to do any harm to the participants or their families, which meant a conscious awareness, at all times, of how we were positioned for and towards each other in the research process. Knowledge shifted from something held by those having the privilege of 'expert' status, based on knowledge and positions they held (with this power exercised in relation to others) to knowledge becoming a co-constructed process between people. Thus it became an 'ethical-political process' in which the construction of knowledge was no longer regarded as a neutral process, but as an act or the art of ethicising (Kotzé et al 2002:21). Knowledge was understood as something happening between people in the course of interaction, with knowledge becoming 'part of a continuous stream of interpretation' (Kotzé 2002:13), so that the researcher/researched positions were transcended to make room for a self-other consciousness. Such knowledge of the other then becomes knowing with the other, in that the participation of and in all becomes the primary commitment in the aspiration to be ethical (Kotzé 2002:18).

In addition to the sharing of power, the research act required me to be accountable to the participants at all times, and to be responsible for the type of knowledge created in the process of doing this research.

4.9.8 Accountability and responsibility within the framework of research ethics

At all times during our interaction, I strove to be open and honest with the participants. Therefore, I provided them with a typed information sheet (attached as Appendix A) which detailed my reasons for doing the research and the objectives I had in mind. I provided them

with a consent form (attached as Appendix B) stating clearly that they had a choice about whether or not to become involved in the study, and also made sure that they understood that they were free to terminate their involvement at any time.

Giving their 'informed consent' means that the participants agreed to be interviewed by me about their illness experiences. The undertaking was open-ended in terms of access; I was not sure how long the research process would take, so I could not give them a firm commitment with regard to the duration and extent of their involvement. Although I provided information about the purposes of the research in advance, I was not able to give details about the processes that were to unfold, particularly because of the essence of the narrative inquiry (Etherington 2007:601). Also, the exact nature of the questions to be asked and the related probing for in-depth responses could not be communicated beforehand, leaving a measure of unpredictability and adaptation at the centre of the research inquiry (Watts 2006:395).

The concerns about preventing distress for the participants became the focus of constant re-negotiation around their involvement and level of participation. Credible ethics would require of me, as researcher, to act with integrity in relation to myself and others in our search for the good; that is, in accordance with those norms that demand justice, humanity and equality, as well as complying with the guidelines for ethical research (Helgeland 2005:554). Hence, regardless of informed consent, ethical conduct depended on my openness to engage in dialogue, on my awareness of the need to discuss the changing meaning in the ongoing process of research and its impact on the participants; as well as the potential dilemmas which might be raised by the research (Helgeland 2005:554).

It follows that research, as a means of creating, constructing or discovering new knowledge, is never an innocent process. Instead, it has real consequences for the lives of people, so that 'doing' research is also a 'doing' of ethics.

Lincoln and Denzin (1994:582) argue that 'the modernist project deeply ignored the spiritual search for meaning and prophecy thought to be hidden in the whole of the universe', in a plea that we should try to live ever closer to the lives about which we write, in order to think deeply about how we use science, and what kinds of science we may have. It is a 'doing away' with expert knowledge to find some spiritual core in ourselves, 'a way of reconnecting to meaning, purpose, and the sense of wholeness and holiness' (Lincoln & Denzin

1994:582), as a growing sophistication surrounding the problems of our own situatedness in texts.

4.10 CHAPTER OVERVIEW

Anorexia/bulimia is known to occasion extreme social isolation and withdrawal. Accordingly, the re-establishment of relationship and connection, through a bodily *felt sense* of emotion and feeling, was considered the element most crucial in the process of healing. The therapeutic/research relationship, founded on a feminist model of care within the framework of a qualitative research design, served as *the* foundation in building bridges of relationship between the self and the body, as well as establishing connection to the world at large.

Having lost agency and control, and lacking a positive sense of self, I sensed their fear as the illness became more powerful and demanding and left them questioning their place in the world. As I considered the therapeutic/research relationship to be crucial, from the very first interaction on, I worked towards establishing a sacred context, within which the participants could affirm feelings of safety, trust and acceptance, re-entering a world where once they had been hurt and disappointed.

Having worked towards developing and maintaining trust between myself and the participants, our relationship could never be taken for granted – it remained the crucial element on their road to healing. Gaining their trust and acceptance also meant that I had to be constantly ‘on guard’, with anorexia/bulimia always devising new plans to derail my efforts. The road to healing was not linear and straightforward, but was marked by many setbacks and disappointments, so that during the first months of our interaction the relationship remained extremely fragile, often leaving me feeling emotionally drained. Having spent so much time with Mariska* before she died had also changed me, and I worked resolutely to step into the reality of their lived experiences in the context of anorexia/bulimia. Only by having intimately experienced the power of this illness could I hope to gain a better understanding of what the participants were experiencing. I developed a bond with each one of them as together we struggled against anorexia/bulimia, something I think they felt and sensed during our interaction.

Feeling differently about the participants meant I did not blame them for the condition they found themselves in, rather I came to consider the relationship to resemble the unconditional love a mother has for her child, a relationship founded on Divine grace. I felt God with us, His

healing and empowering presence enabling the participants and myself to move towards life with courage and strength. Without this presence, efforts to 'cure' anorexia/bulimia are largely thwarted, the reason why so many patients fall back and never fully recover. Ethical ways of working had to be *discovered*, always alive to the possibility of being confronted with new challenges, requiring ways of situating myself differently towards the research participants. Each new situation brought with it new possibilities for the creation of new knowledge, critical for an understanding of and for disempowering anorexia/bulimia.

Narrative ways of working not only provided us with tools to destabilize the problem story, but also opened up a world of spiritual experiences and practices founded on a form of 'conversational intimacy', which further constrained anorexia/bulimia in maintaining the plot line which structured had previously participants' lives. It called for special ways of listening called 'deconstructive listening' and 'deconstructive questioning' (Neuger 2001:141), together with gentle forms of probing, to support the entire process of self-healing, founded on self-acceptance and personal growth. In a move to achieve this, relationships were founded on a shared sense of bodily feeling and emotion through self-reflection, with metaphor, story and imagination becoming instrumental in gaining radical insight and achieving change. With the body considered the site for stimulation and the creation of knowledge, our interactions structured an awareness of the self, body and 'other', creating connection and leading ultimately to healing.

Still within the context of a caring relationship, the participants and I worked together to document the research journey, founded on our discussions, stories, writings and experiences. As I was writing about their lives, it was important and just that they understand and become involved in the entire process, so that their qualification of all written texts, in the construction of knowledge, positioned them as co-owners and co-researchers of the research project.

In the next chapter, Mariska (one of the participants) tells her story. She opens a window onto her life, a life in bondage under the compelling force of an eating disorder, as evidenced by living a disabling spirituality which kept her body in a symptom-producing bind. With the help of therapeutic assistance and support, together with her own self-reflections, she developed new perspectives, not just concerning her relationship with the illness, but also finding new meaning and purpose in her life. The establishment of new relationships was founded on new ways of caring for her body, the self and 'other'. Her story details a brave

journey of healing (of mind, body and spirit), founded on an enabling spirituality which facilitated her own empowerment and eventual recovery.

CHAPTER FIVE

WOUNDING TO HEAL⁴

Mariska's story encompasses our interactions during therapy and research. Mariska initially came to me not wanting to give up the eating disorder. She had already been struggling with bulimia for many years, so much so that the illness had come to serve a very real purpose in her life. Previous diagnosis had constructed a reality damaging to her self (spirit). Hence, Mariska now believed in and was committed to a lifestyle that spoke of 'otherness'. She considered her relationship with bulimia a special secret, with bulimia becoming her confidant to the exclusion of other people, nature and God. Her relationship with the illness had created a particular lifestyle marked by rigidity and isolation. Because Mariska was not aware of her own entrapment, interactions between us were initially strained. She felt unable to open up her world to outsiders and felt uncomfortable looking me in the eye.

I asked if it would help her to keep a journal of happenings in her life with a view to sharing what might otherwise be difficult to communicate. The first draft(s) of her story was(were) co-constructed by Mariska and myself much later into therapy/research, based on notes taken during our initial interactions and on her written notes, referring back and reflecting on what had happened previously. Although her journey started slowly, it evolved into a powerful life narrative – a story of a life wonderfully touched and healed.

MARISKA TELLS HER STORY⁵

It is a hot afternoon in January 2006 when I met Mariska for the first time and greeted the physically small person entering my office. Her mother had made the appointment and accompanied her on her first visit. After a very difficult year at university in 2005, Mariska had again enrolled for academic studies in 2006. She came for therapeutic assistance and support because of an underlying anxiety that she did not possess the necessary skills for academic study. She feared that she would be unable to cope on her own.

⁴ This chapter heading was inspired by the title of an article by Rao. See Rao, R 2006. Wounding to heal: the role of the body in self-cutting. *Qualitative Research in Psychology* 3, 45-58.

⁵ In Chapters Five and Six, no numbering is used. This decision was made to honour the flow and integration of the participants' stories, and to avoid forcing their stories into a 'scientific' mould. The current formatting reflects the interplay of their story and my story, and the meanings we made together.

Mariska was 20 years old at that time, petite, very attractive, with long brown hair and blue eyes. She seemed to me to be completely indifferent and aloof, busying herself by looking at objects in the room. I felt her reserve; she would not meet my eyes as I welcomed her – or rather, her eyes made a nervous pass across my face and then looked away. I sensed her decision to visit a therapist did not come easily, that she found it difficult to trust other people. However, the fact that she had agreed to the first appointment, although perhaps daunting for her, was a significant step in itself. It meant stepping into what was for her unfamiliar territory that would require her to share her past and open her life to a stranger.

In order to foster ongoing dialogue, Mariska's story is staged within the framework introduced by Anderson and Goolishian (1988:381):

...therapy is a process of expanding and saying the 'unsaid' (quoting Gadamer) – the development, through dialogue, of new themes and narratives, and actually the creation of new histories. This resource for change, the *not-yet-said*, is not in the unconscious or any other psychic structure, but in the 'circle of the unexpressed' (quoting Lipps). This resource, this capacity for change, is in the ability we have to be in language with each other, and in language, always developing new themes, new narratives, new stories.

In our interaction, Mariska and I were constantly striving to create new realities, paying special attention to higher meaning and purpose, and to encourage a deeper understanding of what is possible through reading, journal writing and metaphor. We placed emphasis on the use of writing as the means to create new voices and multiple descriptions that addressed the relationship in which the illness was constituted, restored emotions silenced by the illness, so that these emotions could be reflected upon and reconstituted in our ongoing conversations.

Mariska's story is initially dark and troubling, perhaps even unsettling for the reader, but I ask that you remain patient and committed to going the distance with her; this is a slow journey marked with pain, confusion and setbacks, where her own strength and determination will be severely tested. This is her story, written from her own journal notes and recordings made during therapeutic interaction.

MARISKA: I cannot recall much about my growing years. I remember very little about my father except that he was never around. I have a younger brother Frikkie and it was always just Frikkie and me. My father treated my mother badly. I do not know much about how fathers should or should not be, but he did not come close to any of my expectations I had regarding a father figure. He was never there, not physically or emotionally. Eventually he left. To this day we know very little of him, where he lives, what he does.

My mother subsequently remarried and although we thought our home life could not possibly get worse we were in for a surprise. He was a school teacher and it was all important for Frikkie and me to achieve, and to be a credit to our parents. Nothing but A-grades were considered good enough! Frikkie was often beaten for no reason at all. Eventually my mother saw no future in the relationship and they were divorced.

Then came Uncle Phillip. You can imagine when she told me that they were planning to get married, I rebelled. I did not want my mother to marry again! When was she going to understand how I felt? All the years of heartsore and no sense of belonging anywhere! Yet Uncle Phillip was different. Different from all I had imagined. He has been good to us; good to the 'other side'. Occasionally he would attempt to draw me into conversation; usually concerning the Bible and its interpretation. I was unable to keep up with him or to match his understanding and felt lost in his world. He never attempted to enter mine. When I was still very young I awoke one night with him praying over me. It felt weird! Compliments were seldom given, I hardly ever heard 'you are pretty' or 'I am proud of you'!

Of course I tried hard to please my parents but feeling that I could never live up to their expectations, I abandoned the effort with a vengeance, going to the other extreme and doing all the things I knew would be upsetting to them. At the age of fifteen and rebellious, I thought it of little consequence to burn my skin around my ankles with a cigarette lighter

when dared by my friends. This was followed by burning my flesh with cigarettes. There was no pain, only the unpleasant sensation of resistance of the flesh. It became a ritual, pulling me further into a dark hole. I became involved in occult practices without fully understanding what I was doing. I sensed that I had a strange power; I could do things (deliberately mutilating my body) without feeling pain, something my friends would not do. It was the unnatural power that began to scare me. I began to experience frightful things in my life but kept it from my parents. It was like having a secret no-one knew about. Eventually my parents discovered what I was doing. Perhaps they understood that I was caught up in something which had a power over me, a power from which I could not escape. They became very concerned for my welfare and arranged for me to go for spiritual deliverance.

2005 was a year of much heartsore, much pain. Enough reason to hate God and everyone who calls themselves Christian. A year of perseverance, but also a year of quitting. Something inside me died during that year. I began to realize that I was not well and needed help. Joyful Noise Ministries was where I placed my hope, the place where I thought true healing might take place. I set out to make a new start. I was right but also wrong. I felt undervalued in comparison to everyone around me. This was also the time that I was told I have a 'lesbian spirit'! Never before was it part of my thoughts, yet to this day I battle with this. In this 'bible school web' where I was supposed to have been safe, my whole world collapsed as if a carpet had been pulled from underneath my feet. I had to break up with the man I was in love with because people in positions of authority told me that this was 'the will of God'. I was seen as the girl with the 'issues', the one who was not allowed just to be. I was called in by the leaders of the group and told that I was a bulimic, without me even knowing about it! It really hurts a lot to reflect on this. The leaders of Joyful Noise Ministries said that I was not aware of the eating disorder; that when I put my fingers in my throat I changed into someone else! I was so confused! This is when I started to believe the woman on the Christian camp who told me I had a borderline personality disorder. And this was

coming from people that were supposed to be living the reality of the love of Christ? No! No!

I wish I could see inside myself to see how many of the scars are still raw. I carry all these labels around my neck; bulimic, multiple personality disorder, lesbian. Every day I try and convince myself that it is all a lie. I do not know where things started to go wrong. I grab at empty thoughts, but I stare into nothing, everything is empty...empty. My heart is sore because of the falseness I carry with me. I thought I could manage not to make myself sick. I do not want to throw up because I do not want to damage my teeth. I do not want to throw away everything I have worked so hard for. I try so hard to get away from manipulating thoughts. Yet the fingers I put in my throat have become gods in themselves. I do not want to do this anymore but I can feel how I am being pulled everyday deeper and deeper into a black hole of sickness. I truly do not want to be there! At the same time I am not the only one making these decisions, I am not alone. There are voices in my head, fighting constantly and it's driving me insane! I wake up every morning with the same, annoying voice, telling me lies. I go to sleep every night with the voice singing me dark lullabies.

The voice has become my best friend. I can't imagine life without it. There will be nothing left. I'm trapped, trapped inside my own mind and I'm dying to get out. But I am also scared of what will be left if I do get out. I have lost all sense of life. I feel I have lost my identity because people have told me I have multiple personalities; but how would they know? They are not the one's fighting this constant battle and they haven't seen inside my head. It is only voices, not personalities! It is lies and the more you listen the more you believe. These are the issues that make me want to cut myself, maybe to get the voices out ! I can't remember what it must feel like to be free..... How does it feel... is it empty? The voices make my life seem more real, but at the same time I know that there has to be something more peaceful out there.

I'm totally confusedI do not know what I feel. I went through spiritual deliverance, so why am I not healed? What else is there to do? Some say

it is a spiritual battle, others say it is a mental illness. I say, 'I don't care as long as you can make it go away!' I mutilate my body but feel nothing, it is as if I need to see blood so I can make sure that I am alive! Inside me I am all mixed up. Everything that is part of me is in the wrong place. It feels weird, but I am used to it, this is how I have been for as long as I can remember. I have never really figured out my purpose in life, I have always wondered who I am.

JOAN: I am surprised at the power that these voices have over you – the power to take over your thoughts and mess with your life, the power to hold you in their grip making you believe that you cannot do without them ... Making you a stranger to yourself. Are the voices in your head different to the voices of those who pinned all these labels to you?

MARISKA: They are no different; they say the same things about me

JOAN: Earlier in your story you recognized that the voices were telling you lies.....What do you think gave the voices this immense power over you? What are some of the tricks the voices have used to become so powerful and demanding in your life?

MARISKA: That they are always right and I am wrong. That I can only know myself through them. That I cannot manage my own life and that I am helpless. Where does it come from, why do I feel like I do? Am I more caught up in this than I realize? It feels as if I do not know anything about myself! What stops me from doing what I know I need to do? When I look at the scars on my body where I cut myself I know I must stop...I do not feel good about it. The problem is that when I do it I am transported somewhere else... it is not me doing it, rather it is as if something else takes over ! Every single day of my life I try to make the voices disappear. But as the days go by, they become stronger. I don't really think I can fight them, I just try to make myself feel less of a failure.....

JOAN: So what do you do to stand against the voices to show them that you are not the failure they say you are?

MARISKA: I made a decision that my life was somehow going to be different. No-one in my family has gone to university. I work very hard at my studies. When I was at school I used to write songs and then play these on my piano. The music, the notes I play on my piano make me forget. Some evenings I only get home by nine o' clock. Then I can only go and sleep and not spend too much time worrying about the next day. But...it is very hard to keep the pace, I am often exhausted!

JOAN: So working hard at your studies and playing the piano not only gives you personal satisfaction but it also helps you to be successful in a 'world' not dominated by strange powers and voices.....You are working at something that is important to you, these choices you make and challenges you face, this sounds very positive to me.

MARISKA: But the voices are inside my head, the scars of self-mutilation are on my body – this is all part of me, inside me; don't you understand I cut myself to get rid of it all, to make it all go away! How does one get rid of something that is you, your identity? This is how I came to realize that I was different, other.

JOAN: You said the need was there to cut yourself in order to see your own blood, making sure that you are still alive? Is this strategy a form of resistance...your way of saying 'I am still here, I am still alive' in the midst of everything you experience?

MARISKA: Yes... it is possible...

JOAN: So what about the sacrifice to your body? If your body could speak what do you think it would be saying to you.....Would it perhaps be saying that the illness (self-mutilation) has the power to turn you or your body into a mere

object, giving the illness your power, your freedom! You are saying effectively – ‘Take charge of me, you are the boss!’ How does it explain the loss of your own sense of self and your own personal freedom to which you referred earlier in your story?

*MARISKA: There are parts of myself I do not know. Sometimes I feel dead inside as if there are destructive forces within my self. It sometimes feels as if I **have** to be ill, as if I **have** to be in this sick role; as if I am drawn to it by a power bigger than me. Where do I find the strength to confront those parts of myself that breed this shame and self-hatred?*

JOAN: Shame and self-hatred – was this the willing soil in which the voices sowed their seeds of self-mutilation and bulimia? Disappointment in the adult world, the great gap between what you saw as pretension and the world of your experience. You believed that you were special and then felt disappointment when people whom you trusted, hung hurtful labels around your neck, no matter how impressive your specialness was. By so doing they have imposed a ‘reality’ on you that is damaging.

I can’t say to you ‘this is what you need to do, this is good or this is not’.... Rather to help you understand that you are much freer than you believe, that what you have accepted as truth, as evidence, has been built through your interaction with others over time and these so-called ‘truths’ can be critically examined and destroyed.

MARISKA: How? And how does this change me or what I feel?

JOAN: If we can go back to an earlier part of your story, you said that you had much hope when you joined Joyful Noise Ministries. You also indicated you had been involved in occultic practices before then. I do not know what happened and please help me if I misinterpret anything, but it sounds as if Joyful Noise

Ministries was a stepping stone towards a more secure lifestyle, almost a moving away from what you had been through previously. Unfortunately, here you not only felt excluded but your 'otherness' was emphasised by labels they pinned on you. There was no appreciation on your part that the doctrine of Joyful Noise Ministries might be over-taught, unrealistically applied, rigid and subject to abuse and misapplication. What you experienced there you questioned as almost un-Christian, but yet you began to live the 'story' they imposed on you!

MARISKA: This is true I cannot remember ever having had problems with food. It all started when they told me they thought I was bulimic. For some reason I was drawn to the fact that they thought I was sick. I liked the look on their faces.

JOAN: The story gained momentum and power because of your own acceptance of the stigmatized identity! So, are you really going to live according to the dictates of this problem story or are you going to re-negotiate the story by beginning to live a more hopeful story of your life? I think you have already decided and have set ambitious and positive goals for your life. No-one in your family has a university education, you have excelled in your studies, you have a talent and love for music. I do not see *your* story fitting with the hopeless story created for you – Can you hold on to this reality which the 'problem' story wishes to destroy?

MARISKA: I would like to know that I am okay..... but then why can't I stop self-mutilating or keep my food inside just for one day, why can't it just go away! It is as if I am waiting for it to happen! And when it has happened I do not have the tension, I feel more relaxed.....

JOAN: For the moment – until the next time you 'operate' on your body again.

MARISKA: Operate on my body! I do not see it like that. Rather, I feel it is something I have to do. I am so used to doing it that I do not know what life would be without it.

JOAN: Something you have to do ! This suggests a person who has no power of choice, whose behaviour is directed by external forces totally beyond her control! Is this what you really want for your life or is it because you are held captive by an illness which has voices in your head, telling you that it is okay to abuse and ill-treat your body because you are unworthy and your body unlovable? I am curious to know exactly what these voices are telling you?

MARISKA: I think it is fine to be different. I have managed my studies and all I set out to do although I self-mutilate and let bulimia get the better of me. It is a secret, my secret. No-one knows about this. Do I have to give it all up?

JOAN: I am not asking you to give up anything. I am not asking you to give up your world for mine. Your world or reality is comprised of multiple perspectives and of course there is more than one way of living. I am just wondering whether these choices you make reflect what you truly value, and will help you achieve what is important for you. I hope this process in which we are engaged will encourage you to define for yourself your personal goals. It is fine to be different but in which way could this situation add meaning to your life? At the same time I am not sure if this is Mariska speaking or whether it is the voice of bulimia and self-mutilation; the 'tale' the 'body thief' would like you to believe? (Zimmerman & Dickerson 1994:299).

MARISKA: It puzzles me! This 'thing' speaks! Sometimes I am surprised at what comes out of my mouth as if it is not me saying it. It makes me scared to talk; particularly about the things that are negative. Again, I struggle to write or speak about anything positive or empowering. It is weird. The moment I feel I need help or I need to talk about the problem then the voices in my head go quiet for a few days, almost as if they want me to believe that I do not really have a problem.

JOAN: I am concerned though about the subtlety of the lies you are told, subtle enough to entrap you but powerful enough to kill you. It also worries me to what extent secretive behaviour around bulimia and self-mutilation has already imprisoned and isolated you, telling you that your life is fine whilst affecting all your relationships and stealing life from you.

MARISKA: I do not really like people. People can be fake. I find it difficult to trust people. I do not cope very well with people in a group. I cannot share my problems with them, they would not know how to cope with them.

JOAN: I am not referring to people only. You have developed a relationship with this illness through behaviour and attitudes which are giving the illness all the power, making it bigger than you. Through this relationship a particular 'world' or 'context' has been created. Can you accept the idea that bulimia and self-mutilation might only be symptoms, the defences and shields that you put up because of an 'unfreedom' to just be you? Right now it seems as if bulimia and self-mutilation are the only solid ground on which you stand and we are busy chopping away at that ground. That there will be other, firmer ground to support you, you can only accept on faith.

MARISKA: I am trying to make sense of it all. It's fine. I'm doing ok. What makes sense is enough, enough for now.

JOAN: When I suggest that the illness affects all your relationships I refer to the way in which it isolates you; capturing you in its own 'world' so that the general awareness of ties that bind you to self, others, reality and God is diminished.

MARISKA: I feel as if I am falling ...slowly but surely.... Is all this now to become part of my life? I do not know what to feel or think. I do not know whether to laugh or cry. I feel unsure and I wonder about everything. What is going to

stay and what is going to run away? I'm having these irrational feelings of guilt and shame.

JOAN: When will you stop straddling these opposing worlds? I have great empathy for the fact that you are now being called upon to set aside what you have come to know as reality and accept another version of the world on faith. But you will never be able to seize the moment, achieve your full potential until you let go of your double allegiance. It is not the voices that are keeping you from the world, but your commitment. 'Alive' and 'feeling' are not about sacrificing your own self, your body; alive is fighting, it is about self-agency and willpower, using your own power. And feeling ...is it not about participation, being a co-creator in a reality that supports your own growth and potential as a human being?

MARISKA: Some of my days are positive. I eat normally and I do not cut myself. Then there are days when I feel I have been struggling with bulimia for years, everything I eat must come out. My head aches, my body becomes shaky and the following day is like after a storm; I wake up with a 'healthy' soul. How do you understand this? How does it work? I often wonder whether I got so used to these 'abnormal surviving skills' that it has become 'normal' for me.

JOAN: The illness with its voices that manipulate and order, turned you into a kind of robot that went through the motions of reality, and behind it the true person drew further and further away. The learning of 'new survival skills' requires a giving up of the old self and death to all the outworn knowledge. A new start....

MARISKA: Does it all have to go? Do we pile it up and throw it all out?

JOAN: It cannot be a decent bargain now – don't you see? You have to commit yourself completely by taking the first leap of faith. Then on what you

yourself build of this commitment you can decide whether it's a decent bargain or not.

MARISKA: I do not want to think anymore! I am tired and scared and I feel as if I do not care anymore what happens. The more garbage I give away the more I have left. I don't feel like fighting anymore ...

JOAN: I never said it would be easy. I cannot make you well and I do not want to make you well against your own wishes. If you fight with all the strength and patience you have, we will make it together.

MARISKA: And if I fight, what for?

JOAN: It is not going to be easy, but it can be done. This painful situation you are dealing with now may be a turning point for you, bringing with it the opportunity to create a more satisfying and happier reality. Also, you may recognize the degree to which the 'story' you are telling yourself may be helping to maintain bulimia and self-mutilation as problematic conditions in your life. It may give you insight as to how your story is producing the illness in yourself.

Reflections ...

Mariska and I had been in conversation for months. Because of her studies at university we had been able to meet only once a month for approximately two hours. Mariska often panicked when travelling to and from our meetings, which involved a distance of about 100 kilometres. Visiting the practice posed a dilemma for her. Often, she had been overwhelmed by voices in her head suggesting that therapy was not helping her, that it was in fact a waste of time. I was moved for Mariska and I realized that I could not begin to imagine and feel what her days must have been like. Often the temptation to turn back and miss out on her

appointment was almost over-whelming. On arrival, she was often heavily burdened and discomfited. I realized how important it was for us to go 'shoulder to shoulder' and take things just one step at a time. I stressed the importance of every little achievement, how every small step was important to our overall journey.

Mariska's progress in terms of over-powering the illness was painfully slow, yet she kept on coming back for our discussions. Not only did she meet every appointment we scheduled, but remained extremely loyal and conscientious insofar as she kept me advised of her academic schedule and weekends at home, so that appointments could be arranged well ahead of time. The significance of her opening her life to me and knowing how difficult it was for her to do so, made me more conscious of the effect on my own life and this work, of the trust that was being extended to me, the act of inclusion that I had received. These actions came to be highly valued by both of us as expressions of her own persistence, determination, struggle and protest which eventually achieved a turning point in Mariska's life.

However, Mariska's struggle with self-mutilation and bulimia was clearly not over. Often, when she tried to discipline herself not to put her fingers in her throat, the acts of self-mutilation would become more intense. It was always a case of being drawn to one or the other, sometimes both. Some days she described as 'normal'. Because I trusted the hidden strength which I knew was inside her, I believed that the illness would eventually be deflected from its course. However, often during therapy Mariska reported that her concentration was ruined, she found herself conversationally deaf and blind, that she felt herself gagged.

As we approached the second half of 2006 where the illness had been fully externalized and its effect on her life unpacked, she was at a cross-roads where she had to make pertinent decisions for her life. This was not easy. Being a keen writer, her journals reflected how she continued to live in her story, suffering and growing at the same time and being able to reflect on the person she was becoming.

I found it had become very difficult to reverse negative thinking and its effect, particularly because of the physical form and manifestation these negative thoughts had taken. The

struggle continued making visible the power of the illness and Mariska's difficulty to trust and accept change. Peggy Penn (2001:42) refers to chronic illness as a 'relational trauma' because of the illness being a relationally traumatizing experience, producing a language particularly attentive to negative metaphors so powerful that disconnects the ill person at a time when connections must be relied on and above question. Mariska's story continues below in extracts from her journal.

20 July 2006

Perhaps today is the right day to stop with everything. Everything that matters. Something inside me feels guilty...or do I just think so? Perhaps not! When is it all going to stop? It will ...

25 July 2006

[This was an attack on self-mutilation and bulimia]

It was more than your nails that cut me, it was everything that is you! And still, it was not painful. The slits which you cut into my body are there. They are all there but they do not burn any longer. Do you know why? It is dead; it is burnt dead. It is no longer painful, but it screams. It screams aloud for protection, protection against you. You are a coward who hides behind every corner where you find stones to destroy my body! I hate you for your face! You are all that is extremely painful, it is all you! You!

27 July 2006

It feels as if I am going to die today. I am so tired of people, tired of being tired but nothing goes away. It is as if everything clings to me and all this clinging

makes me ache. Today I just want to be inside myself. There is a part of me I know well and which I like because this is where I can be at peace. I am addicted to my own thoughts and that's okay. When I lock myself away in my own world of thoughts, I feel safe. This is where I am now. Through it all I wonder why I cannot forget about you. You were there when I was so sore and now you are gone. I no longer want to hold onto your hand. You are now on your own. I also want to feel what it is like doing something on my own, without you. Without your black nails that mess up everything. Who am I talking with?

4 August 2006

Will I ever be able to just give up everything? Is it really so dangerous or am I only wondering if you will still like me when you see me again. Lies! Lies! Lies! This is all I can hear. And I babble ahead in the ever greyness inside me. Everything wants to be in place. Why am I feeling so fat? I wish to remain smallI want to be thin. Lord, you know about everything inside me.... what is it?

20 August 2006

I cannot understand how everything changed so quickly! Yesterday I was still okay and today I realize that I am not...I also know already what tomorrow is going to be like. I already feel very guilty about it. My fingers in my throat have become like gods ... when I vomit I feel safe ...

My friend Simon wants to know, 'Why are you going through all these changes?' When I could not keep my lunch inside my body today, I wanted to share so many things with him, but the moment I try to speak it's gone and I end up saying nothing!. Inside me it is madness, full of voices and ugly words. Over and over I am brought to my knees with tears of despair running down my face. I feel powerless, but also in charge! It feels good to know that I have a secret inside me that all the strange faces on the campus do not share. I so much desire to be good at everything, also with food. I still need to lose more weight until I feel good about myself. In my head I have a picture of what I

should look like and I know that I can do it. It just becomes very difficult to be certain that I will not hurt the people close to me. I do not want to do this..... hurt people who care for me.

Sometimes it feels as if I want to be sick. All the pain, the attention, the dark side of it, it all pulls me like a magnet. I am so caught up in the pain of 'sick' that it actually fills me. I am sore....The cuts on my body, the fingers in my throat, the dark conversations, this is what keeps me alive. My heart throbs in my throat and there is a strange voice in my head. A new voice but also one I understand. One gets used to the voices in your head, so much so that you feel lost without them...

21 August 2006

I fight against the food and getting sick until late in the day because I do not want my food to come out again. The food I eat is getting less but still I feel fatter. I also feel as if I cannot eat today because I do not want to vomit again. I have a bad headache. My hands are shaky but I must try to eat rather less than too much. My days become very stereotyped; my thoughts are chaotic!

Reflections ...

As time passed and we got to know each other better, I became more aware of the fact that Mariska rarely demonstrated any form of affection; she always displayed an independent front. Despite months of dialogue she remained distant, almost indifferent as if she found it difficult or even scary to reach out or to connect at any level. Often, during our discussions, she seemed totally preoccupied in thought. Sometimes she would busy herself looking around the room as if she made it her business to take in every detail; but not really 'seeing' anything. She rarely shared her life on campus, leaving this part of her life un-storied. Hence there were seldom conversations about friends, hobbies, sport, TV, fashion or anything else that might interest her. Moreover, 'stuckness' in the problem story was congruent with her

body language; sometimes it felt as if there was a wall between us shutting out all feeling or participation on her part.

Mariska had told me previously that her mother struggled with an eating disorder during her growing years and was aware of her (Mariska's) condition. She mentioned though that she found it difficult to discuss her problems with her mother, as she was concerned that her mother did not really know how to handle the situation. She often got the feeling that her mother spoke around the problem instead of tackling it head-on. Because Mariska's mother brought her for therapy initially, I decided to make contact with her. Without compromising any confidentiality on Mariska's part I enquired whether they were aware of her intense struggle with bulimia and whether there was sufficient contact and support from them. She said she and her husband were also concerned about the eating disorder and the fact that she felt Mariska did not eat properly when away from home. However, Mariska continued to do well at her studies and was extremely responsible in all areas of her life. At the same time, she had superficial friends but hardly any intimate ones, certainly none to whom she could talk about her problems. I was concerned that hospitalization might at some stage have to be considered, although Mariska carefully controlled the illness to produce limited pathology so it would not seriously threaten her life. She has, in effect, learned to live two entirely separate lives.

Mariska's stepfather is a pharmacist and the owner of several pharmacies in her home town. I asked her mother that they keep a close watch over her situation. During subsequent visits I continued to stress with Mariska the seriousness of mutilating her body and self-induced vomiting as a means of weight control. We read from Maisel et al's (2004) book *Biting the hand that starves you* for camaraderie and support from the anti-anorexic/bulimic league. I enquired whether she would be willing to see someone else if I was to refer her to a psychiatrist for evaluation. She felt at the time it was not necessary and assured me that she was working hard to overcome the illness, that there were periods in her life when she could not believe the problems that sometimes crippled her.

However, I remained very concerned with Mariska's difficulty to commit to accept and risk change. She wanted to make the right choices for her life but there was always a lingering concern that if she should fall back again, that she might not be able to deal with the

consequences effectively. We often discussed what David Epston and his colleagues had experienced, that the illness keeps victims imprisoned or in bondage because of the lies – lies that emphasise the victim's vulnerability to implement and go with change. I also stressed to what extent it required a complete change of mind, a determination to regard the illness as an enemy that needed to be fought. The following is another extract from Mariska's journal.

September 2006

My throat is sore. This week I am going to try hard not to bring up my food. Lectures start tomorrow and then it becomes a very stressful time for me. My head feels empty as if the voices do not want to communicate with me tonight.

The last conversation with Joan is the one that stays longest in my mind. It is the first time after a consultation that I am really thinking so much about what was said. Perhaps it was the first time that I really heard her. She asked me to reflect on the plans bulimia and self-mutilation have for my life. And she asked me whether I thought bulimia became a god, acquiring a spirituality of its own. This is true and these things become gods that you worship, because they swallow your identity, they take the place God should have. God is so abstract, untouchable, invisible.

12 October 2006

Through it all there is hope. Hope because I get up every day and move forward. Hope because of people who care for me, hope because I am unique. Hope even though I am different, just as others are also different. One day I will arrive where I eventually want to be. I will continue with the struggle although it hurts, I am doing it already. I will fail and disappoint people, but I will also grow through this. There will always be people who may not like me, but one day I will realize that it actually does not matter anymore. I will still cry a lot, I am still

going to be very cross with myself, I may even hate myself for silly things I do. With every irresponsible deed there is the guilt. The voice that tells you what you do is wrong, this voice never disappears, it only becomes softer.

For the moment I take things slowly and try to deal with every emotion when it comes my way. I struggle and become hugely irritated with myself but for some strange reason I carry on. I will not give up. I do not lose hope..... I have hope!

Reflections ...

Feeling somewhat frustrated at the very slow progress we seemed to be making I began to spend more time reflecting on the situation. Going over and over her story in my mind, I was also faced with the fact that patient responsibility for change does not end with the patient being on time, paying an account or any other element of cooperation. Moreover, that Mariska was accountable to herself and this accountability extended all the way to the change which was desired, but why was it so difficult for her? I looked for answers as I searched through literature and gave much thought to her story.

One afternoon in early spring, looking out over my garden from the room where I was working, some thoughts crossed my mind. Outside the plane trees were just bursting into leaf with the late afternoon sun shedding a mellow light through the garden. Masked weavers were methodically stripping a palm tree for their nest making – each nest the same, yet each unique – built in accordance with some cosmic blueprint. I felt touched by the scene, nature being both industrious and yet, so serene.

My thoughts turned to Mariska, her isolation, her body language which kept everyone at a distance, together with the mutilation and subjugation of her body – I asked myself whether it was this absence of the spiritual that had worried me all along. Mariska seemed to be stuck, having created a reality in which the problem story proved to be difficult to unsettle.

If one considers the human spirit the core of our imagination and the body-self as an organic part of the sacred; the communication system involving exchanges with the Divine and others – the body becomes significant in terms of how the illness, together with its dark conversations, constructed a particular spirituality for Mariska keeping her body in a ‘symptom-producing bind’ (Griffith & Griffith 1994:132). Some bodily states hinder spiritual experiences and others facilitate these, suggesting that a body in pain cannot support enabling spiritual practices or experiences. Had the illness in fact gained a spiritual power of its own, having taken on the supremacy of a god in the religious sense of the word? Acting like a sponge, this illness soaked up personal and social significance from Mariska’s world (Kleinman 1988:30), narrowing her existence by violating the relatedness on which true spirituality rests.

Martin Buber (1937:5) speaks about a relation with God as basic to true humanity in all spheres. How could conversations involving spirituality, new images of God, herself and others open a new life-world for her and contribute to her feeling less anxiety within her body?

Our conversations continued and it was late in the second half of 2006.

JOAN: Mariska, I have spent much time reading and re-reading your journals but the paradox is always there; a desire for change, a desire for ‘truth’ about your condition and then ongoing injuries to your body. What is the motive, what is it that ‘feeds’ and ‘maintains’ these injuries to your body?

MARISKA: The first time I put my fingers in my throat, the objective was not to get thin, perhaps rather to hurt myself and to feel what it was like. Also, to get rid of all the soreness inside me. But now, I think it has become an obsession, a desire to be perfect. I do know that it is not possible to be perfect in every way and I also know that it will never happen...

JOAN: What would perfectionism look like if this could be achieved?

MARISKA: To be good at everything I do.

JOAN: But Mariska, you have achieved so much already. You said sometimes there is an urgency to want to get rid of all the soreness inside you. Is there some deeply wounding guilt or pain from your past that manifests itself in a self-hatred that hurts your body?

MARISKA: It is difficult to just be ...There are always the thoughts wanting me to be like some-one else, always something. My life is full of just empty things...I often wonder. Sometimes I have a big heartsore inside me, I want to get it out! I often feel the need to cry. There are things I want to say but they escape me, I end up saying nothing!

JOAN: I think you also said the first time you allowed your cousin to burn your body with a cigarette lighter, friends thought it weird and said you would not do it. But you did, and it gave you a sense of control, you felt bigger and more powerful than your friends. The first time you put your fingers in your throat you said it was not to get thin but rather to hurt yourself....How is bulimia different to self-mutilation?

MARISKA: There is no difference....they both make me feel the same afterwards.

JOAN: And what would that be..... what do you feel?

MARISKA: It releases the intensity of my feelings. I need to get it out, unload, and then I am left feeling more relaxed and in control.

JOAN: So bulimia and self-mutilation are a means of 'getting back' at your body? These feelings of guilt or self-hatred – to what extent have they injured your sense of self, binding your thoughts and emotions to keep you stuck in this cycle of pain? This illness is serious in so far as it has made you lose your

destination and map (Frank 1995:1) what would happen if you began to think differently? What would be different if you make a constant effort to start appreciating Mariska? What would happen if you started to love Mariska? And I mean really appreciating and holding Mariska – becoming the moral witness to the assault of bulimia and self-mutilation on your body? Have you given serious thought to what the voices are saying, it is all about negative ‘self-talk’ which you have internalized and then repeat as part of a never-ending commentary on your abilities, your behaviour and yourself?

MARISKA: I know now that I cut my body because I have never loved my body. Then other things came in, things like blood being powerfulIt was not always like this.

JOAN: Have you given thought to the possibility that the problem you are struggling with could be a spiritual (moral) problem? We spoke earlier about bulimia and self-mutilation as symptoms – perhaps of a woundedness of the spirit?

MARISKA: It does make sense. Somehow it feels right.

JOAN: I would like to read to you from the case study of Ellen West; a woman who grew up during the time of the Third Reich. She spent most of her young life in institutions and sanatoriums, having been diagnosed with melancholia. After two or three attempts at suicide, she eventually took her own life by an overdose of sleeping pills. After her death her diary was released from the archives and a group of therapists researched her story, which together with her diaries, was published in book form. Although she was at the time diagnosed with melancholia it is apparent from her writings that she not only struggled with an eating disorder, but perhaps with an even more damaging spiritual problem. Through the process of medicalization in Western societies, problems previously labelled as moral, religious or criminal became redefined as disorders and dealt with through therapeutic technology. What is of interest is that she somehow recognized it as a

spiritual problem at an advanced stage of the illness, but was disappointed by her analyst who did not involve spiritual talk or open up her story to invite the spiritual or moral aspects of her life.

The following is from the diary of Ellen West (Binswanger 1958a:237-364)

'My thoughts are exclusively concerned with my body, my eating, my laxatives. Often I am completely broken by the conflict which never comes to an end, and in despair I leave my analyst and go home with the certainty : he can give me discernment, but not healing.'

On another occasion the analyst asked her 'Can you eat a good serving of beans or pancake and take afterwards no medicine'. Then she writes 'seized by a veritable panic, and at the mere idea, dread makes me turn hot and cold. All good resolutions, all joy of life, break down before this wall over which I cannot climb'.

'I still do not want to get fatter – I will not give up my ideal. Just so, I must now be able to look at my ideal, this ideal of being thin, of being without a body, and to realize it is fiction. Then, only then can I say 'Yes' to life.'

'The only real improvement, which must come from within, is not yet here; Nirvana in a figurative sense, the extinction of greed, hate and delusion, has not been reached. Do you know what I mean by this? The greed to realize my ideal; my hatred of the surrounding world which wants to make this impossible; the delusion which lies in my seeing this ideal as something worthwhile.'

She describes it as a *'fight between duty and desire'*. Despite this, she feels the entire time, every minute, how terrible that her life is dominated by her *'morbid'* idea. She knows no way to *'help herself out of this swamp'*.

Then there are times where a *'spiritual relaxation'* sets in and with it a complete revolution in nourishment. Her notes and poems show new hope and new courage. She *'wants to be human amongst humans. I feel something sweet in my breast, something which wants to grow and become. Is love coming back into my life? More serious, more quietly than before, but also more holy and more purified'*.

'In the fall of 19... I felt dread for the first time. Only a very indefinite and faint dread; really rather an inkling of the fact that I had become enslaved to an uncanny power which threatens to destroy my life. I felt all inner development was ceasing, that all becoming and growing were being choked, because of a single idea that was filling my entire soul: and this idea something unspeakably ridiculous'. 'My reason rebelled against it and I tempted to drive it out. Too late – in vain. I could no longer free myself and longed now for liberation, for redemption which was to come to me through some method of healing. Thus I came to psychoanalysis.'

'I wanted to get to know the unknown urges which were stronger than my reason and which forced me to shape my entire life in accordance with a guiding point of view. The wish to be thin remained unchanged in the center of my thinking. This compulsion has become the curse of my life, it pursues me walking and eating, it stands besides everything I do like an evil spirit, never and nowhere can I escape it.'

'The comparison with imprisonment is no play in words. I am in prison, caught in a net from which I cannot free myself. I am a prisoner within myself; I get more and more entangled. I am surrounded by enemies. Wherever I turn a man stands with a drawn

sword. I am fighting against uncanny powers which are stronger than I. I cannot seize and grasp them.'

JOAN: A very sad but powerful story. I have read it so often that I sometimes feel I have known her personally. What does the story do for you?

MARISKA: I understand everything she says, the diagnosis and everything. In fact, it could have been my story. I identify with the storyteller in so many ways.

JOAN: What stands out most for you about the story, what do you identify mostly with?

MARISKA: Being caught up in something bigger than herself – something she fights but it has its own kind of attraction?

JOAN: Some of the stories from participants featuring in the book by David Epston and his colleagues refer to the eating disorders as a manifestation of evil – how do you experience it?

MARISKA: It makes sense. However, does it have to be good or evil? This is what makes it so difficult for others to understand. You know what you do is wrong and that it will eventually catch up with you, but yet you cannot rid yourself of it. You know you do it but somehow..... I also do not want to be part of something that is evil.

JOAN: The capacity for love and hate exists in a fragile balance in all individuals. Likewise the capacity for good and evil. Interestingly the Chinese when referring to good or evil, speak of a white dog and a black dog inside every human being. Then they ask the question, 'which of the two will become the stronger?' Their answer: 'The one we feed the most.'

In the case of chronic illness certain practices can become anti-spiritual, particularly when these practices violate the integrity of the body. When the body is manipulated and injured, the body's needs ignored, it constitutes violence to the body and has profound spiritual dimensions. As we communicate with the outside world through our bodies, violence to the body leaves us extremely vulnerable as it affects all our relationships; our existence. A body in pain cannot communicate neither can it speak for itself, it has no language. You have indicated that you do not love your body. How can we speak about this relation between your own self or spirit and your body in ways that would do justice to the 'inner nature' of this relationship?

MARISKA: I never thought of it this way but our conversation takes me back to memories of my childhood, memories of sexual molestation and abuse; long-buried memories all the details of which I cannot remember. But I do think talking about it now makes sense why I have to do this. When I was in pre-school there was a little boy who seemed to know all about sex and often during play wanted to touch and look at my private parts. Although it made me feel uncomfortable, I was perhaps fearful of rejection and judgement by others if I spoke about it, causing these incidents to carry on for quite some time. One day I arrived home with a bracelet he had given me. My mother wanted to know more details, at which point I became very tearful and secretive, something which made her go to school to find out where the bracelet came from. During discussions with the teacher, my mother was told that I should not play with this boy because the school had suspected 'funny' things. Shortly afterwards he left the school. Only much later could I speak to my mother about it, and although I remember the incident, I do not remember much detail. [Pulling up her shoulders.] He must himself have been abused by someone, otherwise how would he have known about these things?

Then, just after I had started school, for three consecutive years I had the same male Sunday school teacher. I remember that when he told us to close our eyes and pray, he always wanted me to sit on his lap. During this time he touched and fondled my body. I understand now that I grew up blaming God

for all this; in the meantime it was about people who pretended to be what they were not.

And then, during my early teen years I was again exposed to horrible pornographic material. Too young to fully appreciate what it was about and through the utter negligence of adults, my cousin and I, unsupervised at the time, played a video which was left lying around. The vulgarity of it I still see clearly in front of me to this day! Unable to deal with the content of the material, I cried non-stop for hours, something which made my mother uneasy and alerted her to what had happened.

JOAN: I am so sorry about what has been done to you at a time when you were most vulnerable, you were innocent, trusting the people in your world and was very disappointed because of what you endured. It brings me closer to understanding your position, is there anything else you wish to share with me?

MARISKA: No, I'm fine as I said I cannot remember much of all that happened...

JOAN: Would you like to talk more about what happened?

MARISKA: No, I'm fine.

Not wanting to re-traumatise Mariska I did not pursue the subject. For me it was more a matter of Mariska coming to understand the effect of these events on her, the way in which she had positioned herself, as a result, her distrust of people (rightly so) and how she could move forward in the fullness of life and not let events from the past steal from her.

JOAN: Thank you for sharing this with me. I am so glad that you felt the need to share this although you cannot remember everything that happened. Perhaps because you cannot remember all the details you may not be aware

of the lasting impact it may have had on your spirituality as a woman; on your body. Would it be okay if we talked about your spirituality, I believe it is important if you are going to heal?

MARISKA: It's fine. Except when you refer to spirituality – the word itself stirs something in me. For a moment you sounded just like Uncle Phillip and everyone else who wants me to believe like they do.

JOAN: Thank you for helping me here. So, perhaps we should clarify what I mean by spirituality?

MARISKA: It would help.

JOAN: Unfortunately it is a concept open to many different interpretations, so there are often contradictions and it becomes difficult to define. I have always thought of spirituality as something very personal, coming from my heart. I regard spirituality as implying relationship, with myself, with others and with God. As I believe each one of us has a mind, body and spirit, with spirit as the core of my innermost being; the centre from where I organise, that houses my feelings, attitudes, beliefs. I see the spirit as counterpart to the self, my identity, connecting me with the Divine. From this I can only say that spirituality is not a set of dogmatic beliefs, neither is it something that can be attained once and for all. Rather, it is a process, the way by which we position ourselves in the world, a way of being in the world to which we aspire.

I refer to spirituality as being in connection with a Higher Power, (religiously speaking, God, by whatever name we choose to call Him), a person invests in this relationship for moral reasons, in order to be more, to become more; thus the individual is empowered by the relationship, referred to as an enabling spirituality. However, in the case of chronic illness, sick people can develop a relationship with the illness with the mindset, 'I am sick and have to live in a subjugated position because of the hold the illness has on my life'.

In effect, the illness is bigger than me'. Not only are the enormous capabilities of the self to heal in the context of illness ignored, but growth is stunted and healing impeded. Hence, the term disenabling spirituality.

MARISKA: It makes sense the way you explained it, though I am still not sure what this would mean for me. I still do not understand what effect this has on my life. Earlier on you referred to me having to learn to think differently. Does it mean that I have to believe in the God everybody else believes in, that I have to believe like they do?

JOAN: I am not sure that I understand what you mean.

MARISKA: When I speak with my mother about the struggle I have with the illness.....Ah....I don't know how many times we have been through this and all they say, her and Uncle Phillip is 'You must come to God'. What if I do not want to believe like they do. What if I cannot believe like they do! What if I do not know how to come to God! If I think of Joyful Noise Ministries, these were people serving God. God was there and yet He allowed this to happen to me!

I recognized an edge of anger in her voice. I was touched by her words because the truth in them was sharp and painful. I have heard them before, from other patients, struggling to find and know God. I was reminded of the writing of James Redfield and Carol Adrienne, in *The Celestine Prophecy* (1995:247):

Our entire evolution will be based on spiritual principles, but the tenets of religions will have to change to include the evolution of individuals. All religion so far has been about humankind finding relationship to one higher source. All religions speak of a perception of God within, a perception that fills us and makes us more than we were. Religion became corrupted when leaders were assigned to explain God's will to people instead of showing them how to find this direction within themselves.

JOAN: In the Bible, the book of Luke refers to the kingdom of God as something that cannot be observed, but rather as something that is within us. I cannot give you a map showing you how to find and experience God. No image for God functions in exactly the same way for every individual. Yet metaphors for God both shape and are shaped by our life experiences, especially our most significant relationships. We are not born with a map, we make the maps ourselves, each is different and the making requires effort. When it comes to questions of meaning, of purpose, of life and death, second-hand information will not do. Similarly a handed-down religion or worse a handed-down God will be equally disastrous. You are not alone in your struggle to find and experience God. We have Biblical laments; the dialogues with God in which anger and grief are freely expressed. In the same context, I would like to share with you the writing of Morris West, in *The Devil's Advocate*. This too is written as both a prayer and a lament, giving voice to the author's experiences of pain, doubt and despair.

To be born into the church – and I can only speak of my own church, knowing no other – is at once a burden and comfort. The burden is felt first. The burden of ordinance and prohibition, and later of belief. The comfort comes afterwards when one begins to ask questions and when one is presented with a key to every problem of existence. Make the first conscious act of faith, accept the first premise and the whole logic falls into place. One may sin but one sins inside a cosmos.

A man must pay for his own sins. He cannot borrow another's absolution. One is constrained to repentance by the sheer order of it. One is free within a system, and the system is secure and consoling, so long as the will is fixed in the first act of faith.... To be a Christian is to submit to a narrow conformity instead of a loose, but no less rigid one. But in the clash of conformity this is not enough. Sooner or later one is forced back to the first act of faith. If one rejects this one is lost....

I was lost for a long time without knowing it. Without the faith one is free and that is a pleasant feeling at first. There are no questions of conscience, no constraints, except the constraints of custom, convention and the law, and these are flexible enough for most purposes. It is only later that the terror comes. One is free, but free in chaos, in an unexplained and unexplainable world. One is free in a desert from which there is no retreat but inward, towards the hollow core of oneself. There is nothing to build on but the small rock of one's own pride, and this is nothing, based on nothing. I think, therefore I am, But who am I, An accident of disorder, going nowhere?

I woke to this realization as one wakes to the first light of the morning. The act of love is like the act of faith, a surrender, and I believe that the one conditions the other. In my case at least, it has done so. But even in sin, the act of love – done with love – is shadowed with divinity. Its conformity may be at fault but its nature is not altered, and its nature is creative, communicative, splendid its surrender.....It was in the splendour of my surrender that I first understood how a person surrenders himself to God – if a God existed. The moment of love is a moment of union, of body and spirit and the act of faith is mutual and explicit.

How does one come back to belief out of unbelief? Out of sin it is easy, an act of repentance. An errant child returns to a Father, because the Father is still there, the relationship unbroken. But in unbelief there is no father, no relationship. One comes from nowhere, goes nowhere. One's noblest acts are robbed of something, of meaning. I tried to do good, serve people but who were the people, who was I?

I tried to reason myself back to a first cause and first motion as a foundling might reason himself back to existence of a Father. He

must have existed, all children have fathers, But who was He? What is His name? What did He look like? Did He love me – or had He forgotten me for ever? This was the real terror, and as I look back on it now from the security I have reached, I tremble and sweat and pray desperately: 'Hold me close. Never let me go again. Never hide Your face from me, it is terrible in the dark!'

How did I come to Him? He alone knows. I groped for Him and could not find Him. I prayed to Him unknown and He did not answer. I wept at night for the loss of Him. Lost tears and fruitless grief. Then one day, He was there again ...It should be an occasion, I knew one should be able to say : This was the time, the place, the manner of it. This was my conversion to religion. A good man spoke to me and I became good. It was not like that at all! He was there. I knew He was there and that He made me and that He still loved me. There are no words to record, no stones scored with a fiery finger, no thunder on Tabor. I had a Father and He knew me and the world was a house He had built for me. I was born a Catholic, but I had never understood till this moment the meaning of the words 'the gift of faith'. After that what else could I do but say 'Here I am, lead me, do what you want with me. But please stay with me, always!'

The church understands doubts and teaches that faith is a gift, not to be acquired by reason or merit. The question of reparation worries me at times. I am changed. I have changed. But I cannot change any of the things I have done. The hurts, the loves tossed and taken away. I am sorry for them now but sorrow is not enough, I am bound to repair them as I can. But how? It is winter. The paths are closed before me and behind me. I am a prisoner in this small world I have found. I can only say: 'When the way is clear, I will do what is asked of me.' But, the way is never clear. There is only the present moment in which one can live with certainty. Why do I fear so much? Because repentance is only the beginning. There is still a debt to pay. I ask for

light, pray for the submission but the answer is unclear. I can only go in the present ...

The man who does good in doubt must have so much more merit than one who does it in the bright certainty of belief. 'Other sheep I have which are not of this fold'. A warning against the smugness of inherited faithThere is more, much much more. Scan it as an advocate should and find the core of it, a core sound and solid. The conformity is there, the conformity of mind, heart and will. And the surrender had been made by which man cuts loose from every material support and rests in faith, hope and charity, in the hands that framed him.

I was born in faith, I lost it and was led back to it by the hand of God. What service I have done was prompted by Him. There is no merit of my own.

JOAN: You have not told me whether you believe there is a God, and if so, who He is for you?

MARISKA: I do believe there is a God. I do not know how to get to Him. I do not understand Him and I do not know what He wants from me in this situation.

JOAN: I understand from the writing of Morris West (and this is also my opinion), that what we need to experience is not just a God who exists beyond the stars, a cosmic intelligence of some kind that keeps the whole show going, but that God is right here in the thick of our day-to day lives, who may not be writing messages about Himself in the sky, but in one way or another is trying to get messages through our blindness as we stumble around in our world. It is not the objective proof of God's existence that we need but the experience of God's presence. This is the miracle we are really after, and

that is also, I think, the miracle that we really get. It is about connection or feeling connected more than anything else. This connectedness comes through the relationships we have, empowering relationships with ourselves, others and God.

Reflections ...

In my mind I was wondering how I could use the relatedness on which spirituality rests to counteract the isolation, despair and secrecy surrounding this illness? I wondered what would be necessary for her to experience something like a 'resurrection', a new-found freedom!

I felt we had come to a cross-roads. We were both silent. Her face was drawn as if occupied in an inner struggle. I think at that moment we were both looking for a sign, for something. I decided to tell her a story – the true story of Corvus the Crow.

Some years ago, my husband Brian, whilst driving on our farm, noticed a crow in a cage at one of the farm labourer's cottages. Because the size of the cage would have better suited a canary, he decided to investigate. He noticed that the crow had a ring on one leg. Feeling for the bird in the impossibly small cage and aware that it must have had another life, he was curious to find out more. He was told that the crow had for some days been collecting scraps of food outside Jan's house and was tame enough to be caught and placed in the cage. Brian offered to buy the bird from Jan and arrived home with the crow, whom we called Corvus.

The ring on Corvus's right leg had stamped on it a Cape Town telephone number. Brian phoned the number and spoke to some-one who told him that Corvus had been raised in captivity by himself and his wife, and had never been outside the confines of his cage and their home. However, their circumstances had changed and it had become difficult for them to keep the bird any longer. The previous

Saturday morning they had driven into the countryside and simply released the crow at the side of the road.

For his own safety, Corvus was placed in a disused aviary in our back garden. He was spoilt on mince, small pieces of bacon and cheese and in the days that followed seemed quite happy and content, walking around the aviary floor sometimes hopping from perch to perch. Brian was keen to help Corvus back into the wild, to give him his freedom, but this proved a most difficult thing to do. Although the aviary door was left open, Corvus would remain inside. Sometimes he would venture for a walk in the garden but was always eager to return to the safety of his cage. Eventually we placed his food outside the aviary – he responded by taking his meals outside after which he would walk back to his cage. He wouldn't fly, he preferred to walk. In desperation Brian shut the aviary door whilst Corvus was outside eating – the crow responded by spending days perched on top of the aviary, surveying all that went on around him.

As weeks passed, Corvus slowly began to investigate the outside world – at first no further than the farm-house roof – then a short flight to the top of a silky-oak tree in the garden. I guess there were some things this crow needed to work out for himself. Perhaps the prospect of freedom made him uncomfortable. Perhaps his thoughts were concerned with what I would call 'taken-for-granted' realities:

- I walk because I'm used to walking – it's a perfectly good way of getting around.*
- Sometimes I feel like lifting myself into the blue sky but it seems far away and I wonder, will I get back safely?*
- On the other hand, perhaps I am better off in my cage after all. I feel safer.*
- I did leave my 'cage' what about other crows, I don't know them, I am nervous of them, will they like me?*
- What about cats, won't it be dangerous out there?*

We are all different, and yet somehow, all the same. Naturally, Corvus was nervous to leave his cage for good. The environment was new and strange. Perhaps he was afraid of other crows. Does Corvus have a spirituality? I think so. Did Corvus know that he had a Creator? Unlikely, yet in his little crow mind he has a 'blueprint' that connects him to his 'function circle', and that is to fly with other crows, he is a crow and nothing else; his very existence ordered. Humans put Corvus in a cage! They violated the 'blueprint' of his existence, his spirituality if you like. Corvus cannot transcend (to go beyond or to exceed) in order to become more, but he can transcend his circumstances. For that, he had to take risks. If he risked, there was hope; without risk he would stay where he was. If he chose not to participate (flying and being with other crows) he would have to sit and become smaller in his cage! Although the cage was opened for Corvus, he had to decide if and when he was going to leave the cage; the 'how' and 'when' attitude to his environment being crucial factors in his pursuit of freedom. It was up to him to accept challenge and to explore what he did not know.

As the weeks passed Corvus began to explore further afield, perching in trees around the garden or on the packshed roof, looking quite happy as his 'world' got bigger. Often, we would look for him and went calling after him, whereupon he would reply making funny chuckling noises we would later recognize as distinctly Corvus. And then, one morning, Corvus lifted into the air, perhaps at first a little uncertain about where he was going and who he wanted to be; he circled again and again until eventually his little black body became a speck in the sky. So high, so amazing, so free!

Corvus did not want to leave us. Flying into the air leaving his cage behind that morning was something he had to do to find out what life was all about. We knew that he would be back. And he did come back, eventually, flying low over the garden and perching in the silver

oak tree he had made his own. But now there were two crows, not one! Corvus was back. We know. For a while.

JOAN: What do you think made Corvus take to the air that morning? I believe he discovered that flying was not a function of his wings, but a function of his heart (his spirituality). At last he believed in himself. He believed that he belonged to the world of crows, that he was not different or other. Most of all he believed in the abilities of his little body to carry him into the unknown. Corvus had been given the gift of wings. It was up to him whether he was going to walk or fly, either way it was still a gift.

Finding God in your life may or may not be for you an important step towards your spiritual growth at this time; and I appreciate that this is something you need to deal with on your own. I am with you in so far as I too believe that the one who can agree on truth/untruth is only the one who owns the feeling or emotion. But the real issue we are grappling with is do you feel the illness is holding you captive; in other words is it preventing you from being who you really want to be? At the same time, being free also means accepting responsibility. It calls on the power within you to make a change, to use whatever you have.

Mariska's reflections from her diary in April 2007 continue the story of the journey.

I think I understand now for the first time what spirituality is about. It makes me feel far more positive just to know that I need not seek and worship God like everyone around me.

It also helped me so much to hear (even if it is not true) that I am not a bulimic but that I have a relationship with it. I so much wish people previously put it like that.

I also realize that I will have to decide about my future. I do not want the illness in my life but it is also difficult to have a life without it. I know that I am going to fall back and that I will have to start fighting again. This is what I fear most, the very big disappointment if and when it happens.

I also understand and agree that there is no difference between self-mutilation and bulimia. I know because both conditions have the same effect on me.

There were issues that scared me; like hearing that I could die because of what I do to my body. Everybody says the same thing but it does not make it easy to hear. I also hear and know what is right and what is wrong. I also understand that I am mind, body and spirit. It is very difficult though because the voices are still there, the lies!

10 April 2007

This weekend was great! I did not once put my finger in my throat to vomit. I am so proud of myself! I felt hugely uncomfortable every time I ate (although I did not eat much) but I kept my food in. I was with friends the whole weekend. Perhaps this is the reason why I did not make myself sick. This coming week I will be on my own again. I am worried but perhaps I should not think about it. It was so good to be at the coast, especially walking through the ice-cold water even though my feet ached! I felt as if I really did something for myself this weekend, not for Simon, (Mariska's friend) not for my mother, just for myself.

I do not want to get sick again this week....PLEASE ! Mia (Bulimia) you destroy me. You hurt me. Please keep quiet just for one week. Then I wonder, how it will be without her voice ... Will it be too quiet...like dead quiet ? Or will I just BE! HOW WILL THIS FEEL?

6 May 2007

Wow! It really is going very well with me. I have not made myself sick although I thought about it all the time. It really feels as if I am moving forward. Today was completely normal. I do not want to say too much. I am scared. Take one day at a time. Take one day as it is. Perhaps I have grown stronger... or is this a strange quietness before the storm?

15 May 2007

My flatmate cooked for us tonight because I was so tired after all the tests today. He brought me two CD's he made for me. It is sweet of him. Everything went well today. I have made myself sick only three times. This is not much. Tomorrow I have music. I really enjoy music so much, it is the highlight of my day. Playing the piano has always been something I enjoy very much. When I was still at school, I wrote songs and afterwards played them on the piano.

20 May 2007

All the years in Church were so unnecessary. All that matters now is when I and MY God are alone. For me God is too big for any church building. God is the autumn leaves and warm blankets. God is in the eyes of beautiful people and in the awareness of those that are rude. God is in the notes of my piano. God is the chunk of peace inside every happy person. God is the ointment for all my scars. God is in the care of my friends. God is the coarse sand on the beach. God is not my mother. God is not Uncle Phillip. God is Nolan. [Mariska's parents adopted a baby from a coloured background, needy and abandoned]. God is the wisdom of a grandmother, my grandmother. God is self-discipline when I need to study. God is not bulimia, but bulimia is a god. God is not the hand that cuts my arm. God is the stranger who smiles at me when there is no need. God is Stellenbosch on Sunday afternoon. God is the precious moments

between two people. God is the hysterical, spontaneous laugh when I need to write my exams. God is in the chill of winter. God is the stretched out hands of orphans. God is the white dog. God is the one that does not get enough food. God IS although I do not know whether I will ever understand Him. Perhaps God does not want to be understoodHe wants to become part of, part of that which belongs to Him only...

Reflections ...

In theology one cannot ignore the possibility of miracles. The possibility of sudden miraculous conversion. Mariska and I continued in dialogue and we both knew that something was happening for her. I knew that because for the first time after a very long period of wrestling with the illness, she one day sent me an sms to **thank** me for the session, saying that for the first time she heard me and could take in everything we discussed, allowing her to reflect and grow. After our sessions, Mariska would always get up to leave immediately. Her getting up, greeting me and walking out was all in the same movement. This sms affected me very much. Never before had Mariska thanked me for my efforts, nor did she give any indication that she was benefiting from therapy. It was as if for the first time she learned how to confide, how to trust. Judging from her journals, she was beginning to open herself to the felt presence of God, although this experience was still fresh and new for her.

May 2007

I had a beautiful day. Something inside me was very excited, excited about life! It rained during the night and the air was full of the smell of damp earth and washed leaves. I literally could not get enough of the smell of the wet soil, it was as if I smelled the rain for the first time!. Everything was overwhelmingly bright and so beautiful. The colours of the autumn leaves, almost too much for my

eyes, too bright, the brightness burned my eyes. I wanted to stay with it longer, I felt God

I had Psychology lectures today. It irritated me very much. I feel the pain in my body on hearing every diagnosis. I wish there was no criteria for diagnosing mental disorder. I was not bulimic until somebody diagnosed me as such. How many people like myself only become ill once you are diagnosed. It is so unnecessary!

Diagnostic features of Bulimia Nervosa :

- Eating unusually high quantities of food during a 2-hour period.
- Sense of loss of control over food intake during the episode.

This is 'truth' according to the DSM-IV. Who decides on this truth? I do not suffer from these symptoms. I have never in my life over-eaten and then forced myself to vomit. I have been eating a well-balanced diet and a 'normal' quantity of food, but I still get the overpowering urge to get rid of the food by making myself sick.

The session with Joan on Saturday was again exhausting, but once again assisted me afterwards to make sense of so many issues I struggle with. I know that my body and my spirit are completely disassociated from each other. It has always felt this way. I also agree that I do manipulate my body. I also became consciously aware of how contrasting and contradictory my thought processes can be at times. One moment I realize that what I do is wrong and the next moment I try very hard to justify what I am doing, telling myself that I will be okay. It is always good just to be able to talk when I am with her, it also gives me the opportunity to listen to and hear myself. There is another voice inside me; a dark voice. A voice that tells me that I am not yet thin enough! A voice that picks up pieces of glass to cut my body!

Later in the month I got an sms from Mariska telling me that bulimia was now completely out of hand and that she was unable to control it. By all accounts it sounded as if the illness had come back with vengeance, forcing her to her knees. Previously she did not recognize a need for what would be called her own voice, a personal voice telling what the illness had imposed on her and seeking to define for herself a place in the world. Circumstances were now very alarming, with Mariska pleading for help and being scared to be left alone. She was busy with mid-year academic preparations, a very stressful time for her, and she was away from home.

Before making the necessary arrangements for Mariska to return home (this was a temporary arrangement), I spent a long time on a phone call to her and was again reminded of her inability to 'get through' to her mother concerning her struggle with the illness. I sensed hopelessness and despair in her voice; she wanted to turn to her mother for support but this relationship, because it lacked the trust, openness and acceptance needed for dialogue, was realistically not present. However, I felt a strong sense for some kind of community, for support outside the therapeutic room, a need for 'outsider witnesses'. The 'community' I was looking for was not the community that existed in a particular place, but the form of community where persons as whole persons can directly encounter and affirm one another, in I-Thou relatedness (Buber 1937:25) while sharing experiences in listening and reflection.

I mentioned that I felt we needed to make the necessary arrangements for her to come home and asked her permission to invite her mother to be present for therapeutic dialogue over the next few days.

Mariska and her mother arrived the following day. Mariska looked gravely ill and weak and I realized that she now questioned her own ability to control the illness. Whereas she had (not intentionally) 'lived a lie' with regard to the power the illness has, she was now openly admitting that she feared the vehemence with which the illness had returned. Mariska's mother was pleased to have Mariska back home, and herself now part of the therapeutic process.

JOAN: She spoke to you many times before about her struggle with the illness. When she phoned you yesterday, what was different?

MARISKA'S MOTHER: Something in her voice. I haven't heard her like this before. She sounded desperate and in need of help.

JOAN: Do you think that Mariska has developed new meaning, new perspectives around the illness, what do you think happened here?

MARISKA'S MOTHER: I know all about her struggle with self-mutilation and bulimia but often I do not know what to say to her. I am glad to be here today so I can also hear and learn more, particularly as to how I can assist her.

Reflections..

The introduction of her mother as another team member in her fight against the illness brought new possibilities into the 'drama' that we enacted through conversation. We talked through the diagnostic features of the eating disorders according to the DSM-IV, about Mariska's experiences and the meaning attached to the illness, together with a felt lack of empathy or understanding about the eating disorders by the outside world. We shared some of Mariska's experiences and fears, highlighting her feeling that if one of her symptoms was improved, another felt much worse. I explained that although during the past weeks there had been improvement, she had never really been happy in herself.

I mentioned that although Mariska often referred to her mother's spiritual influence as a foundation; she harboured a need and desire in finding her God and the essential necessity of building her relationship with Him, in ways that would make sense to her and would be equally empowering for herself. As a yardstick in terms of her own healing, I emphasised the importance of discovering and understanding her own relatedness to, and connection with, her own self and the world; the need of a carefree feeling again when eating, instead of

every meal causing her much inner conflict; the establishment of a positive self-identity through which she would come to discover and value her own self-worth as a woman.

Mariska mentioned to her mother that she (her mother), her stepfather and Nolan (her adopted baby brother) formed an entity or circle, and that she (Mariska) and her brother (Frikkie), were just floating around, not really belonging anywhere. I believe that Mariska felt and also communicated to her mother that one of the principal ways in which her mother could assist her in the healing process was by being present with her in her struggle, listening to her story and offering her unqualified love and acceptance. I believe that this conversation helped Mariska to regain a sense of her worth and value, that her mother in being a supportive presence, helped her (Mariska) to develop her own inner strength.

JOAN (to Mariska's mother): Mariska mentioned before that there were times when she really felt that the illness had become a problem, and then as she was making plans to overcome it, the voices and the illness would become quiet, making her doubt her own misgivings, thoughts that suggested her situation was not that bad after all. Do you think she has not been fully committed to fight back?

MARISKA'S MOTHER: I do believe she is trying hard. I also know that it is not easy. However, I do not know what you will think about it and to what extent this has affected her, but did she tell you that she has given the illness a name.... she calls it Mia. She has made herself a red wristband in support of this relationship.

I noticed the red wrist band on Mariska's arm. I was concerned about the way in which the illness was spoken about, referring to Mia as if she was a young friend of hers, rather than an enemy!

JOAN (to Mariska): When did Mia introduce its accomplice, the red-wristband to you?

MARISKA: I think it was sometime in January 2006, at the beginning of the new term.

JOAN: Under what circumstances did Mia convince you to make and wear the wristband? How does the red wristband feature in your life as a token of your allegiance to her?

MARISKA: It was stupid! Through the internet I made contact with other women who have bulimia and had conversations with them. I also realized that it was pulling me in, because later on I made arrangements for my flat mate to go with me, otherwise I would sit there all night having these conversations!

JOAN: What was Mia's purpose? And then, she must have really tricked you into believing the lies so much so that you had to rely on the assistance of your flatmate to hijack her plans for you!

MARISKA: The idea behind the red wrist-band was that other people on the campus would signify our 'same-ness,' that I was not that different after all! I am still wearing it but it did not achieve the effect I had hoped for. What I experienced has set me more apart, leaving me feeling more alone and abandoned. I still do not feel part of anything.

JOAN: So, do you think that Mia camouflaged her intentions with false promises? Do you think she wants you only to herself?

MARISKA: This is what it feels like. However, I am scared. Scared even to say anything now. I think it is because I am busy figuring things out for myself; it is because I am getting stronger that the illness comes back with so much power.

JOAN: It sounds to me like you are making life difficult for Mia because you are busy unmasking her! Do you recognize your own voice, your own power in this situation when you say, 'It was stupid!' Do you recognize this as a stand you took against the illness? I hear a different 'voice' coming from you Mariska, perhaps a 'voice' that wants you to regain a sense of your own identity and power?

MARISKA: I did not think of it that way.

JOAN: This 'voice' saying 'It was stupid!' is not a voice which stands on its own. Can you recognize it as speaking about or from a particular relationship, situated in a particular context. This voice came from your body, it was your body speaking; it was an embodied voice. This form of embodiment is also in essence an act of witness – only because you have witnessed what the intentions of the illness were with the red wristband, can you now speak from a different place and in a different voice.

Can you appreciate the ability this 'voice' has to change and influence the relationship you have with the illness, to positively impact on the relationship you have with your body?

MARISKA: I can see it. It all makes sense but it is still difficult to put it all in practice.... to be strong.

JOAN: Probably because faith in yourself in the face of this illness is almost always challenging. Perhaps over the next few days at home reflect on what has happened. Think about the stand you took when you decided to make and wear the red wristband, think of the meaning it had for you, think on whose side you were. At the same time, as you noticed, these meanings can change, as changes occurred in your situation and in your relation with the illness. The meanings you give as to why you let self-mutilation and bulimia

get the better of you can be powerful enough to impede any form of treatment, but at the same time these meanings can shift when new perspectives are formed which will shape the way you experience and see the influence of the illness on your life.

Reflections ...

Two days later Mariska and I met again. Still looking quite frail, she reported that it was good to be at home.

JOAN: How is being at home different now from what it was before?

MARISKA: My mother and Frikkie [Mariska's younger brother] are concerned about me, I can feel it. Everything is so different, I cannot say exactly what changed but I feel as if they are together with me in this struggle, they want to help me, want to be there for me. It is as if they want to protect me, there is no judgment, only being present for me. I feel safe.

JOAN: I wonder if this situation could talk, what it would be saying to you now?

MARISKA: I am not alone. They are there for me. I am special, they care for me.

JOAN: How old is Frikkie?

MARISKA: He is only eighteen, in matric.

JOAN: Does he know about eating disorders?

MARISKA: I don't know what my mother shared with him. Being who he is he probably does not understand a thing about it! He has his own issues being a teenager, with girls, etc. But I know that for him, no matter what the problem is, I am important.

JOAN: Have you always had this close relationship, sharing everything and being there for each other?

MARISKA: We have always been close but it was a different closeness. Growing up together, although we were close, we also worked hard to stay out of each other's space.

JOAN: What did Frikkie do to make you realize that he was serious about you, that you mattered to him?

MARISKA: He is currently at home studying for his exams. Yesterday morning, shortly after breakfast I was in a state of despair because I could feel the urge to bring up my food again. I looked at Frikkie and my mother and said 'I need to get this food out of my body, I have the urge to be sick. So,... what now?' Frikkie looked at me and said 'Well, this is not going to happen because you and I are going for a drive'. I saw in his eyes that he loved me, he was physically present for me although he did not understand what it was about. He asked for my mother's car, took me by the hand and off we went. We drove around the town for quite a while talking about all sorts of things. Much later I told him that it would be fine to return home, but he refused saying that he wanted us to spend more time together. I knew that he was trying all he could just to let me get away! Eventually we stopped at the video shop and the two of us selected videos which we took home and watched for most of the day. It was wonderful doing things together, and ...it worked... I did not get sick!

JOAN: Yesterday's experiences between you and Frikkie, I wonder in what direction these might be helping to point you?

MARISKA: I saw how he felt and what he sacrificed for me and I knew that I could not disappoint him, because he would have felt he had failed. Whilst we were watching the movies, I literally felt as if I had swallowed a few bricks which were heavy and uncomfortable in my stomach. The voices were in my head, as always. I must say, the further I was moved away from the urge to make myself sick, the better it became. I surprised myself that no matter how difficult the situation was, there were also other ways of dealing with it.

However, I again struggled to get here this morning. The voices in my head... they left me so vulnerable again, but it's okay, I came. The voices try but can't keep me away. There is something here that makes me return, something for which I have to come back

JOAN: And what might that be?

MARISKA: There is a bubble here, a bubble full of oxygen. When I walk in here it is like 'Wow, I can relax, I can breathe, I can unwind' ...

JOAN: Would it help your body to relax more if you were to take the 'bubble' with you today when you leave?

MARISKA: I definitely think so. I must remember to do that.

JOAN: What about the bubble stands out for you? If you were to take it with you, what feelings would it create in your body?

MARISKA: I would feel safe.

JOAN: What else happened after the conversation with your mother? The fact that she joined us, did you find it useful?

MARISKA: Very much. It is also as if she is now more 'there' for me. I think it was good to include her as she now understands better how I feel. Also, when my mother and I left from here the other day, we went to the coffee shop for something to drink. I took the red wristband off and threw it into some plants nearby. Afterwards I felt a burning sensation on my wrist and my arm had broken out into red lumps where I had been wearing the bracelet. I showed my mother, she also witnessed it.

JOAN: What do you think happened here?

MARISKA: Oh I know! I chose God! I said yes to God and bulimia did not like it. I was punished in the same way as I had been punished before, when the illness gets out of hand and I find it difficult to control.

JOAN: This is very powerful stuff you are sharing with me now. You did not put me in the picture regarding this choice you made, choosing God.....you want to talk about this now?

Reflections ...

The air was full of promise...an unspoken promise. It was as if Mariska was overflowing with the need to share; that she was absorbed by what she felt close to her heart ...but something stopped her. I was not sure myself what happened. It was as if she was struggling to articulate, almost as if she was having problems remembering details. Her body-language

said: 'I have something to share but I do not know if I can trust you, or I have something to share but perhaps it is not that important.'

I was reminded of how often in her journals she referred to having wanted to share her feelings with people and then ending up saying nothing! As a function of being together in a different way and focusing on what we might create together, I was hoping for a new reality to emerge. I waited patiently. And when she began to speak, her voice and body demanded belief! Her testimony *is* her body. Those who receive her testimony must receive her because she is that testimony (Frank 1995:50).

MARISKA: It happened last week on the campus. Something happened to me. What was it? I did not look for it, it just happened! For the first time for as long as I can remember, I see things around me bright and clear; almost as if they were not there before. I see nature, I feel it in my body, I see the autumn leaves, so bright and beautiful it hurts my eyes. I stand in the pouring rain and just let it come, although I am getting wet, it doesn't matter, I want it! For the first time I knew what it was like just to feel ...everything around me was so extraordinarily beautiful. I was taking it all in and was overwhelmed, it was too big, even if I tried, the simplest forms of expression eluded me! It was as if something that had been missing all along in my life was there now! It was like I was anxiously looking for water. I ran and ran, and felt the need for water, otherwise I would die – of thirst. Eventually I can see the water, lots of water and I realize that it has always been there, but I chose not to notice it. How can I drink it, what would make me worthy of this water.....I know I need to bend down now and drink of this water, lots of it, otherwise I would die of thirst.

I always make sure that I have my umbrella with me because I don't like getting wet. That morning in the pouring rain it was different. I was aware of every sensation and feeling....I could feel...I smelled the rain, allowed the feeling to sink in. It was as if I was not in control but I was also not lost. It was a good feeling. In the beginning I was not sure about getting wet. It had to happen. The longer I stood in the rain, the more I wanted. Likewise, the

trees with their autumn colours...strangely I cannot yet see people, I see things. I know I could never really 'see' before. Previously my mother would move the furniture around in the house and when I arrived home nothing looked different to me, causing my mother to ask 'Don't you notice anything?'. I strongly came to believe that I had tunnel vision, that it was all part of my personality. Yet, in the past two days I experienced so much it's hard to describe it all.

JOAN: Wow! Reflecting on what you just shared what do you think happened to you?

MARISKA: It was a thirst ...a terrible thirst for God.

JOAN: Mariska, this is extremely powerful and overwhelming. In the early history of Judaism and Christianity, water was always a valuable and scarce resource. It was often used symbolically as a means of purification or cleansing. As a symbol for the divine presence and activity, water is associated with growth and renewal. Its free gift is liberation. The Samaritan women discovered that there was within her a spring of living water, a font of liberation.

What have you come to believe about yourself through what you experienced?

MARISKA: It is like being part of a world that was not there before. God wants me to be part of this world, His world. It's like the world has been opened to me. Its like I was not fully present before. I do not understand it. Never before was I really able to see, to take in, to smell and experience every small thing. It is as if I now see God everywhere, it was never like this before. I do not know what happened, I cannot explain it, it's like being drawn into something very big, It feels good, I feel safe. I want to remember everything, every small part ...

JOAN: Do you think that you are being called to a new way of being in the world?

MARISKA: Yes ...It is all about the image I had of God before. During Sunday school and church the message was always 'You must just believe'. Now, I only need to feel His presence, I do not have to think of a face, I just feel it. It makes it so much easier, I feel much more part of everything by just being...

JOAN: By which means do you think this 'new way of being in the world' could be available to you to sustain and strengthen you in the future?

MARISKA: I know now what it feels like... I have never felt and experienced it before. I 'see' now...for the first time.

JOAN: Can you constantly draw from this well to give you courage and to centre your being?

MARISKA: I want to. I am going to make the effort to look for and find more. Right now I feel as if my own healing is still going to take a long time. I am still feeling very weak and I cannot be engaged in thinking of my self too much. I am worried that I will be disappointed again.

Mariska's journal 27 May 2007

Sometimes you fall back into the cold holes

Soms val jy terug in the koue gate

of yesterdays,

van gisters,

But you continue to hold on to the invisible

maar jy bly vashou aan die onsigbare

You never taught me what to look for in a good man

You never asked me whether I was okay

You never cooked for me on an outside fire

You never told me that I was pretty

You were never there

You have always been without mercy

You were always absorbed by hatred

You were always absent

You have always been a strange man to me

Despite all, you will always be my father

It is your blood that is in my veins

Your face is always in my thoughts

The hurt caused by your words

Will always remain

But I will continue to long for you

Never is a very long time, but this time it is truly for evermore.

Reflections...

Weeks passed without seeing Mariska. In her absence I was working through journal notes she had left with me. Healing was filtering through much of her writing, but there was also a tendency to fall back on the dominant plot of the problem story. Although her poetry was very descriptive of her mood at the time, I was concerned about the reality she was busy constructing through some of her writing, particularly as the 'plot' was often embedded in dark conversations and the 'sick role'. Griffith and Griffith (1994:132) write that 'stories that are most malignant for the body are those that are not known as stories.' They have become

so much part of the landscape of life that they are known by the patient as 'this is the way life is.' They stressed the 'totalizing power of moods' that can turn a narrative into a structure of debilitating power' so that in the mystification of experience, the power becomes embedded in a self-narrative that binds the body; all the while obscuring this influence from the patient's awareness. Although a new self-narrative was in the making alongside the problem narrative, it sometimes appeared as if Mariska did not fully claim her own healing and the spiritual experiences she had witnessed.

I felt a need to discuss the situation with Mariska, particularly because she also mentioned that words to describe and write about her new self-narrative did not come easy for her. It was in fact easier to remain with the problem story because as she said 'This is who I am'; this is what my life has always been like'.

At about this time, I got the following sms from Mariska :

I can no longer do it. Bulimia is just too much! I cannot control it and I do not know how to get out of it. I do not want to be sick anymore but it feels as if it just gets worse. Please let me know what I need to do to make it go away. I want out!! I know there is no easy answer but I am so, so tired of this!

My reply to her:

Instead of telling me you can no longer control bulimia, I would like to hear what steps you are taking to stand up against it. Looking at something outside yourself to make it go away is not going to help. YOU need to make a stand for yourself against this illness by relying on your own voice, (what you want) and your own power (the hidden strength that is inside you) and be committed to that.

A few days later, after enquiring telephonically about Mariska, she sent me the following sms:

I made a stand for myself tonight. A real one. I don't care if you don't believe me. One between God and me God and I will do it. I have been under attack (by the illness) since being back here and came close to not wanting to live anymore. But..... something stopped me. I have not made myself sick since that sms I sent you the other day. I am proud of myself.

I was curious to know from Mariska what the stand with God was all about and asked her if she could reflect upon this and put it in writing. By asking her to do this, I wanted a repetition of the whole incident to be 'cemented' in so that it could become an important part in the process of change for her.

26 May 2007

I, Mariska, promise (20:37) to never, ever hurt myself without cause. I promise never to cut my body again. I promise also to follow a healthy meal plan and not to make myself sick after I have eaten.

Lord, U feel so far away. I am terribly tired. Will you please help me? I know and realize I cannot help myself. I am too weak, but I also know that Christ lives in me and that I am a child of God. I am so sorry that I have disappointed you. I no longer want to feel fake. Will you please protect me and take my hand, never to leave me again. Jesus, my heart is very sore. I feel as if I have failed.

With everything inside me, Lord, I ask that you will help me. Help me Lord so I can help myself. It is no longer about good writing. It is not about getting attention anymore. It is not about the intense urge to be seen as 'the sick one'. It's not about being allowed to cut myself, because I have issues. It is not about the self-fulfilling, fake feeling of being a captive. It is not about being alternative

and different. For once in my life I need to be like everyone else. I need to be normal. I need to be healthy. I need to stay under God's protection. I need to really see. I need to make a stand, and I just did !

JOAN: Mariska, can you reflect back on what happened here? What circumstances led to your making a stand with God?

MARISKA: I made a stand because I got scared, really scared! I was invited to the birthday party of a friend. All day I was overwhelmed by thoughts that I had not been cutting my body for a while. But it was strange, the idea was there with a mixture of feelings. You must not do it, but you also know you have to do it. I could feel the tension in my body building up. That night when I got home I cut myself again. At the same time I felt very low, almost as if I could not care anymore. I just wanted to do what I needed for the moment and forget everything. Then, it was as if I suddenly woke up! Something startled me, stopped me, pulled me back to reality. I know for sure that God was with me that night. He was with me because for the first time I became scared of what I recognized as being inside me. I began to pray because I could not sleep. I also realized that healing is never going to kick in whilst I still do this to my body. Every time I self-mutilate it just becomes worse and worse, until one day I will give up, give up on life.

JOAN: What do you think God understood about the situation, that other people involved do not understand?

MARISKA: He understands. Only He knows what I think. I made a decision. He knows.

JOAN: You used the words in the sms 'God and I will do it!' How do you see the future differently?

MARISKA: I felt I needed to write down what happened between God and myself. I had to write down that I would never unnecessarily do any harm to my body again. A pledge. It was not easy! Yet, I have not cut myself again and I am going to try my best to stand strong. However, I did bring up my food again and was very disappointed in myself. When I do this I am cross with myself and I feel guilty towards God; and when I do not bring up my food, then I am cross with myself and feel guilty towards myself! From this I can only make out that God and I are not yet working together. I still do not feel Him as part of Mariska. In my head, my imagination, He is still distant from me although I know that His Spirit lives inside me.

JOAN: It sounds as if you perceive God as working with you only when you have victory over the illness. Previously we spoke about small steps. If it was so easy to heal there would not be so many people struggling with chronic illness. To win a war you don't necessarily have to win every battle. Do not let this illness tell you you can't do it. When you used the words 'God and I will do it', I am wondering how this new image of God can contribute to your feeling less anxiety in your body? Knowing that God is on your side?

MARISKA: Despite this struggle, I am becoming more positive. I know it. I feel differently about the illness almost as if I continually search ahead of me, I have a vision to heal and be healthy.

JOAN: So, the words 'God and I will do it', how does this help you to reflect on what you need to do with God's help?

MARISKA: Since that time on the campus when I really felt God's presence, it is as if I am constantly looking for more, wanting to experience more. Because of what I felt, even when I did not look for it, I know it is there, I now go out searching for it. This past week I have made a constant effort to look at peoples' faces on the campus, and to carry a face with me all day long. I

often see God in people. I think He sends people to me. Particularly faces of people who do not want me to hurt my body.

My experiences of God are very different now. When I went home the last time, Nolan was making so much noise, it was as if everyone was irritating me. At home we have a bachelor flat which was renovated years ago for my use. However, because I was nervous of sleeping there on my own at night, the place stood empty as I preferred to share my parents' house. That evening, I decided to make the flatlet my own place and I told my mother that I was going to sleep there in future. I made a point of running a huge bath, I lit lots of candles and soaked in the water for ages. It was wonderful to be just by myself, it was peaceful, I felt safe. The candles brought a restfulness, it was like God.

I feel so happy. I do not want to let this go. Even Uncle Phillip is different, I am concerned it may not last. However, I like what is happening very much, I can see he is really trying hard. It is also as if I am now more appreciative of what he is doing, as if I realize that it cannot be easy for him because previously I did not want him in my space. I also wrote a poem to Mia. Strangely, since I wrote the poem bulimia is much better, I feel more in control.

6 June 2007

Nausea, nausea, and nausea again.....

Every day, every hour, over and over

I was prepared to die for you Mia

You were my god and you were a good god

Someone hiding in my mirror

This was who you were.....

It is you hiding in my fingers when I am nauseous

It is you making me feel ill

You are the one who makes me pretend

It is you who tricks me with your beautiful face

Placing stones in my stomach

But, it is I who chose you

It is I that worshipped you aloud

With my fingers down my throat

It is I who always searched for you

Carrying your presence around my wrist

And it is I who now rejects you

Mia... you are a "fake"

Mia, your face is so beautiful, but you are rotten inside

Mia, to fight you is the most difficult thing I was ever called to do

Mia, you never give up

But Mia.... I leave you!

Reflection ...

The intensity of Mariska's search for God is again recorded in the form of poetry. She described this as *'God is speaking to me.'* *I must give all my darkness to Him so that He can change it into light. I hold on to darkness too much*

God is speaking to me
Exchange all your darkness for my light
Abandon all your brokenness
Look only into my eyes
Forget about your feet
Just throw away all your blades
Take notice of all the people
Just become someone again
Leave behind all the loose threads
Leave behind all your pride
Just leave it all behind.....
Come and get so much more.....and more.....and more!

JOAN: Mariska, we spoke previously about intense spiritual experiences you witnessed and not just having made a stand before God, but being consciously aware that God is speaking to you. How does this tie in with what you said in one of your journals "God does not want to be understood, He wants to become part of, part of what belongs to Him? Does this deepen your conviction that God is on your side and on the side of life, He is asking to exchange all the darkness in you for Light and Life?

MARISKA: *Yes.... He is not telling me how I should come to Him or what I need to be. He is just asking me to be*

JOAN: Martin Buber in his book 'I and Thou relation' (1937:24), writes that the Thou meets us through grace, it is not found by seeking. By speaking the primary words I – Thou it becomes an act of being. The Thou meets me, but I step into direct relation with it. Furthermore he states that every 'means' to find Thou can be an obstacle, only when every means has collapsed does the meeting come about.

24 July 2007

I woke up this morning and felt okay. I drank coffee and smoked a cigarette. I saw the rain and it made me feel safe. I walked to class and I had a moment with God. I felt Him in the rain, I saw Him in the dark clouds above, I smelled Him in the wetness of my surroundings.

I came back from class for lunch and ate a sandwich. Walking back to lectures I had that same old depressed feeling. Mia kept on telling me that I am fat. I felt like crying. I could feel her claws scratching my body. I hate that feeling.

I came back from class only after 7 pm. I ate noodles and drank lots of water. Subconsciously I knew that my food was not going to stay inside. No matter how hard I tried telling myself not to do this, somehow I surrendered. I went to the bathroom and had a talk with Mia. I started throwing up but also looked at myself in the mirror, and I confronted Mia. I told her that I was not going to do this anymore. I told her that she was a liar. She spoke with a soft comforting voice, "You know that you have to do this and it will be okay as long as I am part of you. Keep throwing up, so you can get all the pain and self-hatred out of your body, your mind and spirit". She put my fingers down my throat, she covered my eyes so I was blind. I listened.... I ached.....I felt free. I felt badhow I hate this!

Through her diary Mariska recollected the scene and her emotional posture during the incident when she made herself sick. She wanted to record it as closely as possible so I could understand it. It was clear that her self-narrative evidenced much internal conflict around 'getting sick' or 'not getting sick'. These were always times of considerable tension and stress for her, intrinsically tied to a deep sense of feeling stigmatized. This emotional bind on her body, with feelings of shame and self-hatred, created the breeding ground for the problem story to grow, with recurring symptoms and emotions leading time and time again to defeat.

JOAN: What undermines your control of this illness?

MARISKA: Internal conflict. From the moment I feel the need to vomit, until in desperation I give in to it. It lasts just minutes; if only I could walk away from it or have the guts not to do it. If only you can tell me what to do at these times?

JOAN: Does the conflict arise because you feel yourself under the judging 'gaze' of bulimia.... A 'gaze' indicating that it is something you know you need to do to get rid of self-hatred and shame?

MARISKA: Yes.... A voice that says I am pathetic if I don't do it.

JOAN: Why This sounds to me as if bulimia has taken on the voices of your friends, who dared you to burn and cut your body otherwise you would be pathetic?

MARISKA: I don't know. When I hear the voice of bulimia, it is always a woman speaking.

JOAN: The voice manifests itself in different ways, but always does the same harm to your body! In your eyes you see yourself to be inadequate, the one who has failed; this voice has power only because it brings forth images of inadequacy and shame. How does the story bulimia is trying to tell you compare with God's tender acceptance of you, just as you are? What about your own family who are wanting to give you all the support in fighting the illness, what about your flatmate that would do anything for you? What about your excellent marks at university?

MARISKA: I know they are all lies, but how do I get rid of them?

JOAN: What about your own voice, your own power? You have already confronted bulimia and put Mia on the spot! According to the latest entry in your diary, you told her that she is a liar and that you were not going to listen to her lies anymore. Do you think you can incapacitate her even further by stepping right out of the story she is trying to make you believe about yourself, by living your own story of self-worth and self-agency?

MARISKA: I know all this but I feel pathetic because I have not been committed to what I undertook to do. This makes me angry with myself and I feel I have failed again...

JOAN: And this is exactly what the illness wants you to believe about yourself. You need to be continually on your guard. This is an enemy you need to confront constantly, using all the weapons you can to fight the battle. When overwhelmed by the lies to make yourself sick and to hurt your body, I am just wondering if there is an emotional posture that might bring comfort, countering the feelings of inadequacy and shame. The recent spiritual experiences on the campus, the support you received from your family, particularly Frikkie. By reflecting constantly on these, what effect would you expect these experiences to have on your body?

MARISKA: Calmness and acceptance.

JOAN: Let yourself enter into these conversations. Recollect the scene, see the leaves, the bright colours, the smells. Imagine getting wet and the feeling of abundant freedom. Imagine yourself laughing and stretching out your arms to receive it all. Imagine the emotional posture of 'joyful acceptance' with bodily sensations of warmth and fullness. Imagine the sensations of touch. How it felt to be touched and held, 'He loved me first'! Bring back the look on Frikkie's face, eyes that rest softly upon you, loving and accepting of you. Hands that touch you, hold you and take you to safety.

So there is the story of inadequacy and shame the voices would like you to believe. And there is the story of 'joyful acceptance', which you witnessed through your own body. Depending on which story you wish to enter, both possibilities are available....Stories of warmth and acceptance, you can treat like photographs in an album you can take out, look at, and re-live the memories, anytime you want...

MARISKA: Wow! I must just have faith in myself and continue to be optimistic.

JOAN: I am also concerned about negative self-talk which I often hear from you...destructive stories you tell yourself which cast ongoing blame and disempower you.....

MARISKA: Yes?

JOAN: By telling yourself repeatedly that you are not strong enough, that you cannot fight this illness; do not underestimate the power of your own imagination. Every thought, feeling has an effect on the physiology of your body. If you continue to talk to yourself in this fashion, you create a never-ending

negative commentary on your abilities, your behaviour and yourself; something which places your body in a no-win situation with the illness.

You said that if you thought about the positive, the good things you have experienced recently, this would create a feeling of calmness and acceptance in your body. Can you continually work towards creating this body posture by just talking positively to yourself?

MARISKA: How do I do this?

JOAN: Do you have a tape-recorder ?

MARISKA: No

JOAN: Can you get one? You can create your own audiotapes, using your own voice. Think about what you wrote in your diaries, how on reflection you realized that you are healing. I remember the words, 'I am healing', 'I am unique' 'God is working through me' 'My music teacher says I have extraordinary talent'. Use these scripts as a model to create your own goals. By doing this, you can change negative thoughts and create a positive reality of self-affirming messages.

Reflections...

Perhaps it was more than a coincidence, but for the first time in almost a year and eight months I saw Mariska's left wrist, which through the acts of self-mutilation had become badly scarred. Some of the scars looked raw and new, whilst others were clearly old injuries.

JOAN: What do you feel in your body when you look at the cuts on your wrists?

Shuddering, she turned her head sideways:

MARISKA: *I cannot look at it, even if I tried, I do not think I will be able to 'see' anything!*

JOAN: Perhaps you have come to understand how, through the illness-lies, you have been unable to control the symptoms, but have you come to connect with the oppression your body has suffered? The scars on your body which you cannot 'see' is just another way in which the illness has blind-folded you. If your body had a voice of its own, what do you think it would be saying to you right now in terms of what the illness has done to it?

MARISKA: *I don't know.*

JOAN: What do you feel in your body now?

MARISKA: *I don't like talking about it ...*

JOAN: Because you can't or don't you want to?

MARISKA: *Both.*

JOAN: Do you sense that this illness has somehow detached you from your own body?

MARISKA: *I have never been aware of a connection between my head and my body.*

JOAN: So does it mean that the illness has not only separated your own self or spirit from your body, but also your feelings and emotions?

MARISKA: Perhaps that is why I do not feel anything when I cut my body or put my fingers in my throat. It is as if it is something, someone else doing it.

JOAN: Mariska, we spoke about voices that often manipulate and overwhelm you on the road when you come for therapy. How is the 'power' in these voices, the power to manipulate, different to the 'power' of the voices that make you hurt your body and bring up your food?

MARISKA: It's the same.

JOAN: So these 'voices' tell you that in order to rid yourself of shame and self-hatred it is necessary to abuse your body – do you think the voices have also succeeded in 'silencing' your body, so that the body's pain is placed outside your own awareness?

MARISKA: It makes sense.

JOAN: Because you have lost sight of your ability to challenge the authority of these voices, this illness has in effect distanced you from your own body. You have come to pay more attention to the voices and in the process moved away further and further from your own self, your true being, treating your body as an it, an object devoid of pain. If you are not going to seriously start challenging these voices and their arguments, where do you think this is all going to take you?

MARISKA: I am never going to heal. I will just remain in this cycle of not getting better.

JOAN: Being chronically ill is one thing, but I am concerned about the extent to which the dividedness within you, between your own self and your body, has caused you to distance yourself from the world around you, from others and from God. Does it perhaps make sense to you when I see this illness as

having stolen 'life' from you...I have not sensed any attachment or desire for other people, nature or God, until recently. It is as if the illness has totally absorbed you in its own little world...

MARISKA: I know. I do not understand how this happened.

JOAN: Perhaps we should concentrate today on talking about your body. You communicate with this body, you talk with others through this body, you smell, see and feel through this body, this body carries you everywhere, presents you everywhere. You communicate with God, with nature, through this body...

MARISKA: Uh .. How?

JOAN: When you pray you speak with God through your body. A few weeks ago on the campus when you smelled the rain, saw the autumn leaves, searched for water – you identified this as a thirst for God. You communicated with your whole body – you could not experience this without a body. I look at these scars on your wrist and I ask myself how this ever could have happened to your body. Your body is sacred. Your body is in pain because of what has been done to it. But, it cannot tell you that because it is mute, it has no language. Even the smallest insect in my garden has to eat to stay alive – what makes you think that your body's needs are not important!

I am beginning to believe that your ultimate healing lies in the extent to which you are able to nurture and start loving your body; love that suggests union of mind, body and spirit. You said before that you do not love your body. Love implies relationship and feeling; you cannot love your body, be in relationship with it if you ignore the body's needs. What you have experienced suggests that you are not in relationship with your body, you are not listening to your body and don't sufficiently care for it. Without this

relationship you are also not able to witness the suffering of your own body, to see and fully appreciate, because witnessing is an embodied experience.

Reflections...

As I was busy talking with Mariska, I was deeply touched by her body posture. Previously when in conversation with her, her face would often be drawn, looking down, as if in an intense internal struggle. Sometimes a look would sweep over her face; and then if she spoke, it was as if the logic behind the voice remained mute. The picture in front of me now was that of a body radiating calmness, deep reflection and contentment. Her face was open, still reserved, yet suggesting that every sound now came with meaning. Also, no longer scared to look me in the eye, her eyes were unclouded, her face relaxed, and she had the comfortable air of a person who has come to terms with herself and her situation.

Previously I could not speak to Mariska about the relationship between her own body and her spirit, she would not have understood. Having witnessed her spiritual growth, at the same time becoming stronger in taking a stand against the illness, it was as if she now had far more energy to really connect with what was said.

Reflections...

My conversations with Mariska continue and it is now early August 2007. We have not met for almost three weeks. She has reported that she is coping much better with the illness; this did not mean that she was completely free from bulimia and self-mutilation; only that she was better able to control it and getting stronger in taking a stand against it. She also reported having felt more 'part' of life at home. Uncle Phillip was also 'different' now when she went home for short breaks.

MARISKA: He actually asks me how I am getting on. He is interested in me and wants to know how I am. He does not ask about me and God [smiling], ...I am still not sure if I can trust this, it feels strange.....

At this time I made contact with Mariska's mother who confirmed that her daughter was busy improving all the time. She was delighted in seeing the progress she was making. The story Mariska and I had written about her journey with the illness was placed in a file and her mother mentioned that she would often find Mariska in a quiet place reading and re-reading her story. She also offered the story to her mother to read, with Mariska's mother having experienced the journey metaphorically as light filtering in for darkness to dissipate. She mentioned that it was wonderful to have Mariska at home over weekends to be with them as a family; she felt Mariska was also looking forward to coming home and spending time with them, whereas previously she chose not to become involved. I remember Mariska commenting on a planned hike into the mountains.

MARISKA: We are all going tomorrow as a family. It is not something I do often, but I am looking forward to it very much, doing something with my family.... Although they have often arranged something like this, it is now for the first time that I really look forward to spending time and being in relationship with my family. It brings me great security, friends are okay but they are not always there, this is the way it has to be.....

Weeks later in conversation with Mariska, we spoke about her experience of our journey.

JOAN: Having read your complete story thus far, what have you felt?

MARISKA: When I started reading it, the pieces in the beginning – I could not believe that it was my story or that I had written the stuff. I know it is my story, yes it is mine! I can now see how far I have come. Morris West (I read to her from The Devil's Advocate) and Ellen West (I shared with her from the diaries of Ellen West) why do they have the same surname, is it a coincidence or what?....

JOAN: Why? What is bothering you?

MARISKA: It's just....I feel they both spoke to me.....Also, having come thus far I also no longer feel the need to keep a journal. I am concerned that writing (as I used to write) could transport me back into the little world where I was. I would much rather write when I feel positive about something.....

My mother believes God speaks to us through dreams. Often when I dream, it has relevance to certain life experiences. Recently I dreamt that I was in a bath with water but the water was very dirty. I felt the need to get out and there were people taking my hands to pull me out. I also realized that they were writing/engraving things on my arms. I realized that these were all the labels of the past and that I kind of 'wore' them on my body. I suddenly realized that I have 'lived' all these labels and that there was no need to live them any longer!

Frikkie and I.....He shows me now in so many ways that he cares, he has never done this before! He phoned yesterday. He said for the first time he feels as if we have things to talk about, previously he could not understand me, he feels now as if we can talk about anything. We are both so keen to work on our relationship, it is as if we both know what to do. He still assists me around issues with food, he takes me out and does things for me.

And Uncle Phillip, it is also as if I can talk more easily with him too, as if the two of us also understand each other for the first time. I know the feeling won't go away. He sends an sms or phones before I write my tests. The other night I arrived back home very late. He got up to meet me, something he has never done before. We talked about my future, he wanted to know what I was planning to do after my studies. We did not talk about the Bible. I can feel and sense he is genuinely interested in ME. I am sorry it came so late, he was never really interested to know what was going on in my life. Perhaps I was not ready, I made him understand not to get too close to me. Nolan made everything right. He is so much in need of love, he is the missing link which pulled the whole family together. Always expecting everyone to hug and kiss one another, he is indeed a little angel.

Many wonderful things happened for Mariska over the months following. It did not mean that bulimia was out of the way...not yet, although she confessed: *'The voices have become quieter, much much quieter*'

Mariska and her mother sent me a CD, a recording which Mariska composed and sang when she was in matric. When I sat down to listen to her CD, I was again reminded of her incredible talent in music. With her having composed the lyrics and the music, the words brought new meanings unstoried before. Through the words of the songs she had given herself unto prayer, 'Searching for the Father heart of my God'. I also came to value deeply her expressed longing for a father figure. It was her lively self-centred strength that I drew most encouragement from. She was the child and God her father. Centring herself in prayer to God as Father she experienced love, healing and an empowering presence. There was no war inside her but rather an unnamed hope. Although she had suffered, she also had the grace to forgive; to forgive others and herself.

In conversation with Mariska's mother she confirmed that Mariska was very religious when younger, but seemed to have drifted away. I was so glad that my conversations with Mariska could again open up for her something that was always there, something the illness had camouflaged. I asked her to listen to her CD and I was hopeful that a form of re-newed attention and desire towards God could open her to receiving His gift of grace towards healing.

Back at campus, Mariska was fortunate to have flatmates who stood with her. She described MD, her flatmate as 'he has no issues, he will do anything for me' After the time when she had to return home after a series of bulimic bouts, it was as if they, although not aware of everything that had happened to her, became more focused on being there for her. It was not just about sharing accommodation, but rather a commitment to stand with each other.

MARISKA: We arranged to meet every morning before class at the kitchen table, with everyone getting a turn to read. When I got to the kitchen in the morning, MD would already be there waiting on us with his Bible open. He is so sweet! At first I was reluctant to do my part of the reading, and MD would

send me an sms during the day encouraging me with a Bible verse. Although he did not know what was going on with me at that particular time of the day, the verse would speak to me,It's weird.....But it worked!

JOAN: What are your favourite verses?

MARISKA: I like to read from Corinthians – the message that Christ lives in me and from Romans that I should embrace the power I have within me and not condemn it – I reflect back on my story – actually one negative, the other positive. When I make the latter story my own, it is as if my two lives became one that makes sense to me now ...

The other person in the flat (a female) had not been with Mariska and MD from the beginning. At first Mariska was not sure how to 'handle' her, thinking she was a bit too conservative. One day Mariska came to me looking happy about life.....

MARISKA: Oh ! I and the girl we share the flat with also get on much better now because she opened up to me, sharing some issues concerning her life with me. I realize now things have not been easy for her too.

Mariska was now wearing a white wrist band made from elastic (no more wrist bands from Mia)..Her face completely relaxed, her eyes turned down to where she was rolling the wrist band between her fingers, as if she reflected on the previous conversation we had about the red wrist band from Mia.

MARISKA: After my conversation with her, [her flat mate] she made me this little band.....I am wearing this now all the time.....

During her last visit to the practice, Mariska carried a black book in which she had recorded all her journals. Before handing over the book to me she started to tear out some of the pages. Quite taken aback, I asked her what she was doing.

MARISKA: I have thought about what is in this book and have decided that some of the pages I don't want included in my story. I want to move on. I do not want to write anything negative anymore, there is so much beautiful stuff, at least I think it is beautiful. I do not want to move back to 'my' little dark world where I was previously.....

Her diaries and daily reflection reveal an independent and vibrant young woman's journey to new spiritual insight.

26 July 2007

I am proud of myself. I haven't thrown up in days. Things are getting better, I can feel it. I feel good in a way that I've never felt before. I am taking each day at a time. I feel goodthe blindness has faded since yesterday. There is a strength inside me that I became aware of. One I did not know existed. I am holding onto this with all I can. I do not want to let this feeling go. I don't want to,,,I don't want to, it feels good. Not bulimia-good, not cutting-goodjust good! A healthy good. Maybe God ??

27 July 2007

I can write about a craving to cut myself

But... I'll be lying

I can write about bringing up my food

But.....I'll be lying

Something happened to me

NOW I am not lying.

I saw the mountains around Stellenbosch for the first time today. I am not healed yet but I am feeling so good. God is showing me pictures, or rather, snapshots of his creation.....It's new and it's beautiful and it's God and it's real. My spirit is starting to breathe. My senses are alive and I'm aware of it! I can see colour for the very first time. This is day three!

29 July 2007

Day five! I am so scared that the voices will come back. I am trying to fight this with all that is inside me. I have really had an urge to make myself sick , BUT I DID NOT ! I was in the bathroom and I heard Mia's voice. I was ready to throw up, but then this other voice told me it was not necessary, that I had not eaten so much. I always knew that somewhere, deep down, there was a white voice inside me. I just never cared to listen!

GOD IS STARTING TO MAKE SENSE AND I CAN SEE COLOURS.

30 July 2007

Something inside me is laughing. I am experiencing a new, beautiful feeling. I laughed so much today. I'm different, I feel different and I am seeing things differently. Perhaps all the tears I carried inside me are busy drying up. And it is probable, very probable that bringing up my food and mutilating my body will become less and less important, until eventually it will all be far away and empty.

2 August 2007

To Bulimia

You dared me to love you

With a handful of white lilies

I took the lilies and I tried

Then God came and He also dared me

And I didn't even have to try

Cause He loved me first

I have never seen His face

But he showed me little pieces of what He made

And never can any white lily ever be as beautiful

So, I want you to take back your lilies

And give them to someone else

Someone who'll also, one day, see colour

I am healing. I am healing. I am healing. I have to believe this.

Mariska bought a blue budgie which she called Mystique. She got very attached to her budgie but felt it needed a mate. Something again so significant in her journey to healing. A yellow female budgie was bought and given the name of Lady.

MARISKA: She is a typical female....too obsessed with the mirror in her cage, always picking at it, I think I must take the mirror away perhaps it is distressing for her

JOAN: So, what brought this on the birds ?.

MARISKA: Previously I had a range of teddy bears, all from previous boyfriends. They were in my flat, I often spoke to them as I was studying for exams. I realized I no longer wanted 'things,' I needed life around me....In fact some of these teddy bears reminded me of really bad relationshipssome I gave away and some I gave to my dog to tear apart ...

I am also finding it easier to connect with people. On campus I became part of the psychology discussions group. It is voluntary. In these groups we share some of our life experiences so others can reflect, and as a group we become a source of support for each other. I look forward to our discussions. I enjoy them very much.

JOAN: What is different for you? What is drawing you to this kind of interaction?

MARISKA: I am not just a little number. I am part of something. I feel good about myself. I share my experiences having been through bad relationships. I no longer feel a victim, other people also have issues, some similar to mine. I am not different or 'other'. I am no longer the one diagnosed, I am now the one helping others to make sense of problems they are confronted with. No-one makes me feel weird. We can relate to each other.

JOAN: Wow! This is really good to hear! What else is happening on campus?

MARISKA: The real secret is about accessing your own power. If you think positively then positive things happen. I am not entirely comfortable with people even

now, particularly strangers, but it is very nice when some-one just chooses to come and sit by me. I like it and I can also handle it much better than before. I also make an effort almost daily to remember every face that smiles at me as people walk past.

JOAN: What possibilities do these ideas open up for your future that you may not have had before? How can you use these ideas to help you create the kind of relationships you want?

MARISKA: Everything seems more round. More whole. To be positive is to be calm. Also, I never looked at myself in the mirror, not even when I got dressed. I used to keep myself busy with other things. Now I can look at myself in the mirror. I am not so afraid any more.

Reflections:

It is now 2010. Mariska and I still have regular contact. Often when I read her story I cannot stop the tears from coming, happy tears! I know that she will always have a very special place in my life and in my heart, the little starfish, stranded on the beach, but by grace given another chance, to live and to live fully. Her life bears testimony to that.

CHAPTER SIX

MY BLACK HEART IS NOT MUDDY – IT'S JUST DIPPED IN CHOCOLATE⁶

This chapter focuses the lens on the stories of two participants, Mare-Lee and Heidi.

MAPPING THE JOURNEY OF MARE-LEE

The happy and carefree story Mare-Lee was telling about her life changed when her family moved to another town and she had to attend a high school in the city and became a boarder in the school hostel. Faced simultaneously with the developmental stages of growing up, of having to establish her own identity, coupled with her own positioning in social discourse, her spirit was vulnerable to being traumatized by the power of anorexia.

Mare-Lee's story makes visible how the eating disorder brought about a crisis of the spirit. This is evident in her coming to live an 'empty present' (Abma 2005:338). She no longer had a meaningful story for the self, so that the unique meanings she attributed to her situation became the key components in understanding the lived reality of a disabling spirituality. Her view of the world changed as she separated herself more and more from people, whilst at the same time becoming more involved in the illness relationship. At a crucial time in her life, there was no movement towards growth or fulfilment in the spirit. How the illness had changed her, what it did to her and her family, formed the plotline to her story, experienced as a crisis of the spirit.

Therapeutic strategies incorporated a framework of healing and care, where the initial challenge was to introduce the need for spiritual connection between the self and body as

⁶ From The Book of Heidi, 2008.

well as between the self and other. Such strategies enabled Mare-Lee not only to experience her own spirituality in the context of the illness, but also to gain an understanding of how the spiritual power of anorexia influenced, shaped and directed her life. Therapeutic support based on a freedom to choose laid the foundation for a therapy grounded in care, finding and re-establishing an empowering spirituality. This became a very personal reality where she was able to make a distinction between a healthy and unhealthy spirituality evidenced in authentic living, re-establishing relationships and gaining a sense of meaning and purpose in her life.

MARE-LEE'S STORY

Barefoot with a big smile, that was me. How was I robbed of my care-free existence; pulled into a deep abyss, to be trapped in the grinding jaws of a lifeless monster?

With so much longing I remember the days that were.... The playing fields of the farm school where time stood still; where, when the classroom bell announced break time, I would 'sell' some of my carefully selected coloured pebbles in our 'toy-shop'. How we picked guavas in the sweet-smelling orchards, and when running and falling I tore another hole in my brand-new silk stockings. What I clearly remember is my perfect life. Days without any concern, even without responsibility; an existence which now mirrors an absolute dream world. For a little girl in pig tails, the highlight of the day (after school) was sharing my peanut-butter sandwiches and Nesquik with a black-spotted terrier.... It did not matter that the wet, pink tongue 'spoiled' my hair, or that his four little legs would run me off my feet and trip me in his excitement...

But the nightmare begins when four, heavy, black claws covered my eyes and pulled me away from all my years of enduring security ...

16 March 2004

My diary becomes filled with deadly uncertainty. All of this whilst my mother, unaware of what is going on, reads the letter which I left her at the week-end. I write the details from a heart that is paper thin.

I can only cry and cry, I cannot stop. Mare-Lee is gone, I cannot find her. It is too late, I am scared, where do I start looking for her now? Last year, she disappeared from Monday to Friday, she only returned over weekends. I speak as if I do not know myself anymore, because this is the way it is. Mare-Lee is gone, she has left behind an ugly, moody girl, with hang-ups about who she is and what she looks like. Yes, I admit; I have changed. Mother asks me frequently: 'What is going on? Everybody wants to know why have you changed so much!' I know that some-one else lives in me now, but how do I explain this to others? Some other 'girl' stole my life, I was too weak to avoid it. Everybody believes that I, the extrovert, full of life have changed into a skinny monster, and only because she looks like me. I feel like shouting aloud, Everyone has it wrong! Can't they try harder to hear the cry for help from deep, deep inside me? Can't you see? She is so impatient and very confused, it is not Mare-Lee.....Look!' I choke when I try to be Mare-Lee; but I am forced to be her so I can stay alive. But what does it help me? Does it mean that I will have to be some-one else for the rest of my life?.... all because I have forgotten who I really am. Mare-Lee was lied to, her peanut-butter sandwiches and Nesquick were stolen – here I am, 1.78m tall, weighing 47 kg with two litres of water and four dry crackers to see me through the night. Enough is enough! When is the 'glass doll' going to break? Perhaps it will be safer to creep outside amidst pieces of broken glass, brush myself off and show the real me. Push her, please push before it is too late... I cannot go on unless I have life back to the fullest.

I remember very clearly sitting in the boarding school, filled with so much heartache, longing and uncertainty, making this entry in my diary. I was

unbearably tired, feeling dead in my spirit, as if only my shadow was real, and even this part of me was waning ... I could no longer live in a world that did not belong to me. How does one describe yourself when the self becomes someone else? I feel so trapped in an unbearable life, and yet I do remember good times. Memories from primary school are carved into my heart, like names of visitors on the bark of the eucalyptus trees on the farm. For such a long time I was a little girl full of life, in a world that seems so far away now. But all too suddenly one grows up, it happens too quickly for you, and without realizing it your own world has gone. There I stood, in front of the high school gates, everything had changed so quickly. I was confused and kept asking myself one question 'Why could I not stay 'that' little girl?' I was outside the frame, alone, with 'nothing'. I could only try to recall the little girl, and by so doing bring back what was familiar. I had lost myself, my life like a revolving staircase began to move up and down.

I came to believe that I was not like the rest of my peer group. Everything was half and half, I felt pink whilst I was supposed to have been red long ago. But I did not want to fight against it, I just accepted that part of me was average and the other small, immature and delicate. Now that I was only half, it was up to me to 'fill' the other half. Everyday drove me more and more towards my weaker side, because my 'normal' side failed me too many times. The grade eight girl inside me was just not sociable enough, was a failure at finding first love and did not enjoy 'girls night'....was tired of uncertainty. I was too reserved, with only the extrovert smile of the past remaining. During the following two years, I journeyed to and fro between little girl, adolescent and young lady. Following this period of shifting role play, now in my grade ten year, I was dealt another blow.

My life changed over night when our family faced the trauma of having to move to another town. For reasons I regarded as un-necessary, I was removed from my home and community. Everything changed in minutes, questions filled with reproach, stalked me for days. All that we had come to know and had held dear over the years now had to be left behind, to make room for a new start in a new town. My December school holiday that year was a nightmare for a fifteen year old. Whilst summer sun, sea and ice-cream were calling from beyond, I was caught up inside the house; wrestling with my own thoughts and fears. I would

not have minded in the slightest if the signpost on my path of life was a stop sign; I no longer felt up to going the distance. I prayed over and over for the clock to tick slower, for the stark reality of time to go astray in the night. My fear was like that of a moth, having to make its journey into the light. I couldn't accept the way things had turned out. The fact that I had to move to boarding school blocked my way like a wall. I could not see myself as being alive in the midst of the nightmare that was coming. Perhaps because of all my fears, everything I was so afraid of happened in exactly that way.

I remember the morning when I had to say goodbye to my doggy-children, only to see them again in two weeks' time. I felt it would be better to run, to hide somewhere, where it would be too late to leave by the time they found me. The tarred highway taking me to boarding school; I lengthened in my head but shortened it in my heart. I was lost in my own feelings, light excitement and pressing fears, anger, despondency. I was dropped off at the door of a large, soulless house, the shock was so great, reality so overwhelming that there was no room for tears. Perhaps my own fears crippled me, I cannot tell, but from the very first day I hated the dark, feeling-less, empty hole in which I had to live. The place was eating away at me, tearing at my own life. How does one remain human in a place like this, bringing only misery, uncertainty and nightmares? How do you remain 'alive' in a place that smothers you? I had to change in order to survive. I could not be forgiving towards the place that had done me so much harm. Every day I lost more and more of my old, known self; I felt as if pieces of my skin were being stripped off. There were days when I tried very hard to make things bearable, to make myself happier, as if I was caught up in something, too frightened to move.

One day, when everything had just become too much, I found a friend who will always remain in my heart. I discovered a person with feelings, like mine, with fears and uncertainty also gnawing at her existence. On this particular day, amazingly, all my fears felt lighter. In that soulless boarding house I managed to track down another lost soul! And even today I believe she is an angel. I remember vaguely that we got talking, ordinary words which over time grew more meaningful and touched me deeply. My eyes, ears and heart responded

to her deepest feelings, we were there for each other; night or day we supported each other, just listening and being there. She made me feel that she understood, she became the inspiration to fight my circumstances.

Although I now had a friend, I still had to keep my mind occupied. Loads of school work were accomplished in minimum time, only to assure myself that I was still in control. But all this was to my disadvantage; I found I couldn't control the things I tried so hard to accomplish and my academic grades began to fall. I went searching further for things to keep me busy, to keep me positive and provide me with reasons to carry on. I signed up at a gym, something which made me feel alive and happy with myself. But even this healthy pastime changed into an ugly obsession. I could not miss a single day from the gym. The 4km walk there and back became a challenge, more so than the biting winter cold or rainstorms that left me shivering.

Before long, the gym was not enough. I added extra sporting activities plus a further 5km of walking to the daily routine ... anything as long as I kept busy. I neglected myself, my body began to shrink away and I appeared more and more uncared for. The only time I made for myself was to keep my thoughts occupied. There was no time for friends, 'outings', movies, eating cake or even just chatting. I was caught up in a routine that was stealing my life, I was no longer living. Of course, at the time I did not think about my situation as desperate, rather I labelled it as my 'comfort zone'. I felt safe and in control. But, it was becoming too much ... people began to ask questions, they withdrew from me and even became hostile. My eyes were opened as I began to realize that my 'comfort zone' was actually a tiny, empty black room; a black hole from which I couldn't escape. This day, 16 March 2004, I faced the stark reality that something was dreadfully wrong and that I would have to make plans to change it. I was very confused, fearful and uncertain. I did not know which way to turn; behind me was a single track, but that was all I could see in front of me also.

But despite my feelings, something inside forced me to search for help. I could not speak, because I knew I would have to explain something I myself did not understand, but I persevered. And the letter that follows brought forth the seedling that grew into a young tree with strong roots ...

Mare-Lee's letter to her mother:

I am sorry with all my heart. Forgive me ! I do not wish to be the reason for heartache, hatred, rudeness and coldness. I DO NOT!!

I would love to smile broadly and to paint these smiles blood-red with a permanent coki-pen so they would never fade, but I fail.....why? Every-time people argue I swallow my guilt knowing that I am to blame.

I cannot and I do not want to.....I am serious now; and I do not know how I will ever be able to state clearly that I do not want circumstances to be like this, it really hurts me. And it becomes even harder, particularly when people believe that I made a choice to live like this. I do not want to be impatient, unhappy and intolerant with myself. What healthy person would want this?

Why is it happening so much against my will? I know what it is to be beautiful, satisfied and happy – but where is it ? It feels as if the world I am caught up in has discarded all this into pitch darkness.

I love you all so dearly and immeasurably, but it is 'her' (because she does not feel like me) What makes things continue like this ?..... Her?? Yes, it feels as if someone is taking over my life to live in this loveless fashion.... And all this whilst I stand powerless to do anything. I mean every word I write, even if it appears to be only words on paper! It is not as if I am scared or do not have the guts to say what needs to be said, it is only that I fear 'her' becoming involved and that my intentions will be wrongfully construed.

I truly struggle to carry on and to be, because of this other personality who wishes to take over and live my life. People often say this, but I also feel it : I CANNOT GO ON ANYMORE!! I pray and ask for my old

life back when I knew who I was. Everything is blurred and out of control and I am really very scared and unbelievably uncertain of everything! I search for love, happiness and self-satisfaction but do they exist?

(a) I do not know what is the reason

(b) I do not know why (!)?

(c) I do not know why it is happening to me

(d) And, worse, I do not know what it is that I do not know.

I will work hard to find myself, so that you can all know I'm trying my best. Thank you for everything, mommy! I love you very much!

It was Wednesday just after school, and when I got back to the boarding house there was a message on my phone. My mother was on her way to see me. Suddenly I was robbed of all the certainty I felt when I left the letter in my wardrobe at home. I was so scared, unsure whether I wanted to continue living or not. I began to drown myself in questions to which I did not have any answers. I remember the feelings so well but I cannot describe them. I wanted to hide, but in a place where no-one would ever find me; I felt it would be better to remove living from life. But that afternoon, I somehow decided to face what lay ahead, the even more difficult road to healing.

It was a very ordinary afternoon out with my mother.....but we both knew what was in the other's mind. How do you make yourself clear, if you yourself do not have clarity? How do you share your innermost fears when the key that opens your heart is lost? And, worst of all, how do you look someone in the eye whom you have hurt and disappointed, over and over without intending to do so It did not matter what I had done, I felt drained, I was exhausted and in front of me everything was black. And yet, from afar, there was a faint ray of light trying to break through on this dark road, faint but bright enough to give me some hope. I agreed to seeing a psychologist the next day. During the night I wrestled with thoughts which kept me awake, I was hoping and praying for a 'slip-off' road that would take me in another direction. For the first time in my life

I felt 'darkness' and I saw only 'night'. I desperately tried to 'think through' why I was so fearful – I wanted certainty over what was to happen.

I was physically trembling when I arrived to see the psychologist. An inexplicable feeling of 'life' inside 'death' got hold of me. I was nauseous and felt I wanted to faint. Somehow, I held on to my senses. The person in front of me, the man in the chair, was immediately an enemy. And my worst fears were confirmed when he asked 'What is the problem?' And I felt like shouting in his face 'YOU STOLE MY QUESTION!' But, I was too tired to fight and all I could utter was 'I don't know.' What else could I say? How does one describe something you are not even sure you are feeling? Emptiness filled me, my own fear was destroying me, burning into my flesh. I no longer wished to cover my sores, I just wanted healing to begin. The monster was playing games with me. It made me think of 'pictionary,' with him drawing through me. He was winning because I could not explain myself, nothing made sense. But, I wanted to become strong, I would do everything in my power to break his lead pencil and tear up his grey paper. He would soon see my own bright colours on a white cloth, dancing in front of his eyes.

I (Joan) was approached to speak at a women's forum about issues facing women in modern society. Gender inequality, depression and the eating disorders were some of the topics discussed. Some days later I was contacted by Mare-Lee's mother, who told me that her daughter had been diagnosed with anorexia, and asked if I could provide counselling support.

During the latter part of 2004, Mare-Lee arrived with her mother at my practice. Mare-Lee was wearing a red track suit and jogging shoes. Her blonde hair was tied into a pony tail, her broad smile and green eyes were captivating. Although she was very thin, she displayed a bold front to the world around her.

They sat down next to each other on a two-seater couch opposite me. I was told that a decision had been made to take Mare-Lee out of the boarding school. She was now living at

home and attending a local school. Mare-Lee was very happy with the new arrangement although it entailed changing schools mid-year in a senior grade.

There was a tension in the room when Mare-Lee's mother told of their struggle with the illness and the anguish they all suffered as a result. An 'intruder' had invaded their lives, leaving her daughter a stranger to those around her. As the 'problem' grew, she retreated into herself, withdrawing completely from those around her. At the same time she became more agitated and obsessive. She never wanted to talk about anything, she refused to participate. She was on a mission not to eat. In the process she forgot to include those who loved her, she had forgotten how to confide, how to trust.

I shared with them my experiences about the eating disorders and mentioned that the illness causes separation in families. I could feel that the air was tense as I asked my question.

JOAN: Are you able just to hold each other, are you able to sometimes cry together, particularly when you don't have words for what you are feeling?

Mother and daughter turned to look each other in the eyes, and both began to sob uncontrollably/

MARE-LEE'S MOTHER: We are not on the most companionable of terms. She will not let any of us get near her, touch her! Her father may not come near her, they don't talk, their relationship is strained. Demonstrations of affection from her are rare, as if she has no capacity for love!

Mare-Lee's mother looked sick with pain and I was tortured by her recollections of the past. Touched by her suffering and her bigness of heart to forgive, it was clear that she was convinced Mare-Lee was not to blame, it was what the illness had done to her, to them all.

I remember the late afternoon sun, shining through the outside creeper, making dancing patterns on the wall. In contrast, Mare-Lee sat motionless, upright, looking at me, unblinking.

I felt a strange heaviness in my heart. Entrapped by the illness she sat alone, an unwilling actress in a silent movie. Suddenly, straightening her back and astonished at her own voice, she came to life.

MARE-LEE: I do not want to be like this, everyone thinks I am the problem! she cried out, why me, why did it choose me?

Many conflicting thoughts and ideas crossed my mind, but I realized that for Mare-Lee it was important to be not only a witness, somehow we had to 'connect', I had to make her aware that I understood even if there were no words to express what she was feeling. I had to choose my words very carefully.

JOAN: It is clear from what you are saying that you are troubled by the thought that everyone sees you as the problem, because you choose not to participate; to eat. It is obvious to me that you need to confront that idea, dismiss it, make your peace with it – whatever. You are feeling overwhelmed right now. Would it help if I tell you that although I do not understand fully what is happening in your world right now, I do believe what you are saying. I can sense the difficulty you have in expressing what is happening for you. Nothing happened because you wanted it. The plans anorexia has for people are never good, they are always cunning and subtle. So subtle that many girls and women struggle to understand what has happened to them after anorexia came into their lives. I am sorry about all the questions. Sorry that you are sad.

The conditions that make anorexia possible are complex and hard to pinpoint. I don't see anorexia as part of you, rather I regard anorexia to be created within socially specific ways and practices, practices which concentrate on mainly the female body and issues about food. It is easy to fall for anorexia's lies because many women search for a kind of specialness which they feel they do not have and which anorexia promises to achieve.

What do you think of the medical diagnosis of anorexia?

MARE-LEE: I cannot make sense out of something I do not understand. The name means nothing to me and does not make any sense at all. It does not tell me how I got where I am, and neither does it tell me what I need to do to get out of what I am experiencing. It brought me despair more than anything.

JOAN: Can you share with me what it is you are experiencing...

MARE-LEE: I am uncertain about my own self. I am not able to live fully because I don't experience being in touch with my own feelings and needs. Uncertainty about my own self feels as if any dreams and aspirations I may have are subjected to the opinions of others, I am not free to just be me!

JOAN: What is affecting you most, is it self-doubt or being judged by others?

MARE-LEE: It's both.

JOAN: How did self-doubt came to take over your life?

MARE-LEE: I think it started in the boarding school.

JOAN: And...?

MARE-LEE: I started to feel uncertain of myself, felt I did not quite fit in.

JOAN: ButWhy?

MARE-LEE: My peers looked happy and ready to take on the challenges of growing up...

JOAN: What were these challenges?

MARE-LEE: The girls were comfortable talking about boys, sex, fashion, while I found myself not quite part of that.....for me it came too quickly, I became overwhelmed.

JOAN: Many people take long to 'grow up' as you put it. As people we are different, and it's good to be different. Growing up is one thing but if you could not relate to what seemed the group's interests, typically talking about boys and sex does that make you unfit for their company or does it mean you were just not ready for it? Who decides what is right or wrong and what change should look like? Has it occurred to you that you were perhaps in the wrong group?

MARE-LEE: I did not consider myself to be socially outgoing, girls night was not something to look forward to but then I was also not good at finding first love.

JOAN: So if one is not socially outgoing does it mean that you are also not fit to participate in 'normal' society and then what would 'normal' society look like? By considering yourself to be the problem you are putting enormous stress on yourself by giving up on your voice, your self-agency, effectively you give up taking control over the issues that affect your life, like having to make choices about growing up and what it entails for you..

Mare-Lee was crying and very upset, almost helpless.

MARE-LEE: I am at a loss as to how I got where I am, I am so confused. I know something is missing and something serious is wrong, but I cannot explain what is wrong or how I got to where I am right now. Everything is blurred and

nothing makes sense to me at all. I do not want to hurt people. I do not want to be like this!

JOAN: I believe you. I am just wondering whether anorexia has anything to do with wanting to be different, or perfect? Did it grow out of pressure you felt to be different from the person you have come to know and value as your own self, but as something you had to do in order to fit in better?

MARE-LEE: Still crying I don't know I can't make sense out of anything. I feel so trapped, so as if the problem I am having remains almost insurmountable, I cannot describe it and I am afraid and fearful that I will never have my life back.

JOAN: What are your thoughts around 'proper' or traditional girls schools?

MARE-LEE: What do you mean?

JOAN: I am just concerned about the way in which your school environment shaped your ideas of womanhood, in other words how women should be in terms of body shape and beauty to be acceptable in society. Conversations amongst girls growing up often concern body shape and dieting so that the ideal of being super thin can lead to dilemmas where control of the body and dieting become major issues. These cultural 'taken-for-granted' realities in terms of how a woman should be to be acceptable are very subtly promoted with women often becoming the victims of media and the conventions of society.

You are right in saying that you were not ready to face the challenges of growing up and that's okay. Feelings of not measuring up occurred because you were being pushed to respond to other people's 'shoulds'. You cannot give up on your own self-agency and power in order to meet the opinions of others in terms of your own personhood.

MARE-LEE: It makes a lot of sense, I feel lighter...

JOAN: So your idea of being caught between two selves at the moment makes perfect sense, on the one hand there is the self which is you, wanting to be part of life and enjoy it, then there is the other self who aspires to the ideals of society and anorexia, pushing all the time to 'operate' on yourself in order to be recognized. In the process your own self got left behind and this is what I think causes the tremendous confusion which is going on right now.

MARE-LEE: It's as if I've forgotten how to express myself, as if I don't know what to say about myself....don't know where my own self is. All the time I am in a bubble, I want to put my finger through it but I do not succeed. I see people but they are all outside and their voices are muffled. I want to get out, but there is this little man jumping in front of me, blocking the exit...I have turned into a glass doll with no feeling, only aware of the constant nagging voice in my head, bouncing a ball and telling me that I have a problem...

She suddenly turned quiet and seemed to be caught in an intense internal struggle.

JOAN: Caught up in a bubble.....Can you recognize the way in which anorexia has succeeded in isolating you, drawing you into its bubble of non-existence where you become trapped in a world that is surreal and bombarded with voices. 'Others' made you feel that you were not measuring up and anorexia came with its false promises of helping you to obtain perfectionism, not just in terms of your body shape but in every area of your life, stepping towards overcoming what 'it' considers to be weaknesses on your part. At the same time these ideals fuelled an obsession intense enough to isolate and blind-fold you to injure and abuse your body.

MARE-LEE: It is sly....I know it slips away when I want to expose it. Then at other times, 'it' fogs my concentration, while I try to listen to people who want to help me, 'it' always has a problem with these people, arguing that they are wrong and that 'it' is right, that 'it' knows me better than anyone else.

JOAN: So, instead of taking care of yourself in your own way, anorexia draws you into its world where you start to doubt your own self. With its ultimate aim of perfecting you, it encourages you to become obsessed with your body, as it is the body which needs to be controlled and manipulated if perfection and self-worth are to be achieved. Although anorexia is controlling you, it wants you to believe that you are in control, that you have the power no-one else has because you have the ability to starve your body and subdue all its needs.

If you are serious about claiming back your life, you need to make a constant effort to turn down the volume of the voices terrorizing you. Remember you have your own voice, it means taking seriously what anorexia is doing to your being, mind, body and spirit. That means challenging the cultural stories of what it is to be normal, whilst taking seriously the value of relationships, moving your own spirituality from the edges to the centre, in order to see what spiritual practices are giving life to anorexia and its claims on your body.

It is all about standing up to anorexia by living for yourself and fighting to be your own self, paying attention to what you want and not just what pleases others, or anorexia. Remember what I said about your own voice, your own power Somewhere, buried underneath all the fear and anxiety, is your own self or spirit wanting to be free and grow, but it can't happen if you are suffocated by the rigid demands of anorexia.

Mare-Lee remained very silent as she sat almost motionless. As I had come to know her family quite well, I knew that she came from a religious home with the family reading the Bible and going to church together. It is the premise of my work that by bringing the client's spirituality to the forefront of therapeutic intervention in the context of the eating disorders, positive spiritual practices can become a source of great support for developing preferred ways of being for those struggling with the illness.

JOAN: I was wondering about an ongoing source of support for you outside this room given the chaos anorexia has caused. If it is okay with you I would like

to talk about spirituality, your spirituality, and the way it features in the context of anorexia. Are you comfortable with that?

MARE-LEE: Yes.

JOAN: When I refer to your spirituality what comes to mind – what ideas do you hold with regard to your own spirituality? What is spirituality for you?

MARE-LEE: My faith is founded on Christian principles with a belief in God and the Holy Spirit, so that all my values and principles are derived from a Divine source. My spirituality is my relationship with God.

JOAN: What do you think God understands in the circumstances, which is not possible for another human being to understand?

MARE-LEE: He understands me although no one else does. He knows all about me so it makes talking to Him easier, plus the fact that He promised to be present always...

JOAN: So does it mean that you can go to God with the problems you are facing right now?

MARE-LEE: Yes.

JOAN: So what happens for you when you talk with God about your fear and anxiety, do you sense being close and connected, does the relationship provide you with strength and meaning?

MARE-LEE: I don't know. He seems distant. It's hard to say.

JOAN: But He was not always distant...what is different now?

MARE-LEE: I do not seem to be able to read my Bible or pray as I used to do. I try but it is as if nothing goes in. I also find it very difficult to concentrate, so in the end my efforts end up becoming meaningless.

JOAN: And you drift away...I am not surprised....it is just one more way in which anorexia tightens the isolation it has created for you. Have you given a thought to anorexia's aims, that of wanting to absorb you totally in its daily routine, that of keeping your mind occupied with food and calories and encourage you to over-exercise? So in the end there is time for nothing else...

MARE-LEE: It is about wanting to be healthy, to eat healthy foods and not overeat.

JOAN: However it is also important that you understand how your relationship with anorexia is placing pressure on you to be better and become more in terms of its ideals for you, in very much the same way the girls at school put pressure on you. You had to be someone different in order to meet the ideals of 'a proper woman'. It is all about learning to love the self again, to live comfortably with what you want, not what others or anorexia want from you.

MARE-LEE: How do I bring this together?

JOAN: Well, what about your own power, what about seeking new meaning in all around you. Opening up your spirit to new experiences will not only be enriching but also very meaningful in your life, it will break into the isolation the illness has caused you. At the same time it will open up ways in which you can come to know your own self and its capabilities through new

activities that don't focus on anorexia.. You have been very involved in doing exactly what anorexia demanded of you and in the process you forgot how to live. Becoming more spiritually alert and aware may also help you to see the affects of anorexia on your life from another angle.

MARE-LEE: I struggle to concentrate and plan anything ahead of time. My dogs often lie at my feet when I feel sad. I can just sit there, dead quiet, it is as if they understand. I noticed that my horse often bend its head round and nudge comfortably. I like being near my animals, when they are near I feel safe.

JOAN: What about taking your dogs on a long walk, feel the wind or the sun, listen to music, keep a diary of all the good things happening in your life, the things that move you spiritually and have a special meaning. So much has disappeared from your life since anorexia got all the say...

MARE-LEE: I never looked at it this way. I know that there are things that were part of my life before which is no longer there, and yet it is difficult for me to say exactly what it is I am missing from my life.

JOAN: If you find it difficult to read your Bible or pray because of a lack of concentration, there are numerous everyday possibilities in which to find God. It just calls for a willingness to see and be open to the experience of His presence, knowing that God is with you gives new meaning to everyday situations. Caring for the spirit or self starts with loving yourself again. Start a routine of caring for your body, do the things you have excluded or overlooked from your life for a long time. Claim back your own freedom which is already present.

In the months that followed I sensed that Mare-Lee was trying hard to overcome the isolation caused by the illness. It was as if she was more 'open' noticing events around her and eager to participate in what she called 'the new'. Excerpts from my notes, taken during our

interactions, suggest the growth that had taken place, in contrast to the 'isolation and control' so common in cases of anorexia nervosa.

MARE-LEE: I stop to look at a flower. I think about the plant, it looked like nothing without the flower, only a tiny twig with leaves. When the bud broke through, the plant did not stop growing but invited bees and butterflies to participate in the scene of colour, in the nectar, sugar- sweet, no longer just a flower, but a source of undivided joy. A cycle to make new, a cycle that touches, a cycle of life.

I wake up in the morning and I am Mare-Lee. This is my day. I convince myself that it is easy to concentrate on the 'not-so-good', but this I try to avoid. I know that God is with me, but it is like having to cut away something that has become part of me, and it's not easy. It becomes a struggle of the mind and body and I feel powerless with everyone around me thinking that this is the way I want to be. I need time to think, think about what was there. I'm coming to understand about the new and old... Also that the issue with food is probably the last that is going to be resolved...I am concerned that my mother will think there is no change, but for now I am growing in other ways. I understand that there are still things I must uncover, but I am honest when I say I am drawn to what I am experiencing now, I do not get tired of connecting to it over and over ...

JOAN: Wow.... Now this is new and exciting! What kind of flower.... what was its colour?

MARE-LEE: Yellow! Striking, energetic, joyful! A sunflower – growing in the sun! A small seed that fell from the parrot's cage – it is so incredible, now a sunflower with bees everywhere, it is a 'wake-up' call; I made a breakthrough.

JOAN: Where does that memory sit within you?

MARE-LEE: *I feel it in my body [placing her hand over her chest].*

JOAN: How did it make you feel? How do those memories affect you now?

MARE-LEE: *I guess it is a feeling which radiates warmth and a calmness in my body. It radiates out and fills my body with a feeling of nurturance and complete peace.*

JOAN: What can you access now that is already available to you, that will stand against sad times and anger towards yourself?

MARE-LEE: *I guess it is my spirituality?*

JOAN: So what do you understand about your spirituality, what will make it present for you now?

MARE-LEE: *Connection. I could also invoke a connection to God who might comfort and accompany me everywhere.*

JOAN: So, tending to these relationships which are already there, bringing more than just connection, and are able to exist alongside anorexia, is this a form of caring for yourself spiritually and emotionally?

MARE-LEE: *Yes, definitely, it was something I discovered...it was just there without much effort...*

JOAN: So instead of being forced into a relationship of aloneness with anorexia, can this new discovery nurture a new kind of relationship with your inner self, becoming part of your spiritual practices, bringing new modes of being and thinking into your life?

MARE-LEE: Now that I know what it is like, what it did for me, I look for more because I know it is there. It is like having to take a step back in order to notice things around me, taking and giving myself time to notice....When I speak, it's as if people want to hear a fairy tale, they want to hear the end of the story.... But this story cannot end, there is not going to be a final page, there can be no end to my growing. I am excited, I now concentrate on what I enjoy. I used to ask too many questions and worked hard to get rid of 'bad' feelings, now I try to be myself, to be happy, I also feel much lighter.....

JOAN: And focus on remembering those moments, bringing them back?

MARE-LEE: Oh yes!

On another occasion Mare-Lee told me that she had been invited to go to a camp with others her age, from different schools, with a view to becoming part of the Christian youth leadership programme at her school. Anorexia was again trying to highjack everything.

MARE-LEE: What do you think, I am not sure if I should go. I have not completely made up my mind.

JOAN: What would stop you from going?

MARE-LEE: I do not know the other children, there will be some from my school but also many others I won't know.

JOAN: And...?

MARE-LEE: It is difficult having to go with people you don't know, I am just not sure if I will fit in. I'm not sure if I will be able to comply with what is required.

JOAN: And I guess this is a first for all the other children going on this camp?

MARE-LEE: Yes.

JOAN: I think the old lies of self-doubt are trying to cripple you here. Of course you can do it. Given your relationship with the Lord, I thought this is something you would want to do, or am I missing something?

MARE-LEE: You are right. I want to be part of this outreach. My parents are also keen for me to go.

Although she felt uncertain about participating, unsure of what would be expected of her, she nevertheless chose to become part of the adventure. During her next visit I wanted to know more about this outing, particularly about her place in it and what it did for her.

MARE-LEE: I surprised myself. You know I was uncertain whether to go or not, and yet deep down I also felt inspired to take part. It was like, who knows, I may be of use somewhere, to someone. I think this is what made me decide to go. It was so nice. Everything. I am so glad I went.

JOAN: So tell me what happened for you, I am curious to know.

MARE-LEE: Everyone was so nice to me. It started already on the bus going there. I felt included from the very first moment right through the whole weekend. And what's more, the tremendous scenic beauty all round us, now that was really something! I felt so privileged to be part of nature! I enjoyed everything, all the birds, the noises from the forest, everything I saw and heard, I was moved to a deep appreciation of it all. I wanted to take it all in, at the same time it was like being drawn to making a confession for all that I experienced and had. I had mastered a lot, even when it came to food, I ate what was on the table, I ate everything with them!

JOAN: Wow! This is great! What else happened?

MARE-LEE: Everyone had a turn to fulfil a leadership role and was required to do a presentation. I presented a story of 'Brother Bear', which focused on the injustices many children suffer because they are weak and vulnerable. It was like standing there with everyone listening to what I was sharing. I think my input was much appreciated by everyone. I also valued it because it brought a sense of confidence in my own ability, like yes you can do it! I was also appreciative of what there was to learn from the others.

Then there were interactions with a theme on personal attributes. I was asked to share with the group what I regarded as my own strengths and how I viewed these qualities as giving me direction and meaning in my life. I did not find it difficult to rate myself positively. The thrust of my input focused on God the Creator who had planned my life for the purpose of using me.

JOAN: And.....what else happened for you?

MARE-LEE: The real excitement happened during praise and worship. I sang with focused attention; never before could I sing with so much commitment.

When I closed my eyes I was filled with energy, a creative energy filling my body. I felt differently, I knew it was there, that it was up to me to grow or not.

JOAN: So was it like the recognition of a higher virtue, a form of self-transcendence? What do you think motivated this shift?

MARE-LEE: I was searching for a connection with God, I experienced something like a surrender but also a transformation, my thoughts and behaviour changed from myself wanting to be in control to just being one with everything sacred. I will submit my name to become part of the youth mission movement at my school. I realize there is still much work ahead of me in terms of living fully, and trusting myself that I can do it, but I also feel safe because God is with me. He cares for me and knows everything, the rest does not matter.

JOAN: And are there some ways you include these values and assumptions in your practices, directly or indirectly? How are these practices present in your life now?

MARE-LEE: For the moment it is important for me to work hard towards feeling good about myself every day. It's like when I care for my body I end up with good feelings. It develops almost its own routine, I know it's something I have to do like having to care for my nails regularly. When I look in the mirror I do not really see what is there, because I'm now living something different

Mare-Lee was taking small steps on her way to becoming part of the world again, and I was excited for her. I sensed a will to fight back, to become involved in living. Her participation in the camping experience opened new opportunities for her, where her search for self-belief was taken explicitly to the level of the sacred. As she grew spiritually, she came to appreciate that life was worth living, even in the face of difficulty. For her it became important, not only to understand her own spirituality, but also how her spirituality could offer a new connectedness, transcending the demands of anorexia.

Mare-Lee obtained a pocket note-book in a blue marbled finish – we came to call it the Little Blue Book. In this she recorded moments of silent prayer or Bible verses she connected with or which spoke to her circumstances. She would often bring the book and asked me to do the same and then return it to her for reading. Through this little book we created an opportunity for her cherished values to become more richly described. We believed that these richer descriptions of her preferred values would make possible other options for living.

With all the new found experiences connecting her to ‘other’ versions of her life, for which anorexia previously did not make space, I was excited for Mare-Lee as I sensed her efforts in becoming part of her world again. Some weeks later, another opportunity came up.

JOAN: My husband and I will be going to Cape Town later in the month to see Andrew Lloyd Webber’s Joseph, and I was wondering if you would like to join us. We will also be taking our grand-daughter. It means we will be staying over with family for one night – it would be nice if you could come along.

MARE-LEE: Yes, I would love to, I’m sure I’d enjoy it very much.

It was what I would call an ‘extra-therapeutic endeavour’, an attempt to encourage Mare-Lee to think and feel differently about herself outside the confines of the illness, to stimulate her own freedom and choice of actions.

JOAN: Remember you told me about having moved from the little girl in pig tails who left home to be confronted with the challenges of life at boarding school, in a new town. Joseph must have experienced a similar culture shock arriving in Egypt. A semi-nomadic shepherd was suddenly thrust into perhaps the world’s most advanced civilized society, sold as a slave, falsely imprisoned, only to become the ruler of Egypt, second only to the King.

The story of Joseph (Genesis 37:1) teaches that through suffering, no matter how unfair, we can emerge stronger, both physically and spiritually. I believe it was Joseph's positive responses which enabled him to overcome each setback he faced. He did not waste time asking 'Why', rather his approach was 'What shall I do?' It highlights how we respond to these challenges, despite changing circumstances in our lives.

Our outing to Cape Town proved to be great fun. After the show we went to a little Italian restaurant that combined views over the coast together with the buzz of city life. 'What are we going to have?' Nikki, our granddaughter asked, turning to Mare-Lee, not knowing that Mare-Lee was struggling with an eating disorder. 'What are you going to have?' Mare-Lee responded. Nikki said: 'I eat everything, pasta is my favourite.' To my surprise, Mare-Lee responded: 'So let's have pasta!' Although I was a little apprehensive at first, I was quietly touched when Mare-Lee showed no difficulty in ordering from the menu. I also could not sense any internal struggle, in fact she was so much part the evening that it was hard to believe that anorexia still had any power in her life.

Of course, there were also 'not so good' days when Mare-Lee found life very difficult. With tears rolling down her face she told me about it one day.

MARE-LEE: I keep on trying but nothing works, its all about food! I cannot carry on anymore! Everybody wants to tell me what to do! They do not understand my struggle, we end up arguing and I am always the one to blame. I am irritated with my parents, but I miss the good night kiss from them when things are like this! Why does it have to be like this, why can't this thing go away!

JOAN: What brings on this intense struggle, separating you from the warmth of those who love you?

MARE-LEE: I have these really bad days. My mother would ask me what I would like to eat and I become completely over-wrought, stuck, totally out of control

as if I cannot think for myself and end up literally not being able to decide what I want! I end up telling her I am not hungry, with her telling me I have to eat! It is all due to these voices in my head, always telling me what to do. Everything is easier when they are quiet, I experience more peace and those are the better days too.

JOAN: So when the voices are there, does it mean you end up listening to them and what they want for you, rather than giving your own voice a chance, listening to what you want and not giving in to anorexia? I am curious to know what these voices are telling you, what gives them this immense power over you?

MARE-LEE: Always the same old message, that I have to say no, that I cannot have what I want.

JOAN: So this is about them controlling you, don't you also have control? I am concerned about the power you allow these voices to have and why you can't see through their plans to keep you isolated and alone. What would happen if you turned off the volume! What about your own power? I am also curious about the 'good' days, are these just days the voices decide to be quiet or are these days when you decide not to listen? How might you be able to?

MARE-LEE: With the help of others, I have already managed to turn back much of this and although I would like to go all the way in taking back my life, it is not easy – this thing keeps on coming back! Some days are good other days are horrible. I just can't fight anymore, what for everyone else seems easy or normal, is for me an intense battle.

JOAN: But you have taken the first steps and have worked at it. I wonder where the resilience came from, what would be an emblem for this resilience?

MARE-LEE: I try not to think of food, I try not to be so absorbed with what I eat and how much. I try new things, if I concentrate on the 'new' I feel I move forward. However, if I am constantly reminded that I am not eating enough I tend to fall back, making me want to give up because I feel hopeless.

JOAN: I think everyone is concerned that if anorexia persuades you to keep treating your body badly, the problem is not going to go away, you become smaller and it is gaining strength. I would like you to think about the affect anorexia has for you connecting with your body and with others, and what seeds it is planting in your mind about who you are

Reflections...

Sometimes on her visits Mare-Lee invited her mother to accompany her. White (1997) talks about 'communities of acknowledgement,' and Epston (1995) discusses 'communities of concern' when describing people who meet together to construct alternative knowledge as a form of co-research. Her mother acknowledged that Mare-Lee was trying very hard, but was deeply concerned that her weight was still dropping. The relationship between Mare-Lee and her father had not improved, she felt that Mare-Lee either avoided her father or was abrupt in her dealings with him. The atmosphere at meal times remained tense, and in the afternoons when she would like to spend time together over a cup of tea, Mare-Lee refused to drink tea, preferring water instead. She felt that Mare-Lee was still allowing 'the thing' to control her, to come between her and her own happiness, between her and her family.

Given my understanding of healing as ultimately a healing of the self or spirit, and although Mare-Lee had made certain concepts of spirituality her own, she still doubted herself when it came to her relationship with anorexia. I was concerned as to how we could structure the development of alternative narratives, particularly with Mare-Lee's lived reality (her spirituality) still contributing to the problem-saturated story. Focus was now on how her spirituality was still privileging specific practices with regard to the manipulation of her body, and how this was affecting her relationship with others.

Mare-Lee admitted to a fear of becoming fat and a dislike for what she regarded as 'unhealthy' foods. Her negativity about food contributed to the way she was experiencing the illness, rather than her having the illness. I believe this is one of the most difficult issues when confronting the eating disorders. I found myself in opposition to much of what the medical model currently proposes with regard to the eating disorders, in discipline, policy and attitude. I felt trapped between the medical model of treatment (diagnosis, force feeding, psychiatric wards) and the extent to which it gives rise to pathology and undermines the self - and helping her to grow spiritually towards healing, where in the process her voice would not be prejudiced or her spirituality marginalized. I spent much time reflecting on how my interaction with Mare-Lee could be structured to come alongside the medical model, where I could continue to support her therapeutically.

I suggested that Mare-Lee should see a medical doctor and dietician for a thorough medical examination and an appropriate meal plan. The medical report expressed concern regarding her weight and recommended that in the event of any further weight loss, she should be hospitalized. The visit to the dietician was a success, Mare-Lee was allowed to help in the preparation of a meal plan from foods of her choice and undertook to follow the new programme. This was also welcomed by her mother, who felt she now had a better understanding of what her daughter should be eating.

My conversations with Mare-Lee continued. She made follow-up visits to the dietician and was confident that healing was taking place. I also kept in touch with the doctor on Mare-Lee's progress. I think everyone involved, including Mare-Lee, realized that it would be a 'protracted' battle; the war had not been won.

JOAN: You say that you are busy getting stronger. Can you tell me what you are experiencing and how you are coping with everything.

MARE-LEE: I feel more in control. I'm able to succeed in what I do. At meals I don't restrict myself to only one portion like before. I absolutely love peanut butter and honey, yesterday that is what I had on my bread, then a second slice with syrup.... And ...no guilt feelings afterwards! After lunch I sat in the sun

and read the paper. I played with my dogs after school, I haven't done that for a long time. My sessions with you have helped me to feel much safer because I have you there for me, it is as if I see more light, previously everything was painted grey. This is the way everyone wants me to be – forever! But sometimes I'm still frightened, I know how strong 'it' is.

JOAN: If I should ask your parents, or Zettie (sister) or your friends at school, what is there now that they notice that was not there before, what would they tell me?

MARE-LEE: I participate more, we are doing more things together...

JOAN: How did you manage to get this into place, it sounds to me like a big step forward?

MARE-LEE: I am trying to focus more on what I want for my life, focusing on the things that brings me pleasure. Previously I felt so disheartened, immobilized, I just did not have the energy for anything. It took away my hope, I couldn't think or concentrate! I was concerned and knew that something was wrong, but at the same time I did not want people to bother me. It was still the old problem, being inside a bubble, seeing people through a glass wall, with people trying to help you but always from the outside. Even coming here, I was so scared that I would find the answer to my problems, but that I would not be able to succeed. It is like getting stuck in a fence and you cannot release your shirt, you try going backwards and then forwards but you cannot free yourself, and there is a hole afterwards that remains. It is this 'thing' that causes the unhappiness, I want to be free from 'it'.

Because of what I am now able to do, I see progress. I feel more normal; not weighted down by guilt feelings whenever I eat something. I now enjoy what

I'm eating. Maybe there's no visible difference, but for me, inside me there is change.. For me, this is what it means to be normal'

JOAN: Sounds like anorexia is losing ground?

MARE-LEE: He wants to be there, but I'm making it difficult for 'him'. It is a male voice, forever questioning what I want to do. Why do you want to do it? Why don't you just leave it? Then there is the noise of small children repeating verses, over and over, or they clap little things, any tune that is annoying...Previously I could not claim it...it is inside you and when you want to confront 'him', then 'he' slips away... 'he' is very cunning, 'he' hides....and when you need to be in control you aren't because its 'his' turn to be strong...

Mare-Lee kept me informed of her progress during visits. I received the following fax from her, sent after her return from school one day.

I need to study for my Biology exam. But, that can wait because I first need to share something with you that is infinitely more exciting ...

TODAY *two more lambs were added to my animal kingdom; [on the farm where she lived] but an even greater gift was MY OWN PATIENCE.*

TODAY *my breakfast was Muesli again ; but this time I was HUNGRY and it was not just niceIT WAS VERY NICE !!*

TODAYjust a few minutes ago.... hmmm a steaming cup of bush teabut not on its own, no, a few wholesome rusks to round it off – just as it's supposed to be!

TODAY..... There is much calmness in me:

I wear dancing shoes, but not a pair that is stiff with high heels and tight straps that press me.....I am wearing a pair of comfortable 'Matthews'. A pair which allows me to step where I want, to order my next move, dance to my own music!

It is raining and the drops falling outside bring me the assurance of God's living water.... And one look at Oscar (her dog) made me decide

I WANT TO PARTICIPATE!

Thank you for everything. I cannot tell you how grateful I am for our conversations. I believe and trust in a future of change : a new life as Mare-Lee. Thank you for praying for me. It brings much peace.

The above reflections indicate the progress of the healing journey for Mare-Lee, however anorexia had not yet been defeated. I provide the following account as an essential part of Mare-Lee's story in order to provide knowledge and insight into the ongoing power struggle surrounding the illness. As Mare-Lee began to participate in new ways, she became more relaxed about food, resulting in her beginning to gain weight. This immediately raised the old fear of being fat and sabotaged all efforts at buying new clothes, particularly long pants. Mare-Lee's mother was very sensitive to her daughter's response and her fears were confirmed when Mare-Lee decided to abandon the meal plan provided by the dietician. Mare-Lee became agitated, she now refused to eat bread or potatoes. The home situation became tense, Mare-Lee's mother feeling tired and blaming herself. She felt unable to cope with the situation, especially with Mare-Lee's father very involved in his business and not always available. She had been courageous and had suffered with her daughter. I asked Mare-Lee

to give me an account of what had been happening at home over the last few days. She forwarded me the following by e-mail:

FRIDAY

After my last session with you, I left feeling at peace and wholly satisfied. My mom and I visited some shops on our way back home, as she wanted to buy Christmas decorations. We bought angels carved out of wood, it was so nice for me to be part of what she was doing and to become excited about Christmas. My mom bought me a packet of jelly tots which I decided I would have for lunch. My mother was clearly upset, and reminded me that what I was doing was wrong. I cried a lot and asked her to help me, just to be able to eat normally again, like they all did, like I used to. It was not an easy conversation, we argued a lot. When we got home I went to my room without having lunch, I continued to cry and felt bitterly angry and heartsore.

At some point I came to my senses ... I realized that the situation just could not continue – and I did not want it to be like that. I went to my bathroom where I stared in the mirror and asked Jesus to help me. It was as if I received clarity; I had to ask my mother's forgiveness. This was very difficult for me, I felt much aggression inside me. A part of me could see a bright future, another part felt it would rather die – I was so tired of struggling. Then I heard my mother calling me and on the kitchen table was a sandwich and a glass of fruit juice. With great difficulty I ate. I was still angry and continued to cry. I went to my mother and told her how sorry I was. My mother held me tightly against her body for a while, rubbing my back and telling me 'Don't worry, you need not be sorry'. I decided to also apologize to my sister, Zettie, which was also very hard for me to do. When my father got home, life was more or less back to normal. We all went to sit by the river. My parents enjoyed a glass of wine, there were snacks as well as my jelly tots, (by now my mouth was literally watering!). The rest of the evening was most enjoyable and peaceful. Much of the day was really

unpleasant for me, but I believe it had to happen to help my own growth and future well-being; but it was terrible.

Bible reading that night: God is always there – always!

SATURDAY

We all went to town for business and afterwards my father treated us to cake and coffee. My mother and I ordered apple tart, Zettie chocolate cake and my father pancakes. Unfortunately the apple tart was disappointing, perhaps it was the fact that I did not have any peace about having agreed to eat something like that! In the afternoon my father went to play golf and we (my mother, sister and I) decided to walk around the mall. Driving there, a part of me was already making plans about how to skip lunch. At the same time there was the other side of me trying very hard to explain just how normal lunch would be. Walking around at the mall was not nice. I was uncomfortable, feeling that people were staring at me all the time. Later in the day, when I discussed this with my mother, she confirmed that this was the case. I decided to have a bran muffin which we bought at a farm stall on the way home. Later on, supper was more or less normal, I was motivated not to have people staring at me. Altogether, it was not a very nice day for me, but despite that, I did not give up hope.

Bible study in the evening: I made a greater effort to get to know God and to become more aware of His presence.

SUNDAY

We all went to church; I was moved by the sermon. From early on I felt I was not in the mood for talking; just wanted to be quiet. It was a weird feeling but not necessarily negative! With regards to food, I felt that I did my part for breakfast and lunch. Late afternoon, after everyone had rested, my

mother came through to the kitchen to make coffee. She always bakes for Christmas and holidays, biscuits and small cakes. She took these out of the cupboard and offered me some. Although I took one and really enjoyed it, it was not long before the terrible guilt feelings were back. Fortunately there was part of me which said this was the way things ought to be; that people would stop looking at me, that I would just be punishing myself by refusing it!

In closing ... You asked me to tell you what happened over the last few days. And now well, I feel so much better! I now have new hope and energy. There is actually so much I would like to share with you but for now I don't have the words. Please pray for me, my father's birthday is approaching and I don't want anything to spoil the day for him.

Reflections...

I came to realize that although Mare-Lee was trying hard to fight the illness, she did not fully appreciate how much control the eating disorder still had over her life. I spoke with the dietician and asked her to report back to me more frequently on progress. My conversations with Mare-Lee now focused on the effect of the illness on her body; that we could not ignore any further weight loss. We spoke about hospitalization and what would be involved if this became necessary. I noticed that Mare-Lee would try to steer the conversation in another direction when we talked about anorexia and its plans for her life. She did not want me to focus on the issue of her weight or eating habits. This was also confirmed by her mother; any attempts to encourage her to eat properly invariably ended in an argument.

My conversations with Mare-Lee focused on creating an awareness in terms of what was unfolding, how she was inadvertently participating in the creation of a context in which anorexia flourished. I explained that the healing journey was also a surrender to the process of change. If we accepted that anorexia was in a sense a story about her wounded self or spirit, the illness barred the transcendent agency allowing her to be in touch with the core of her being and her spiritual connection with life. Could the illness experience have occurred because of a reluctance to change, at a point in time when change was most called for, her

growing from the little girl in pig tails to womanhood? We discussed specifically the issue of power, inherent in the illness relationship, which we unpacked as follows:

- The power of anorexia to control her diet
- The power of anorexia in manipulating her into abusing her body
- The power of anorexia to imprison her, thereby estranging her from her own world and those who loved her

JOAN: I was reflecting a lot on our conversations during the past months and how you also found new spiritual meaning and growth when you opened yourself to participate in life in new ways. As a means of curbing the power of the illness and finding hope for your life from within, you convinced me that you have faith in a powerful God, that you are longing to be healed and be able to eat normally again. However, I have been wondering whether it is just possible that you overlooked something which is very important, that is, that your spirituality is not disconnected from moral obligation and responsibility towards the other.

Caring for the body becomes caring for the spirit and vice versa. As long as you deny your body's needs, that is not feeding it properly, you are still tied up in a relationship with anorexia, a relationship which is basically anti-spiritual. Seeking God's power, to help you against the power of the illness, requires living out spiritual commitments in the light of this relationship. It is finding self care activities and ways to feel positive about yourself, relying on and claiming your own spiritual power in seeking new strategies against anorexia. Is it possible for you to see the connection how the development of new perspectives about your self and body, also holds the possibility of re-claiming your own freedom? Please tell me if this does not make sense to you, or any ideas you may have so that we can keep moving forward.

MARE-LEE: It all makes sense but it is hard to put into practice.

JOAN: The practice of acceptance through careful observation and openness to experience takes effort, it is actively opening yourself to life, turning your

mind again and again to what is real for you in order to transform how you see and value life.

Reflections...

It was now close to Christmas and there was a wonderful vibe of festivity everywhere. I sensed in Mare-Lee a renewed strength in wanting to move forward. Whilst busy with my Christmas shopping, I looked out for something suitable for her. In a city bookstore I found a little pocket-size book entitled *When I loved myself enough*. I wanted her to start accepting and caring for herself, to be free to be some-one different, to see the world as a less threatening place.

Christmas came and went, the new year brought Mare-Lee's final year of school. During discussions with her and her mother they reported progress, but there was still an underlying awareness that the eating disorder had not yet been defeated. The idea grew on me that anorexia could only exercise such tyrannical control because of a felt disassociation or separation between self (spirit) and body. Did this 'dividedness' within result in the manipulation and abuse of the body. Was this to be the starting point if healing was to take place? Convinced of the possibility of discovering new realities, Mare-Lee and I decided to spend some time at their holiday cottage at the coast.

We arrived late in the afternoon and after we had unpacked, we went for a drive, as Mare-Lee wanted to show me the village. We stopped to get an ice cream, my idea! The first soft serve was handed to me but I noticed Mare-Lee was struggling to make up her mind whether to have an ice cream or not. Being aware of the torment she felt, I walked away licking my cone to find a place on a bench outside the supermarket. I was hoping that she would decide to join me and have an ice cream and was delighted when she eventually did arrive with an ice cream in her hand. We walked around, eating our ice creams and chatting about various things. As we had not had lunch, I asked her how she would feel about eating out for dinner. Enthusiastic about the idea, she asked me to choose a restaurant while she pointed out those she had visited with her family before.

MARE-LEE: Please choose anywhere you would like to go, I will be happy with whatever you decide. The small restaurant specializing in pizza and pasta is good, I have eaten there before.

Later at the restaurant, Mare-Lee had no problem ordering a pizza from the menu. As our food arrived she asked if she could pray for us. Her face was open and happy as she stretched across the table to hold my hand whilst asking for a blessing. Mare-Lee was very much at ease and talkative while she enjoyed her pizza. The bill arrived with two small sweets on a plate. I passed one across the table to her. I noticed her hesitation....but as we walked away she unwrapped the mint and popped it into her mouth. Months later I found the sweet paper glued into her 'Little blue book' (mentioned earlier) with the inscription

My first sweetie in almost one year!

Not long after we got home Mare-Lee had to fight back the tears. I had an idea what was going to follow as her face gave the impression of an intense internal struggle.

MARE-LEE: The voices are back! They are chanting at me 'What you have just eaten is so terribly unhealthy! Can it be that the pizza is so bad, that no-one can ever have pizza?'

JOAN: I know that I've said this before, but don't you think you are making too much of this issue? I don't think food can be healthy or unhealthy, it's how much we eat, or don't eat that's important. Starving yourself can be just as 'unhealthy' as over-eating. Have that pizza or cup of tea and enjoy it, and the idea of whether it is healthy or not will probably never bother you again.

Reflections...

Mare-Lee seemed confused by society's interpretation of healthy living, exercise and the ideal of the female body. She became fearful and started to cry. She spoke about her uncertainty about many things, particularly when different thoughts 'played around' in her head. We talked about there being two sides to every story and the paradoxical nature of life itself. When we finally got ready for bed, I noticed that she was more at peace with herself.

The next morning we got up early for a walk on the beach. A soft mist wrapped around the sea and the sun silvered the gentle waves. We walked, at one with the stillness and beauty of it all. Small fishing boats painted in bright colours lay rocking on the water, like a picture in a child's colouring-in book. Watchful gulls circled silently overhead. We sat down to rest, but also to reflect, to find ourselves and to become quiet before we turned back home. Mare-Lee talked about her parents and sister, and told me about things they did and cherished as a family. She spoke about Oscar and Lucy, her dogs back at the farm, and being worried because they sometimes chased after snakes. She thought she had the long, slim fingers of her father, but shared a love for walking on the farm with her mother. With the breeze off the sea softly playing with her hair, I sensed that she was at peace, but missing her family. Difficult to imagine that the person sitting alongside me was troubled by an eating disorder.

When we got back to the cottage, Mare-Lee set the table for breakfast (muesli and yoghurt).

MARE-LEE: We do not need to do much today, I'd like to stay and talk, it would help me, I'm very happy to just stay here all day if that's ok with you.

Later Mare-Lee confided in me.

MARE-LEE: I do not know whether people realize or have any idea of the constant internal struggle I have over food, whether to eat or not, what to eat and when. So often I feel like something really nice, a pudding perhaps, I know if

I were to ask my mother she would not think twice about making it for me. But....I cannot ask her, 'something' tells me I am not allowed to ask her anything! When my mother and Zettie prepare sandwiches, I so desperately want to join in, but again 'something' tells me to turn away and prepare my own sandwich. Please help me, I need to understand why this is so, why can I not bring myself to participate like everyone else. She cries a lot. I so long to be different, but I can't!

Reflections...

My heart went out to her. I tried to explain how anorexia deceives, how it used its cunning tricks to isolate her – to stop her joining in and enjoying life through the voices that manipulated her. Mare-Lee and I were in a place at a time where the values of honesty and integrity in our relationship opened space for a truly participatory discussion where we both were open and honest to create space for the other.

JOAN: Surely you understand that non-participation brings isolation. To be human and to participate in our own growth and development we need other people, we need to be connected to others, nature, something higher than our own selves. If you ask your mother to make you that pudding, it is all about hearing your own voice, about choosing for yourself. It is about being 'part of'. Non-participation at every level brings disconnection, not just from everything around you but also within your own body-self relationship, giving the illness all the power to abuse and hurt your body by starving it. I would love to see you reaching out and allow the people whom you trust to care for you, allowing them back into your life, only then would you start living again. As things are at the moment you are not living, you do not have life because you do not give wholeness that space as coming from within you. When we talk about spirituality, it is about having a form of integrated energy which involves mind, body and spirit. Where are you with this, tell me what you feel, experience, it will make it easier for me to try and understand what reality is for you right now.

MARE-LEE: I do not think of my body and spirit as a unity. Rather, I experience my body as being completely separate from myself, sometimes outside myself.

JOAN: How do you feel about the development of your body, growing to become a woman?

MARE-LEE: I do not like everything that goes with having to become a woman. It is about the traditional female role, having to menstruate and have children, coupled with all the other social expectations.

JOAN: Where do these ideas come from? You have a version of what it is to be a woman, but it is only a version, based on a taken for granted reality that puts the lives of women in a box. For instance, it is generally accepted that a woman will marry and have children. This becomes a kind of self-evident truth, bound in the dominant cultural message laced with obligations, where a person believes that she has a duty to be compliant. All these discourses do is to totalize us, constructing 'fixed' identities of what is required to be a woman. It provides a limited view of the self, what we choose to be or not be is multi-storied, it is contextual, relational and not fixed, we have freedom of choice, we can choose what we want for our lives.

Experiences coming from social expectations plant the seeds about what we 'ought' to be and this relates to how you treat your body. We have the ability to choose, it is up to us to decide how we want to be in relationship and what we can become. Only then do we live a well integrated and balanced self, aspiring to have that which is important to us in structuring our lives and not becoming overly concerned in what society expects of us. It is okay to be different. It doesn't mean there's something wrong with you – just that you are not ordinary or average, which you're not.

Reflections...

We discussed the body, what we eat, how we dress, the daily rituals through which we attend to the body, as a medium or product of our culture. Mare-Lee and I discussed how a relationship with anorexia, and its relentless pursuit of thinness, could easily become an obsession for perfection in terms of society's ideal of the physical, rather than spiritual beauty. Pursuing this ideal is often considered a measure of strength or self control, but can in fact injure the body and imprison the imagination.

My wish was for Mare-Lee to gain a better understanding of how her body can become a political playground situated in the midst of various discourses. I discussed with her how this ultimately becomes a spiritual struggle, a struggle to be, between self and body, ultimately a struggle for balanced existence.

In opposition to dualistic conceptions that structure separation between mind and body, I tried to help Mare-Lee visualize her body not merely as a physical entity, but as a self or spirit embodied, or a body infused with emotion and feeling. Our discussions aimed at helping her to move away from a 'thin' description of self, in an effort to 'grow into life', beginning with the acceptance of others into her world. I explained that we only grow and develop when we receive fulfilment in contradiction, seeing and appreciating the 'other' side within us. Hence, as long as we polarize ourselves, according to rigid absolutes, we will be unable to understand the full implications of any situation.

Given her love for animals and nature, I wanted to promote the search for alternatives to the story she lived. We talked about life, of its never-ending cycle. We had an interesting discussion about female birds, how these little creatures do not enter the breeding cycle when there is a scarcity of food. Nest building and egg laying are delayed if the body is not fed. Like them, we are linked to nature. When the body is starved due to the demands of anorexia, (no matter how much food is in refrigerators or cupboards), the body-self senses this body is starved and can no longer fulfil its functions as a woman, resulting in amenorrhea. We talked about the care of her body as an essential part of being human and

living life fully. That freedom is the very nature of our being, and that whatever stands against that freedom must be set aside, be it ritual or limitation in any form.

I shared with Mare-Lee the story of *Jonathan Livingston Seagull* by Richard Bach. It is a story about daring, for those who dare to follow their own dreams, even if these contradict the norms of their flock, friends and family. For most seagulls, like those we'd seen that morning, life consists of squabbling for scraps at the water's edge, flying is just a means of finding food. However, Jonathan is no ordinary bird, here is a gull who would fly like a falcon. Against the conventions of seagull society, he seeks to find a higher meaning, to live his own dream. Through the metaphor of flight, Jonathan's story shows that soaring (taking on life's challenges) happens when we believe in ourselves.

I believe that during our visit to the coast, an unburdening took place for Mare-Lee. There was a new-found spiritual strength, so that whatever was obstructing the flow of that energy was now removed. On our last evening together, she offered to pray, and whereas in the past her words had come with difficulty, they now came freely and without effort. She praised God for all she had and asked His blessing on her family, her dogs and her will to overcome the eating disorder. She asked that God would provide her mother with wisdom and necessary insight to help her. She prayed for me and for my family. I sensed the freedom in her voice, like a song of unnamed hope.

This led to a conversation about the importance of bearing witness to what we experienced, and the new knowledge we had developed. On our way home we visited a shop which made and sold candles. We each bought the other a candle. The idea was to develop a spiritual discipline of witnessing, whereby as the candle burned, we would pray or reflect and symbolically be there for each other. Through this ritual we could both focus on creative, beautiful and sacred moments and take time to maintain a regular practice of stepping back and witnessing the spiritual encounters of life. Moreover it was to help Mare-Lee focus on what was important for her, an opportunity to move away from spiritual isolation and connect with her own sense of self-worth and strength.

During the months that followed, Mare-Lee became more aware of the constraining patterns that prevented her from experiencing harmony in her life. At the same time it meant that she had to practice new ideas of being pro-active, in order to produce expanded realities. Because of her renewed involvement in a network of relationships, she no longer thought of herself as alone, but rather as cared for by God, her family and friends. She began a routine of self-care. She now told her mother when she experienced feelings of guilt and asked for her help and support.

My father made a fire and we were going to eat outside. So often I spent my time indoors when they were enjoying the afternoon or evening outside. Now I wanted to be part of everything. I asked my father to cook me a soya sausage on the coals. I helped my mother to prepare the rest of the meal. As my sausage was cooking, I warmed myself at the fire while talking to my father and playing with the dogs. The food which I prepare for myself must not stand out as different (Mare-Lee is vegetarian) and make me look and feel 'other', but must complement what we are all having. It makes me feel good, I feel part of what is happening.

I see Zettie is coming home (Mare-Lee's older sister at university). I will help my mother to get everything ready. I so look forward to all this. The four of us at a beautifully set table together! I also like preparing food, and the others enjoy what I make. I also now prepare my own food, I participate in everything.

My mother and I went food shopping. She got crumbed chicken patties for Sunday. I know she always tries to make it nice for me too. She bought me a wholegrain bun. I cannot believe how I now look forward to what she is going to prepare for me, lunch or dinner; how on earth did I get by the whole day with only an apple.....and water.....

Reflections...

It is February 2005 and Mare-Lee's family is making preparations for her confirmation. She arrived at the practice holding a parcel which she invited me to open. Inside was a pink skirt in soft, silky fabric and a pair of pink shoes. I felt honoured that Mare-Lee had brought her clothes for me to see, that she also wanted me to share in this very special day in her life. After the Sunday and back at the practice shared with me:

MARE-LEE: My mother bought me a new Bible, we went shopping for this together. On the evening before my confirmation, we read from the book of Matthew, the parable of the ten bridesmaids – how they were waiting on the groom and the oil ran out. [reflecting] I have to be ready. I must be responsible for my own spiritual well-being.

JOAN: Now, looking back: It was a special day – what stood out for you?

MARE-LEE: The peace I felt knowing that I am never alone. The cards and good wishes I received, I truly felt that everything brought me closer to God and myself. I even let my cousin manicure my nails, I would never have allowed that before.

MARE-LEE'S MOTHER: There are still times when 'the thing' has a hold over her, but what is really good now is that she comes to tell me when she is not coping or when she feels confused.....When she is in a bad mood I know it is not her, but this 'thing' trying to come between us.

JOAN (to Mare-Lee's mother): What else is different now?

MARE-LEE'S MOTHER: Many things ... a fear of clothes, before she could not choose anything for herself. A fear of food, it was hard to go with her to the supermarket because she would not let me buy food, it was either too much

or unnecessary. She is now much more 'herself'. [She started to cry softly] I only wish I was not so ill-informed. I could have done so much more for her, but I truly did not know! Already in grade 7 (approximately 12 years old) I noticed a change in her. She became isolated, she wouldn't join in. I spoke to other mothers who insisted that it was just a phase, a part of growing up. I took her to a psychologist who told me that I was imagining things. But already then she had issues with food!

JOAN: So... If you look back, how far do you think she has come?

MARE-LEE'S MOTHER: Three-quarters on her way to healing, perhaps even more. She now enjoys being joyful!

MARE-LEE [interrupting]: I don't want to sound ungrateful, but I think I'm more than three-quarters of the way! It is still difficult for me to be comfortable around my father. And yet, I know he also has a need to talk with me. When he dropped me off at school this morning, he told me he was sorry, but that work would keep him late every night this week. When he came in the night before, I felt safe and at peace when I heard his voice, knowing that he was there.

JOAN (to Mare-Lee): So when all the family members and friends left after Sunday, what stayed with you? What do you think they noticed?

MARE-LEE: I think they all believe that I am on the road to healing. They all told me to keep on looking after myself. [She turned to look at her mother] Before, I fought all of you – I was convinced you were all against me – now you are all my 'powerade' on the race. Earlier today, I was thinking back to when I was little. It was Zettie and me at the television. We were sharing Smarties from a bowl – one for you, one for me! It was so nice today just to be able to

remember these times again, going over them in my mind made me feel so good!

Mare-Lee's story comes to an end with her spirituality reflected in the importance she gave to everyday happenings in her life. Mare-Lee's fear of growing up and having to meet criteria of traditional female roles gave form to a spiritual power which structured the relationship between her and anorexia. This caused boundaries of self and body and self and other, with the illness creating separation and control whereby she disconnected relationally, resulting in the colonization of the everyday – her lived spirituality (Andrews & Kotzé 2000:331).

In order to establish connection and relationship, it was important for Mare-Lee to understand spirituality as the 'integrative energy' (Tuck 2004:69), involving all aspects of mind, body and spirit, and to experience the body-self relation as an integrated unity. Taken for granted realities in terms of her role as a woman were challenged by presenting a view of the self or spirit as multistoried, always open and evolving (Russell & Carey 2004:126). These views helped her to move away from the thin description of self, to accept her own personal freedom as the very nature of her being and the core of an empowering spirituality that provided self-agency, and a voice to speak out about the issues that affected her life. Mare-Lee came to understand and know her own existence, her relationship with God and her own power to make choices between healthy and unhealthy beliefs and practices.

MAPPING THE JOURNEY OF HEIDI

Heidi's story is staged differently to that of the other two participants. For study purposes, Heidi was obliged to move from her home town. Because of the distances now involved, the research process was unfortunately interrupted. I discussed the problem with my supervisor who advised that Heidi and I should continue to collaborate as far as we could. I contacted Heidi with the possibility of her still completing the journey. She remained keen to share her story in order to inform others of her life with an eating disorder. We decided that Heidi should stage her story, detailing the phenomenological reality of living with an eating disorder and how by discovering her own spirit, she found healing.

Heidi's story provides insight and understanding into the lived reality of a disabling spirituality. Feelings of intense dissatisfaction with her body, coupled with questions regarding her competence and worth as a person, made it possible for bulimia to enter her life. What started off as an ordinary diet turned into an obsessive, repetitive cycle, where disassociation between body and spirit made her vulnerable to acts of self-destructive injury against her body. With the body in pain, all forms of relatedness with self and other became seriously crippled with Heidi becoming more alienated from herself and the world.

Unable to cope with the escalating demands of the illness, Heidi became fearful and in need of support. Therapeutic assistance sought to help her in connecting to her own self or spirit. Her underlying dislike of the self had to be addressed if Heidi was to find and develop her own empowering spirituality. Bulimia was staged as the enemy, trying to enforce its own destructive spirituality. Heidi had to know and understand that her life had meaning and purpose, that she was lovable, her own unique person and most worthy. She needed to discover that there was a Power greater than her who loved her and accepted her just as she was. She was encouraged to nurture the self by reaching out in the act of participation, becoming part of her world again and to connect to the 'more' that life had to offer. Her story testifies to healing as an ongoing process, finding her own empowering spirituality affirming wholeness of mind, body and spirit.

This is her story with extracts from her journal, *The Book of Heidi*.

THE STORY OF HEIDI

'Still, I search in those woods and
find nothing worse
than myself, caught between grapes and thorns.'

Anne Sexton

In July 2005 I started Weight Watchers. I was fifteen years old.

At fifteen, I am disillusioned with myself:

I am an unexciting adolescent girl. I have acne. I am insecure around people I don't know. I shy away from every sort of attention. Yet I crave it simultaneously. With my whole being I desire to be wanted. To be noticed. But I'm not. And so I opt to hide away behind slouched shoulders and comfort food. I am therefore overweight. And abnormally sensitive about it. My body is beginning to grow in places I don't want it to. All I want is to shrink, and my impending femininity is almost unbearable. I am too self-conscious to wear a bra. I do not want to be seen as a 'woman', or even a girl. I wear baggy and boyish clothing, never because I *want* to, but because I simply must. Girls' clothes – dresses and skirts and pretty tops and make-up – are for girls. I'm not a *girl*.

I am a blob. Why try and be beautiful and attract attention? I don't deserve it.

Forever known as: 'Heidi? The fat one?' I am tired of a life being 'on the chubby side.' Tired of being teased and poked fun at and called fat. Tired of being excluded from male attention while all my friends *bathe* in it. Tired of being complimented on my 'prettiness' despite my 'big bone structure.'

I eventually reached the point that I was sick of it. Hence my joining Weight Watchers. And I put my mind to it. I don't know where the drive came from, where the force, the discipline, the rigidity came from. I'm not a structured person – I don't plan ahead, I hate routine, I love food. I really love food. Joanna, my best friend and I decided to do it together. We both tried millions of diets before and nothing seemed to work, so we figured that doing it together we wouldn't lose our incentive. Because I tried and pretended to be aloof and disinterested as my friends start to receive attention from boys. But how could it *not* affect me? Boys found me abhorrent. Repulsive. I found myself rather abhorrent. I wanted to change.

But it became obsessive, the point counting. It became addictive, watching the scale dial move down. Fitting into smaller clothes. The compliments – there was a glamour about it, a shimmer, a sparkle, that I've never experienced before. The unattainable fantasy lodged deep within me seemed to be nearer and nearer, and my fingers were greedy – over-eager – to grasp it.

You get to a point after the initial, major weight-loss that the rapidity of your losing weight lulls. It was nearing the summer holidays. I started lowering the point count – I wasn't losing weight fast enough. I was eating 7 points a day from the usual 20, just fruit and carrots and cherry tomatoes. I was starving but it was worth it – there was no danger, because I didn't think I was really that thin. I'd gone from about 73kg to 67. In two months. Joanna restricted her food with me, but stopped after a couple of weeks. She's never had problems with food. I didn't judge her for giving up. I didn't hate anyone else for eating. I didn't even realise that I wasn't feeding myself properly – I just had this mental block: I'm not like everyone else. Food is delicious and heavenly, but not fit for *me*. My body had had enough food to last it a lifetime. A tug at the fat peeping over my jeans or a pinch at the rolls of my tummy proved that. It was something I just needed to accept.

Because like I said, in the beginning, I never thought much about my eating habits. It was just a decision – like ticking boxes on a voting poll, not really knowing much about one party but, considering the alternatives, choosing it anyway. I had two options on my mind's shelf:

eat, stay the same (fat)

|

eat less, be better

And 'FAT' screamed at me.

The more weight I lost, the more attention I got and for once I started feeling normal. Pretty. Almost. People admired the fact that I'd lost weight – it felt oddly... respectful.

So I chose to restrict. And no-one noticed, I didn't even notice that I was eating less and less. It was easy at hostel, you could skip meals and no-one even realised. No-one cared what you did or didn't consume, no-one checked up on you. On weekends it was harder though because I'd go home and my mom would make food and I couldn't resist. Essentially I love food. I couldn't resist. And my weekend binges didn't bother me so much because I'd go back to boarding school and be good again. Monday, Tuesday, Wednesday, eat almost nothing – just to make up for Sunday's massive overeat. The two environments were different, allowed for different things. At home, I was with my parents, relaxed. At hostel, I was surrounded by my beautiful friends – my skinny, thin, popular friends, by stress and a constant feeling of needing to measure up, to perform – constantly reminded of my lack of everything.

In December 2005 I threw up for the first time.

It was meant to be a one time thing, I'd over-eaten and I could feel the mass of food in my stomach. I felt I didn't need it; I felt it was hurting me, it was dangerous. I was on holiday with Joanna and her family when it happened and it happened about three times after that too. It wasn't serious, I told Joanna about it, she sat in the bathroom with me when I threw up once or twice. There was no secrecy, no guilt, no shamefulness. I explained to her that I was ok, that I didn't have a problem – I was hardly close to the rake-thin Carte Blanche types who we'd seen on TV professing their eating disorders and mental disturbances. She took my word for it. She could see with her own two eyes: I was still me. I was still Heidi. I never thought of it as abnormal, or damaging. I was just dealing with a **matter**.

But then I got to a point where I wasn't Heidi anymore.

If I ate less, I lost more weight, but I couldn't stop eating because people were noticing and I also didn't want to. Throwing up seemed like a logical progression, for those times when eating was unavoidable – such as when I was at home, or at friends' houses, or on holiday. A way for me to control my weight. Because that was the main thing for me, more than the desire to be thinner: I was **dreadfully afraid** of picking up weight. It ended up becoming a distorted and aggravating attempt at self-therapy, which backfired horribly.

But at first, no-one seemed to notice. Notice why there was always foodstuff floating in the toilet. Or that I'd disappear for abnormally long periods of times after meals I'd eat with people, depending on how long it took for it to come up again. Maybe they did notice, but never said anything. Either way, I was suspicious. Horrendously suspicious – self-conscious, defensive, on the look out for someone who'd make me stop. Perhaps contextual events help create understanding.

When I turned sixteen, I met my first boyfriend, and it didn't turn out well. I walked away from that relationship confused, degraded, and hurting. I reacted by not eating. The boyfriend had teased me and taunted me about my weight – pulled at my love-handles, joked about my

thighs – harmless stuff usually. I wasn't overweight then, I was healthy. A healthy *weight* at least. But I had a hurt that was a little bit open, and him rejecting me pried it open further, open enough for his taunting to affect me, to become one of the many voices in my head, but by no means the only one.

This hurt is difficult to explain, because it's so complex and I have no absolute certainty where it stems from. But it's a feeling, a sore and empty feeling which has no English name but lives real in my chest; sometimes in the pit of my stomach. My head does not control it, and the closest way to describe it is a mixture of inferiority and a want for compensation, for assurance – a sense of loss though you haven't lost anything, a sense of fear though you don't know what you're scared of. A dull, aching sense of anxiety that can't be pinned down and simultaneously can't be ignored. All of this, met with defiance, suspicion and distrust for everybody outside yourself. Because no-one understands.

The irony of it all is that I didn't understand myself. Thorns are almost invisible, and this one was lodged deep inside my heart, festering and oozing into the toilet bowl. Spreading its poison into the rest of my body, leaving me vulnerable, sick, disgusting. Despite the rock hard guard I was building, I wished I could let someone in. Tell them: please see my heart and how sore it is. But I couldn't. Every time I wanted to, every time I tried to tell of what I did when no-one was there or no-one was looking, something inside me stopped me. It said if I tell, I'll have to be fat. I'll eat and eat and eat because I have no self-discipline and then I'll become huge like a whale. And then the rest of the world would be able to see I'd fallen apart, not only inside, but on the outside too. Everyone would see how lazy, how incapable, how pathetic I was. How disappointing. Conflicting thoughts that played backwards and forwards and backwards and forwards leaving me with no resolution, no certainty, no peace of mind. Just immense and inexplicable confusion.

I was having dreams, starving myself, and when I wasn't, purging. I managed to go so far as to consider the vomiting 'cleansing'. Doing whatever I could to make myself... *better*. I was immature and I didn't understand anything – not myself, not my body, not what I was doing. I was having dreams at night that were so awful that when I woke up, it felt like I hadn't even slept. Me in dance dresses, me in a room full of people, thin, thinner, thinnest and my ex-boyfriend in the middle, loving me less than ever. Joanna and my other good friend Hayley

on the side-lines, jeering. Simone and Bianca, former friends of mine, laughing. Outside the window, animals. Cows and sheep and goats, so thin you can see the ripples their intestines make in the dried tautness of their flesh. Bone. Sinew. And they're on green grass – golf course green grass.

And interspersed with these things that were happening to me, these feelings that were happening to me, I had to deal with real life, and I couldn't. I morphed into a perplexed little ball of mess. I was changing on the inside and I changed on the outside too. I died my hair dark, I didn't recognise myself when I looked in the mirror. This lack of recognition, of association, helped widen the rift between my mind's image of myself and actual image of myself even more. I didn't identify with my outward appearance. I was losing touch with my inner.

My parents started to make me eat at home. The food didn't fit in with my discipline, I could no longer relax on weekends. I had to get rid of it. Expel it from my body. *Had* to. So I tried sticking my finger down my throat, but it didn't work. Then I discovered that the more water I drank, the fuller I made my stomach and the easier it was for the food to come back up. Somehow, I'm not a scientist so I don't know how, the water helped the passage of the food as I purge it back up. Coffee worked just as well, and took the sick taste away. So much so that it didn't feel like I was vomiting at all. I wasn't throwing up. Not in my head anyway. I was just dealing with things that would hurt my body. That would make me fat again. That would take away all the compliments and attention and acceptance I seemed to have obtained.

Boys started taking an interest in me, I started drinking. As much as I could, whenever I could. It made me feel full, it made me feel numb, I wanted to eat, but I couldn't, it just wasn't an option. If I got drunk enough I could throw up and a hangover would keep me from eating the next day. I binged on my own. Only human, I *wanted* to eat. That is why I threw up, because the guilt that hit me thereafter was agonising. Insufferable. *Awful*. My mind was twisted. *I* was agonising. Insufferable. Awful. Somehow, my thoughts had been programmed to plait themselves in the wrong direction. My brain folds had become intestines of negativity and deprivation. They required attention, food, constantly. Somehow, *somehow*, by emptying my stomach I fed this monster, this devil, wedged unexplainably beneath my skull and simultaneously in my heart.

I did not feel sorry for myself. I wanted attention, but I also didn't. I *hated* myself. I threw up, because I was nauseating. It didn't matter to me what qualities my personality had. In my eyes, life had shown me that personality meant nothing. I'd lived fifteen years exempt from the joys of society, from admiration, from respect, because society wanted beauty. It wanted flawlessness and perfection. It did not want me. So I would change. I wanted to be universal. I wanted to accept myself, and by conforming my body – I didn't know how to commercialise my character – I'd have the best of both worlds. No one told me I'd in anyway lose my character in the process. No one told me.

My first boyfriend hurt me, and I couldn't deal with it. Joanna told people I was throwing up, my other friends threatened to tell. I was fighting with my mother – horrendously. I felt alone. I felt fat and unwanted and conspired against and alone. Sorry for myself, yet void of sympathy for myself. Everything I seem to think in hindsight seems contradictory, but at that moment in my life it felt real. True. 'It' is the hurt.

And those voices in my head weren't hallucinatory. They were memories. Selective memories of times that I'd felt inferior, sub-standard. Of comments I'd received and situations I'd been in that had made me feel worthless. Embarrassed. Voices that haunted me, that spoke to me in the back of my head:

My mother who looked at my report card, saw none of the nineties but only my science which was just below sixty, and told me to work harder.

My brother whose favourite come-back was always: 'You're fat. You're ugly.'

My father who told me to 'exercise more.'

My best friends who told me not to worry about my weight, because 'you've got such a nice personality.'

My ex-boyfriend who told me he didn't love me.

He didn't love me.

I got told these things and they stuck to me like chewing gum to the bottom of a shoe. I took them all out of context of course, heard only what I wanted to hear, but then again, that's the skill and mastery of an eating disorder. Of *my* eating disorder at least.

I don't love you you're fat you're ugly LOOK AT YOU your personality's okay
but you're unattractive who'd give you a chance You're fat you're meaty you're
fat you're fat you're **FAT FAT FAT FAT FAT** I don't love you.

I lost my initial drive to diet and lose weight after a while, but now the hurt which I used to feel on occasion became a constant factor in my life, and it was fed by these voices. Always in the background, yet slowly but surely forging their way forward: inferiority. Those little jibes and insults. The public humiliation my massive body induced. The heart-pain and disappointment I experienced because of it. The constant physical and visual reminder that I was not at all laudable. From people I cared about, people who's opinions I cared about. I didn't fit the beautiful mould. I wanted to prove that I could. That the rest of the world was wrong, and they couldn't shut me out forever.

And these voices fed my problems with eating, and my problems with myself. It's incredibly difficult to try and produce a logical and coherent account of what I thought, what I felt. There wasn't much logic to it. Only a progressive and intensifying hatred for myself, an exponential growth of dissatisfaction and disillusionment that wasn't there when I first started dieting, wasn't there when I first started making myself bring up my food. It started when I tried to compensate for the hurt.

I lost a lot of weight, but I wasn't happy. I felt worse. Sometimes, there'd be brief satisfaction at the fact that I was in 'control' of my eating habits – for example, when I'd go a whole week at hostel with hardly eating. But this feeling was incredibly short-lived. At hostel it was easy to avoid food: when I was faced with food again, I became anxious, and didn't know how to react. As was the case when I came home. When my parents weren't watching me eat, I'd binge, only to be met with that familiar and *overwhelming* sense of guilt thereafter. So I'd throw up, and then eat again, and throw up, and eat again – again and again and again until I couldn't anymore. My parents worked all day so I could spend an entire day just eating and throwing up and feeling so sick afterwards but somehow I was never worried about the sickness, the feeling ill, the sore throat, the raw nose that throwing up causes. I shut off from

my body, food was a commodity, something that I had to put in, something that I had to get out.

The worst was when the food didn't come back up. Then guilt was replaced by hate and a sense of complete and utter helplessness. Which happened often. And I felt these feelings fitting – I deserved to be punished. Fatfatfatfatfailure I deserved to be punished. I shouldn't have eaten so much. I shouldn't.

I withdrew from my friends, I felt they were all betrayers and not to be trusted. They didn't accept the fact that I wasn't eating, they didn't accept the vomiting, but what did they know anyway? I couldn't talk to my parents, my mother was judgemental and my dad was just my dad. I shrank away from my teachers, I felt like they all could see through me, see what a failure I was. I honestly thought that nobody liked me – how *could* they? The older girls spoke, watched me, whispered. I'd go to school then come back and sleep because I had no energy. Eat fruit for supper, study hard, go back to sleep by 9 pm. I faltered on, confused and hurting and sixteen, spending most of my time and the little energy I had convincing myself and everyone else that there was nothing wrong, despite the fact that there was no denying I was changing. Had changed. Until my mother caught me throwing up in the bathroom at home for the umpteenth time and sent me to Joan.

My first session with her was absolutely dreaded. My mother told me Joan was a pastoral therapist. At the thought of religion I felt my courage dwindle. It had done nothing for me yet. Why should it now? I began to dread my session even more. I didn't talk to my mother at all on the way there, a half hour drive from my house, and she dropped me off and I went into the little patio room on my own. Joan smiled at me and invited me to sit down. I felt uncomfortable. I didn't know where to look. She asked me how did I feel. I didn't know, I was confused. It felt as though I was on display. I didn't need to be there. Want, need, they both seemed the same thing.

Joan wanted to hear about me, how she could be there for me. I told her about the problems I had with the other girls in the boarding school; not about my problems with food. She asked me about my eating patterns, I immediately defended myself. She told me my mother had

brought me here because she loves me and is concerned. I told her I know she says that, but she doesn't have to be. I am not to be concerned about by her. I am my own responsibility. She does a lot of nodding. Not as much writing as the psychologists do on TV. She called my mother in. She told us both that there was a problem, perhaps an eating disorder, she was concerned and she would like to meet me again. My mother was crying, I was crying. Who knows what for. It was emotional. We said okay, made an appointment, and left. I felt tired. I went to sleep. I wanted a new body. I wanted a new life. I didn't like who I had become and I was just... really tired.

Life went on as it so often does, I threw myself into school work, tried my best to be human with my new boyfriend, avoided my friends, whose erratic behaviour I'd attributed to jealousy and possessiveness. Sometimes I had confidence, but it stemmed more from the promise of what I will become if I carry on as I am, than from self-liking and acceptance. What was self-acceptance anyway? Being okay with your flaws and imperfections? I couldn't do that. I wanted to mean something. Go far. Find things. Self-acceptance would make me self-indulgent. Ordinary. Fat.

I cried, so often, for no reason, bombarded with overt emotionality. This was odd, uncharacteristic, as I was not a habitual crier. I had friendship problems – my other friends couldn't understand why I'd only speak to Joanna about things. I couldn't explain, so I shut everyone out. It was a secret, it is my secret, and I had to hide it from anyone who threatened the eventual outcome. The eventual outcome was not completely clear, but I knew it involved a sort of happiness. Potential. Or at least I thought it did.

People continued to give me funny looks at school. I felt as though everyone was speaking of me behind my back, and everyone wanted to know my secret. My paranoia became worse as I found out one of my old, good friends has told her friends that I throw up. I am furious. I feel betrayed. I feel hurt. These feelings were compounded as I then found out Joanna, my only real confidant, had told people too. I cried again. I was angry, I was upset and I had no one to go to. I couldn't tell my parents, or the boyfriend I had at the time. I didn't trust anyone.

I kept the soreness inside, and tried my best to pocket it away somewhere, tried my best to harden up my heart once more. I struggled. I was ashamed. Embarrassed and humiliated. They'd stolen my secret and my secret was the one thing I didn't want anyone to be able to take away from me. It was the place I could go to, to disappear. It was the place I could go to for some kind of promise, assurance, the only kind I could accept at the moment. The heart was hard, it didn't want human affection. It didn't want human feeling at all. Human meant hunger. Hunger meant food. Food meant fat, and who didn't know what fat meant.

But why, why then was I so distraught at the thought of people knowing I couldn't stomach my food? A tremendous power, force, voice of some sorts within me absolutely, by all means **forbids** me to let anybody know, or let anybody in. People hurt you. You couldn't trust them. Just look at my ex-boyfriend. Look at my parents. Look at my friends.

I didn't want to go to my therapy sessions. I tried my best to persuade my mother not to make me go. My father put his foot down, there was more screaming and fighting and name calling and I retreated into my bedroom to fall on my bed and cry like a little girl. Why couldn't they just understand? My father came in, sat next to my sobbing, curled up body, and asked: 'My girl, what's happened to you?'

I couldn't breathe. I was crying too much.

'Nothing,' I manage to splutter out. 'Nothing'

Just his being there made me cry more. I wanted him to leave!

'It's not normal for people to be sick all the time.'

I didn't reply, and he put his arms around my shoulders and hugged me tightly. The last time he did that I was a little girl. I felt familiarity, I felt security, I felt trust and care and concern in his arms. I couldn't talk, still couldn't really breathe – my nose was completely blocked from crying. 'You need to go see this woman tomorrow,' he told me, and I knew he was right. I didn't want to know that he was right, but I did, I could feel his honesty in his hug. He let me go, looked at me before he got up. Told me something I'll never forget.

'You know you'll always be my daughter, and I will always love you. And whatever you're going through we can get through it together. But then you can't shut me out.'

I wished things were that simple.

And so I went back to Joan. We unpacked everything and yes, the problem was the eating disorder. How did I feel about the thought, was there stigma?

I felt accosted. I was annoyed at the 'stigma' because I wasn't a hormonal little girl who didn't eat to get attention. I wasn't the freak they interviewed on 3rd Degree who is petrified of carbohydrates. I was just... I didn't really know what I was, but I knew that was not me. I knew with all my heart that wasn't me. I couldn't yet see the division, but I would come to that later. I didn't know that then.

I didn't like the stigma. Why not? It wasn't true.

It immediately created a preconception about me and I didn't wish to be stereotyped. Because I'm not mentally disturbed.

Joan didn't treat me like a circus animal. I have a heart, I have a *beating* heart and it bleeds and bruises and *feels*. It wants to feel wanted and it wants to feel needed and it wants to feel beautiful. It belongs to a life and a person and a body, yet, somewhere along the way, all these aspects became confused. Does that make me crazy? I certainly didn't think so. Could it be reduced to a name, a label? I didn't think so. She acknowledged that I had **feelings**. That my feelings couldn't be encrypted in a diagnosis. Let me know that she cared about **what** my feelings **were**.

My feelings. Someone was asking about my **feelings**. Not about how much I was eating or when or why. Not what are you, or who are you. Just: *How Are You*.

And I could deal with that. Finally, there was something I could deal with.

And I was blown away. Silent.

'I want to know your feelings Heidi'. 'I want to hear you'.

There was something about her. What was it? I really believed her. Believed she was interested, even though my mother was paying her to speak to me. But I felt confused.

Entirely confused, because my head tried to rationalise things but it couldn't. I couldn't understand why not. I couldn't explain myself properly even though I tried. Yet there was nothing wrong with my head – Joan reassured me that there was nothing wrong with it. My heart was the problem.

As she spoke to me, my exterior started to lose its footing and I was mildly alarmed. I wanted to cry again, I felt naked, like a little girl. Self-conscious. Fat. Yet she wasn't encroaching on the secret, my secret. She was just asking about my heart!

My heart. What was that again? I'd seemed to have temporarily forgotten but I knew what my heart was. That strange thing inside my chest that beats blood around my body and had this annoying habit of breaking. Consistently . Like waves.

Oh, my heart.....

What was my view on spirituality, on religion?

Was this an intervention about being 'saved'? I would be inclined to shut off although I didn't *not* believe. But my family wasn't stout. Religiously. My mother's bitter, because life's been hard to her, my father's quiet: neither gave me much guidance. I did believe though. It was just hard sometimes to be a good person. I wouldn't consider myself a good person.

Joan told me that perhaps it's not about being a good person. It's not about going to church. It was about discovering myself. We didn't really get to what it was about in one fell swoop. It was a long journey, the experience of discovering myself, who I wanted to be and can be. I was invited to start a journal, write in it anything I chose – quotes, memories, events, whatever I felt like. The idea was that we could also discuss my journal writing in order to get closer to what I felt and experienced. I was advised to try and take a stand against the 'eating disorder'. To try and personify it, give it a name, treat it as an external entity. It was a bit much for me to grasp, but I vaguely comprehended. Kind of like 'don't hate the sinner, hate

the sin', but don't hate yourself, hate the 'eating disorder'. I had never thought of things in such a way before. How can something you do not be a part of you? There was something appealing about it. Perhaps I was not so awful after all. Perhaps the self-induced nausea wasn't so self-induced? Perhaps I wasn't in control. I knew I wasn't in control. I decided to try the journal thing.

The book of Heidi

I'm so desperately (is that the word?) no, constantly, striving towards something, but I really don't know what. I am beginning to define what I truly care for, what I truly believe and stand for, not what this silly little voice in my head tells me.

Woke up again as I do every morning. I feel a distinct ball of stress deep in the pit of my stomach, but I struggle to experience it in its entirety. I know that I can't measure success on worldly activities I partake in. But it would sure be nice to do well.

My eyes are swollen and would like to close but don't. I'm anxious, but not restless. Not indecisive.

I can do anything as long as

Someone's holding my hand

I was 53kg by then. I was weak. I wasn't dying, but I think it's worse. I was a mess inside. A mess. And I wasn't getting prettier. Why was I not getting prettier?

The book of Heidi

Life wasn't so understanding. Nothing stopped, nothing understood, it was pressure. I was hurting but there was pressure and no-one understood because I couldn't really tell them now could I. I didn't get a special get-out-of-life-card for seeking therapy.

I sat in the bathroom between classes, just to get away, be alone for a second, cry on my own with no-one watching. Those two-minute moments were my sanctuaries. I felt like the world was a monster, everyone was standing with fingers pointing at me, reprimanding. Condescending. Anorexic bitch. Pull yourself together. And it seems like such a dark and pathetic little dreadful existence, but it is. There's no other way to tell it. I'm not a glutton for punishment. No kicks here, just hurting. And I wish I could express how pure and innocent and naïve this hurt is – I might not be a five-year-old who doesn't know any better, but I'm a sixteen-year-old who's sitting with this complete and utter hate for myself and an innate desire to become something great – acceptable, beautiful. That's it. That's all of it.

I only saw Joan every now and then, and it was hard for me to see her, because of my being in boarding school and her practice being rather far from my home. Not to mention that every time I did I was faced with all the things I spent every day of my life avoiding and attempting to stuff under covers. Yet I always felt better after I'd seen her. I always dreaded it, but I always felt better afterwards.

Keeping a journal was harder than I thought it would be. I struggled immensely to put my feelings into words, the things I produced all seemed so pathetic, and nothing made much sense. It was haphazard anger and aspiration interspersed with profanity and cynicism. And the possibility of my journal writing to be shared, obviously restricted me a bit. I wasn't being honest to myself, I was enlightening someone else. And I didn't really *want* to.

The book of Heidi

Heidi felt forlorn this day. She felt unworthy and misfitted, and reminded of her past that she still is sensitive, even though she makes as if she doesn't care. Heidi has been looking in the mirror and accepting the image staring back. But now, she has been thrown into a spot-light, she is not even sure she wants, and with that comes criticism – she knows she isn't as model-perfect as the others. But she still feels scratched when people point out her flaws; and no-one elses.

You see, Heidi cannot really take any criticism at all, and this is her weakness. She takes criticism, stabs it like a stake in her heart and allows it to form its

very own voice in her subconscious. She can't help it, she wants to be flawless.

However, it made me feel slightly better though, knowing that somebody *wanted* to be enlightened as to how I was feeling. Made me feel as though I mattered.

I wished so many times that there was someone who could just *read* my thoughts. Know my deepest desires, feel what I felt. I felt isolated, and I felt alone.

Then spirituality came in.

Without painting me full of crosses or hitting me with a Bible, Joan taught me that I didn't have to feel the way I did. I didn't have to feel cut off and inaccessible, I didn't have to feel confused and hopeless and failing.

That there is something bigger than me, something stronger than me, and by implication too, something stronger than the ties that kept my heart in such bondage. There are ways to get back in touch with myself. Ways of getting to know myself again, associate with myself again. It was my thinking that made me confused, more wrapped up in myself, more tangled. I needed to try and spend more time with people. To go for coffee, to spend time with my parents, to read more, even just get outside. Made a concerted effort to notice things – notice nature, notice seasons changing, notice the weather. Feel the wind, smell fresh air, taste. Touch. Take long baths. Pamper myself – take pride in myself, even if it was only superficially and with creams. And getting outside of myself helped me tolerate myself more, unlike those times when it was only me, when I was forced to think and mull and hurt. Because the more wrapped up in myself I became the harder it was to connect to 'the more' that there was to life. That there were people doing things, wanting me to become involved, that the world was not shutting me out - *you're excluding yourself from the world*. Because I love reading, Joan suggested I read Kahlil Gibran's *The Prophet*.

The book of Heidi

The Prophet is one of the most inspiring books I've ever read. That a book so old could still be so, so relevant. Within its pages lie promises and advice that my parched soul found overwhelmingly soothing. When trapped by an eating disorder, you refuse to reach out, to read things, to consider any other perspectives / perceptions other than the warped one you have of yourself.

I was unfamiliar with the Bible in the beginning of my healing stages and The Prophet held then the same comfort the Bible holds for me now. The reminder that there is another way of living outside of your confusion, a promising, prosperous, Happy and carefree life that can be lead by feeling differently. By working and loving and giving and doing in such ways that you can't feel guilty or hate yourself. That self-worth can actually be encouraged – even considered a necessity! A contrast to an anorexic state of mind. IT HELD HOPE !

By treating me not as a patient, but as a person – as a friend – she gained my trust and I valued what she had to say. Just as I don't know what sparked the drive of my eating restrictions, I don't know what made me decide to follow her advice. It was just another choice – hope and prosperity. Or confusion and haplessness. I managed to make this decision at a relatively early stage of my therapy sessions, but only four years later, can I **honestly** say I that I've chosen hope and prosperity. I've seen: healing is an ongoing process.

The Book of Heidi

Positivity isn't a constant thing. I also get annoyed, still get frustrated, still lose my temper – it's part of being human. But the difference is, I make a concerted effort to overcome my listlessness, and I feel so much better for itSometimes though, the old me will come back, with these ideas of failure and hate and dissatisfaction. With big smiles flecked with muddy tears and

hugs of insecurity. I know them all too well, which makes it all the easier to tell them to leave me alone!

I ended up getting to know myself better through the journals – they helped me so much, they gave me an outlet, a place to voice the dark thoughts that crept through my mind and help me to see how conflicted I really was. It was possible that not everything was my fault. That I had weaknesses – I felt inferior, I felt damaged – was damaged – but that those weren't my fault. I didn't have to blame myself, I didn't have to detest myself. I really wasn't all that bad.

But it really wasn't easy. I couldn't spend my whole day with other people, I *had* to spend time with myself. And the more time I spent with myself the more I didn't want to leave my little self-absorbed cage, the more scared I became of the world again, the more suspicious and secretive and defensive, and it was a vicious, vicious cycle. If other people were talking to me, they drowned out the voices. But the moment I took time to sit, to be still, the voices came to fester – so much so that even when I was spending time 'outside' myself, they'd overpower. So Joan and I worked hard to drown them out. And I couldn't do this on my own, even with Joan's help. In order to heal my spirit I needed to feed it and I chose to do so with Christianity.

My parents are confirmed Methodists, and I myself was christened, but that's about where the line is drawn. I attended a primarily Christian-based high school, and most of my friends were Christian, but none of these factors ever influenced me much. Religion seemed to me to be a matter which had mostly to do with where people go when they die. Never a means of helping you to live while you're still breathing. Because you can breathe, and not be alive.

But I *needed* to believe in something higher. Stuck at the level I was in, the only thing I managed to accomplish was self-degradation. And I tried and tried and tried to love myself but it didn't work. I tried to hug and hold my heart but that didn't bring comfort, did not console.

One day with Joan, a metaphor spoke to me. Joan told me that some sufferers of eating disorders referred to the voices, the external will and pressure and force to comply to strict

rules of self-hatred and rigidity as evil, as darkness, as harm. It all made sense. I came to figure it out. I had to find for myself purpose and meaning and in doing that I had to find God, only He could be the combatant of what I was going through, self-hatred and severe dislike of myself. And it said in the Bible that no matter what happened to you, how deep you are in any ocean or high up in the sky, nothing – *nothing* – could ever separate you from the love of God. And this made me feel hopeful. It made me feel safe, soothed, relieved even. And I fell in love with the idea of having someone or something in my life that promised not to let me down, that had been believed in by millions for centuries, that claimed it could love *me* and heal *me* and protect me unconditionally. *Because that's what I craved so dearly.* And if these promises could be trusted, I was willing to latch on to them.

I started talking to God about things, connecting in that way, reading my Bible when I felt sad. I took up my parents' offers of support and tried my best to speak more openly about my sickness. My problem. I carried on with my journals. And eventually the intense feelings of hurt and constriction began to subside. They never went away, not totally, but they were overcome. I do not think that they ever totally disappear.

But by connecting to something bigger than myself, by trusting something bigger than myself, I managed to feed my soul, my spirit. The very thing that was running on empty and causing me such heartache and sorrow. I found a Comforter, a source of hope and inspiration, and I think for every person this source is different. Just as the hurt is different. But I looked at the ideas of Jesus and God and I could relate to what was preached. The concepts *appealed* to me – how could I hate myself if something massively influential and powerful, a so-called creator of every single living thing, made me and loves me? If I was designed especially the way I am, if I was blueprinted to be the person I was, surely there had to be something meaningful – purposeful – and *beautiful* about me?

The book of Heidi

I see that now there is still a voice, and I know where it is too. It's embedded in the lining of my brain, and it's this voice that has hated me for the past two years. Still hates me, and still tries to manipulate every situation in my life into

getting me to hate myself too. But I won't. How can I, when God loves me SO MUCH. Yes, I feel small and insignificant, but is that not perhaps merely because God is so great, and I've been living past Him? Just a reminder of who is really in contact.

I can't look after myself and I'm silly to think I can. God made me, God sustains meI'm just the puppet and He as the puppet master knows how to let me perform the most beautiful dances. Yet, he can't play me if I'm stiff and resisting His heartstrings.

How could I choose darkness and self-violation when there was an alternative of life?

How could I hurt myself, starve myself, use my body to inflict and impose discomfort upon myself when it was its own temple? A living place of veneration and worship?

I found One voice that managed to still all the others.

It was this hope and belief in prospects that helped me climb out of the tunnel I'd believed for so long I'd dug for myself; but had actually been chucked into.

The book of Heidi

There is no greater inner peace than that experienced after reading a piece from the Bible you have related to, a piece that has spoken to you, made you feel better. What strength does a little voice in your mind have over the Creator of mankind? None.

My life has changed – I feel it every day. I notice beauty – in streetlights, in stars, in flower buds. I work readily and am less burdened. I ask less questions – because, somehow, I feel deep inside me they are already answered (questions about life). I feel I have purpose. FINALLY I have purpose. And it doesn't matter what that purpose is – it just matters that its there.

It is difficult for me for the most partI can't speak to my parents about spirituality, they don't even own Bibles. But on the other hand its okay – its my own life that I have to live, and so it makes sense that for a great part, my spirituality has to be developed within me first, before it can be either touched or spread to other people. I think they can see a difference in me. They will never condemn me for being religious, and 'its' not that they don't believe, they're just very private.

It' s irrelevant though.....

God lives, He loves me, I am LIVING again and

I am so, so thankful !

I may not be the poster board for Christianity – in fact, I am sure I'm not. But: I can attest to having felt rejuvenation. To having felt the healing and curative power of an entity larger than myself, of seeing words of truth in a Bible that guided me through some of my most turbulent moments. Moments when I felt as though I was never going to feel normal, as though I'd forever be a pitiful girl who battled with eating – life's most natural practice.

Discovering the fact that I had an eating disorder, unpacking all of the aspects it entailed and coming to grips with what was happening and what I felt was the easy part. Establishing a personal relationship with something higher than myself was more difficult, but once I had, my symptoms decreased. I stopped throwing up as much, I stopped worrying so intensely about food. I still worried. But it was a different *kind* of worry - a tolerable worry.

A controllable worry.

A *containable* worry.

A worry that became smaller and smaller with each passing year thereafter, and a worry that is now,

finally,

gone.

The book of Heidi

It's so easy to write a whole lot of words and sound impressive, but there are
no words for that quiet moment –

When I'm peaceful and complacent and at rest

WHEN I'M OKAY

When everything that doesn't add up doesn't mean a thing

In the light of eternity, your worry is irrelevant

CHAPTER SEVEN

THE PARTICIPANTS REFLECT ON THEIR JOURNEY

7.1 INTRODUCTION

In this chapter, I stage the journey of recovery by means of first-person narrative accounts which provide testimony to the healing which took place in the context of anorexia/bulimia. Moreover, these accounts reveal the inherent strength of the participants in facing and challenging the demands of anorexia/bulimia, in a journey characterized by a renewed sense of hope and purpose as they grew beyond the limits of the illness to reclaim their lives. Their narrative accounts indicate a progression of individual spiritual growth as they journey towards healing, which makes available an enriched knowledge base to guide innovation in theory and practice.

7.2 RE-STORYING ANOREXIA/BULIMIA: LEARNING FROM FIRST-PERSON HEALING NARRATIVES

People tell stories to re-affirm the possibility of creating, and the possibility of redirecting the relationships about and within which the story is told, so that each narrative has many turns. Each narrative has value in a particular way, which is respectful to the purposes of the story. Stories are not told outside relationship – stories as acts of telling *are* relationships (Frank 2000:354).

In Chapters Five and Six, the participants offered their stories. It is true that these stories were part of the therapeutic journey, so that these stories stood in a particular relation to their purpose at the time. The stories were also the experiences of narrative therapy that provided the basis for our connection with each other. Through our discussions, the participants were able to change their relationships with anorexia/bulimia and the voices that were troubling to them. This opened up space for them to break free from the ‘prison house’ of isolation created by the discourses of anorexia/bulimia. The texts for the initial stories (see Chapters Five and Six) were created two to three years ago. In the meantime, we have maintained ongoing contact. I became a witness to the changes that took place in their lives, with them getting stronger, changes that often left me silenced and awed.

Very much aware of how medical and societal discourses still silence the 'lay' experience of anorexia/bulimia by reducing it to the story of diagnosis, I joined Frank (2000:36) in wondering: '[H]ow would the world look different if seen from the perspective of the other, the disempowered, the often silenced?'. Narrative self-knowledge and narrative self-revelation by a client are inherently the only valid and authentic modes of knowing or interpretation. A new journey had begun, with the participants providing their reflections as a means of reconnecting to their previously re-authored stories, further enhancing the self and shaping other, even more powerful, ways of being in the world. The re-authored story became the vehicle through which the participants were challenged to broaden or change the stories they have now come to live by.

To go back to what I mentioned earlier, namely that stories have a storytelling relation, the reflections offered by the participants now also stood in a different relation (Frank 2000:354). Our intention was clear. These were new stories about connecting with others engaged in similar projects. Our reason for doing so was to share the extent to which the participants lives had changed, and how the experiences we shared could continue to broaden discussions concerning anorexia/bulimia. As long as society continues to neglect the spiritual and existential realities of anorexia/bulimia, as long as the emotions and experiences of those people suffering from the illness are not taken seriously because those individuals are diagnosed as mentally ill – the riches housed in alternative perceptions will remain 'underground' and 'unmined', with stigmatization leaving those struggling with the illness to suffer alone as they desperately attempt to negotiate new ground (Pinks 2003:458; Ridgway 2001:338).

In offering their reflections on the journey, the participants took the opportunity to speak openly about their experiences of living with anorexia/bulimia, and the brave strategies they employed to stand firm against the demands of the illness. I salute the courage and strength it required of them. No longer burdened by diagnosis, no longer tormented by voices, with anorexia/bulimia 'dethroned', and they themselves de-stigmatized, they have entered new depths of meaning underlying these acts of courage and strength, allowing their readers connection with and insight into the unique journeys they embarked upon. Above all, the participants wanted to be heard, they wanted to find others who would answer their story's call in relationship (Frank 2000:355). They sought to create a 'hybrid discourse' in which their stories address those living a life without hope, but also practising clinicians and academics. Through their reflections, the participants create a powerful community of listeners, a representation of their purposes and intentions. Hence, the participants offer their reflections

with the intention of encouraging their readers to think less about the stories and more *with* the stories, in order to expand the community called into being by the stories, creating improved understanding and care in the context of anorexia/bulimia.

7.3 THE PARTICIPANTS' REFLECTIONS: MY OWN POSITIONING

Research stories are more than data analysis (Frank 2000:361). The reflections offered by the participants' provide a unique biographical experience, a spiritual unfolding of the self wherein a life history of each is presented. Rosenthal (2003:922,927) believes that if we are able to support biographies and their narrations without posing additional questions, many memories surface easily for the storyteller, providing continuity to the biography with the narration becoming more detailed.

Within this context, I felt there was no place for analysing of the participants' reflections. Instead, I felt almost compelled to step back from their first-person testimonies to allow those who testified to speak for themselves, as Frank (2000:361) recommends. In this case, I also believe that '[b]iographical narration becomes biographical self-presentation', as Rosenthal (2003:918) puts it. This means that the participants, in offering their reflections, set out to share their stories with interested others, with the intention of building relationships. Whatever the value of analysis, there is always a risk of misunderstanding when a text is deconstructed for analysis. The risk is related to the reason for the participants' offering of their reflections in the first place – the engagement in relationship-building: analysis may misinterpret this relationship. Hence, the main narration is at no time interrupted by questions from the interviewer, or comments by the researcher. Instead, words are allowed to give meaning and expression to the stories (Rosenthal (2003:918). Inviting the participants to take centre stage provided life and continuity to their stories.

7.4 TRAVELLING WITH THE PARTICIPANTS: A MAP FOR THE JOURNEY

The texture of illness stories is intense and is often difficult to actualize. A storyteller can only invite those who are interested to travel together for the duration of the journey. Those who accept this invitation into the reality the story offers also open themselves to seeing, feeling and hearing life differently, to experience things with which they are unfamiliar. Whether the story makes analytical sense or not is unimportant: the significance of the story is whether it encourages a thinking *with* the story, invoking and evoking experiential experiences, with meaning becoming embodied. Meaning that is not embodied remains only an empty

possibility (Hermans 2002:231). In the sections below, I provide a map within the framework of the research objectives which details the journey as reflected on by the participants in their search for healing.

7.4.1 Investigating the relationship between mental health, physical and spiritual health

The participants tell of lives affected by a medical diagnosis and how they came to live the reality prescribed by that diagnosis, 'other' and not fit to participate in normal society. All three experienced the stigmatization attached to anorexia/bulimia, something which left them alone and fearful in their struggle to make sense of what was happening to them.

However, the participants also indicate that what they needed most was someone willing to listen to them, someone who would believe them and was willing to try to understand what was real for them. This not only highlights the absolute necessity for the client's illness narrative to be told by her, but also the argument that this story can only be told from a position of safety and security, in a context where she feels understood, no matter how chaotic her narrative may sound.

The participants' suffering was clearly not 'just' physical. *The* issue concerning food and body weight did not make sense, because it did not belong in their horizon of experience. The diagnosis of mental illness remained far removed from what they felt physically and spiritually. Given the current treatment approaches which seek to heal the bodies of those struggling with anorexia/bulimia in an identical way, the participants' reflections emphasise how these approaches limit options, with the mistaken assumption that healing means a *physical* change for the better.

Accordingly, they question treatment approaches which rely on force-feeding and rigid control of the body, because they experience these practices as humiliating and devoid of ethical morality. In a world dominated by suggestive voices, leaving them disempowered and hopeless, they perceive their struggle as a spiritual one. Healing means not only a body free from the tyranny of voices and injury, but a sense of forgiveness, belonging and caring.

7.4.2 Exploring the roles of discourse, power and knowledge in structuring spirituality

Although social discourses contributed to the participants' positioning, it appears that healing from within went hand in hand with coming to love and accept the self. Moreover, the participants' stories indicate that the healing journey was connected to the idea that they could have a more powerful story to tell about themselves, that there was life outside the framework created for them by anorexia/bulimia and the medical diagnosis. It called for a willingness to want to get better in order to take control of and be responsible for their own lives.

However, judging by their stories, the healing journey proved difficult. Healing only began when the participants came to realize they could no longer be actively involved in acts which were injurious to the body. Their vulnerability was born in difficulties in the area of discernment – difficulties in distinguishing the abuse from nurture, and neglect from care (White 1995:93). The difficulty was in having to give up the reality they had come to know for so long that, in fact, it was difficult to imagine a life without the voices. The voices provided their own perverse sense of security, whilst forgoing food, and acts of self-mutilation, also served to give meaning to their lives. Eventually they had to face the consequences of their relationship with anorexia/bulimia. They confess that they found it extremely difficult, a matter of staying committed to what they really desired for their lives.

7.4.3 Encouraging the re-negotiation of the client's relationship with the eating disorder: re-authoring narratives of limitation

Despite all efforts to thwart the voices, taking on the journey did not mean that the participants' would not be subject to relapses – they needed to revise their relationship with these voices.

Challenging the discourse of anorexia/bulimia meant that the participants had to arrive at a greater understanding of the tactics and strategies whereby its power was defined. Situations of sadness or vulnerability, or being in the wrong company, gave anorexia/bulimia a foot in the door. Moreover, to cope in times of relapse, they had to learn new strategies for dealing with their setbacks, without judging or blaming the self. It required them to stand firm, to gather the resolve to start again, until the times of relapse became less frequent. Identifying and adopting these ideas and practices, the participants found themselves in a stronger

position to resist the demand of the voices. By so doing, they reclaimed their own voices in overcoming the power of anorexia/bulimia. With the voices of illness now subjugated, space was created which provided new opportunities for living.

Having created the space to explore other ways of being in the world, the participants were able to reduce much stress in their lives, as well as to become stronger in standing against future relapses. They became very appreciative of the little steps they took to make their lives worthwhile again, reminding themselves how good it was to live almost without voices. These little big steps provided them with 'power to the journey' (White 2004:203-213).

7.4.4 Establishing connection with the larger meaning and purpose of our lives

Revisioning the participants' relationship with troublesome voices and the demands of anorexia/bulimia, the stories indicate how the participants stepped into an experience of life they could never have envisioned. This went hand in hand with an exploration of the uniqueness of their own spirituality. This in turn led them to develop new insight into their relationship with God and their own existence. God became the Power bigger than anorexia/bulimia, changing the feelings of hopelessness they had harboured previously. This change in attitude made the greatest healing possible, where healing stemmed as much from a changed perception as from a changed body. At the same time, they were continually challenged to really see and experience nature and others around them. Acceptance of the self made them feel comfortable in the company of friends and family; they no longer felt excluded or 'other'. Having opened themselves to accepting the gift of participation, their stories serve to testify to lives empowered, healed from within, reaching into the circle of life outside the self, as no healing can take place in isolation, only with the 'other'.

The reflections on healing staged by the three participants are now presented on the centre stage. (Their words appear *verbatim*, and are printed in italics in order to make their stories more easily distinguishable from my writing.)

7.5 MARE-LEE'S REFLECTIONS ON HEALING

'It is not about food. It's about connecting the dots...mind, body and spirit.'

7.5.1 Introduction

Having developed and lived with an eating disorder, I would have loved to name my story 'A Long Walk to Freedom',⁷ because that is what the journey entailed. A long road, rough and marked with setbacks, but culminating in a life-changing journey. I too found FREEDOM! Having lived 'inside' the illness, I fully appreciate how difficult it must be for 'outsiders' to contemplate the anxiety experienced by those suffering from anorexia.

7.5.2 A puppet on a string

The story of my journey began in 2002. I do not know what caused anorexia to enter my life, I do not have the answer; perhaps I was not ready for the adult world. In an earlier discussion [see Chapter Six], I shared my experiences moving from a farm school to a high school in the city. All in all I remember it as a time of transition, I was entering adolescence and called on to face the changes of growing up, facing the challenge of establishing my own self or identity. My world and everything familiar to me changed almost overnight, opening the door for anorexia to enter my life.

I am not able to remember much, only that I suffered long periods of confusion; I did not understand what was happening to me. And so the torture of anorexia, a dark hole of nothingness, with myself becoming a 'Puppet on a String'. Deep down I knew something was wrong, but what? I could not tell what exactly it was I felt, what I was fearful of, yet I felt compelled, almost obsessed to maintain control. I was also a perfectionist. I was living a nightmare, as if in a maze and had to figure a way of getting out. I took many roads and shortcuts, but there was no exit.

While suffering this indescribable illness, my spirit died more each day and I ended up living by the guidance of his voice. Best explained: I had a GPS. Just like the real one, with an irritating, sharp voice, taking me on detours. 'He' made sure that 'he' knew everything about me, 'it' read my mind and convinced me to let go of my own spirit in order to join his. People may ask 'so why listen to his voice?' I could not see it then, neither did I have the insight to understand it all.

⁷ This a reference to Nelson Mandela's autobiography by that name.

As I tried to negotiate the swamp, the voice fed me with lies about my own self, made me believe and see things that were not real. This was easy as I was unsure of my own self, my spirit broken, I had to find another. Anorexia became my confidant, his voice in my head always very convincing when I was too scared to go on. This voice provided the shortcut I began to know.

7.5.3 Medical diagnosis – helpful or a liability?

Eventually things got to the point where I was not able to cope anymore. Everything around me was grey and senseless, I was no longer able to see anything clearly, not able to feel or smell. It was into this dull, grey world of nothingness I isolated myself from everything around me with my body reflecting what was going on in my spirit. Everybody saw this except me, I was blindfolded, I could not see how thin my body was getting. I had to inform my mother. We were off to the psychologist and so began my experience with the mental health system and diagnosis, experiences that were not particularly positive. People struggling with an eating disorder get no sympathy; not like if you had cancer; instead people look down on you, you chose it, you wanted it!

No-one explained mental illness to me or my mother and I did not find the assistance I got sympathetic or helpful. The psychologist bombarded me with questions about my diet and relationship with food. I felt a storm erupting inside me. What was it about food? I could not see the connection. All I wanted him to do was to help me account for the changes in me.

After having answered what felt like a million questions I was sent off to see two more doctors. The first took blood samples whilst looking at me with eyes which spelled out ‘just get over your issues’, whilst the other one only stared me up and down, shook his head with a sarcastic smile on his face for the duration of the conversation. No words of comfort or any sign that they at least tried to understand what was going on inside me. Was I responsible for my condition? They certainly gave me that impression!

And so I was diagnosed, what now, where to from here? Rather, the diagnosis was outside me as if it did not quite fit, as if it was meant for someone else. I did not know what the diagnosis meant, I did not know how I got there in the first

place. I was stuck with something I did not want and the thought that the people I was relying on for help did not connect to my feelings left me with indescribable fear, feelings of isolation and loneliness. All that stayed with me was the cold, angry eyes and sarcastic smiles. In my mind there was no hope for my problem.

In some ways it felt like the beginning of something, as I now at least had a diagnosis for my condition, and yet the diagnosis left me fearful, as if I had come to the end of my life. If only they could give me medicine, I wished for an overnight cure. It did not happen. I wanted to escape the eyes of people who did not have a clue what I was going through. I felt like an alien, weird and as if no one understood me. I wanted to get away to a place where someone could tell me that everything was going to be okay and where I could find love and some kind of understanding. It was a long, tough road and it was scary, there were many days when I wanted to take my life, I wanted to end the torture, I just wanted to give in to the controlling voice that stole my identity.

7.5.4 Journeying towards healing

It was when I left the city and the hostel to attend a school closer to my home that my journey of healing began. After a period of despair following the psychiatric diagnosis and the negative stereotypes that accompany diagnosis, I found my hope renewed when I began to see Joan as my new therapist. Looking back, I am so grateful that I had her to assist me during this very difficult time of my life, particularly because she made me understand that anorexia should not be the main focus, rather what was happening deep down inside me. I still regard this spark of hope as grace coming into my life, making it possible for me to regain control over my life and become independent of anorexia. Having come to believe my condition to be inexplicable and hopeless, my own healing was set in motion because Joan was willing to listen, willing to connect to what I was feeling. She was wanting to hear and learn more about anorexia in order for 'US' to overcome it! It was the way in which she made herself present, the way she used her voice, often coming to sit with me and holding my hands.

I am not even sure how healing happened, but I remember the process as stages that were not clear-cut. Best described as a journey, I would move forward but oftentimes fell back again. It was a journey about re-discovering myself, that I

was unique, that there was much more inside me that others could not see, that I had the power to fight anorexia's 'say' in my life. I had a life but I was not living fully. There was a life outside the framework of anorexia if I was willing to participate and become part of life again. I could be someone else, someone I wanted to be. Briefly, it was about discovering that there was a 'self' that was not being looked after and not given the time and attention to 'be'. What I came to regard as an eye-opening experience was woven into new ways of 'seeing' and 'being', making it possible to reclaim a meaningful life again.

For the first time I felt the focus was on me, not on anorexia. Instead of him getting all the attention, his title was taken away, and time, and help and love was given to me. For such a long time he had the upper hand, it was difficult to think that things could ever change back to normal again. I can only say that I recall the process as a time where it became essential to 'fight' in order to hear my voice, not that of anorexia. What was empowering was that I was attracted to the idea that my life could be different, that there was still a 'me' who wanted to live, wanted to have my own say over who I am, where I go and what I do.

7.5.5 Coming to understand wholeness: connecting the dots – mind, body and spirit

I always felt as if my body and self were separate with no feeling of connectedness. I thought this was the way it was meant to be. I was out of touch with my body, with its needs, was unable to care for my body. I knew my body was there but it was largely absent from my experiences, I was not living through or inside my body. At the same time I did not experience any form of connection with my own self, I did not like myself. I now regard healing as a coming together of that which was missing, a process of connecting the dots; mind, body and spirit. For this to happen I had to re-connect with myself, had to become aware of my physical self. All along, due to anorexia's dominance, I could not see, I couldn't really connect with what anorexia had done to me. Where I was once full of life, what remained was a tiny body, dead eyes and emotionless face.

However, in order to move forward, I had to accept responsibility for the condition in order to make decisions and choices that would ensure my own growth and healing. It called for a shift in my thinking. I had to think differently about anorexia,

about the space given to him. I had to see him as a ruthless enemy, a liar, definitely not a confidant! My heart had to change, it was important to let love into my life again.

7.5.6 Coming to know anorexia's power games

It was during this time, Joan bought me a pocket-size book, When I loved myself enough.⁸ Each page has only a sentence or two, for example, 'When I loved myself enough I came to know my own goodness'. It was small enough to carry with me everywhere; I spent much time reading and re-reading this little book. Something happened for me. It brought positive feelings and thoughts, I thought it must be nice to be able to live like that. It was something positive I could hold onto and reflect on all the time. It was at this time I also put the wrapping of a sweetie in my diary – I had not had any sweets for over a year. Looking at this little wrapper continually gave me a message: 'You are strong enough, you can do it!' If things between my mother and me was not working out (always and only about food), the little book was there to give me hope again, it always gave me advice one way or the other. When I was confronted with difficult situations, I would consult this little book. Even thinking about it now, I treasure the insight and wisdom I gained from it. Small things that brought about huge changes for me and helped me to heal. I realized how easy it was to concentrate only on what I experienced as negative, instead of focusing on all that was positive. Whatever anorexia was and whatever he set out to do, I could take myself away from it, I had other reasons to live. The book helped me to move closer to loving and appreciating the self inside me, it planted the seeds that would grow into healing.

However, despite my new found hope and strength, anorexia wasn't going to give up on me easily, I needed a lot of inspiration and courage to continue this fight. Just as I thought I was making progress, the voices became more demanding, the lies more convincing, often weakening me to the point of wanting to give up. However, giving up the fight would have meant the end, as I had by now also developed an awareness of the power of this illness.

It is difficult to explain to 'outsiders' the real nature of anorexia. He is like a little thing that is alive – he craves for attention and it's all about food. He is childish

⁸ A delightful little book of simple but profound philosophical thoughts and reflections.

and has an attitude. Whenever people would stare at me and talked about my body, he would make sure that I became aware of it! When those suffering from this illness are force-fed, it is in essence anorexia that gets fed and grows stronger, anorexia is getting all the attention! All attention had to be his – when people constantly stared at me or there were issues between myself and my family about food, they did not realize that anorexia was getting all the pampering instead of me! I was seen from the ‘outside’, people did not understand the torment of anorexia. If people asked me about my dogs Oscar and Lucy, if they enquired about my day, I was open to talking with them, I could open myself to the ‘new’. If no-one enquired about the thinness of my body, if no-one asked what I ate, anorexia was not in the spotlight, my mind was occupied with other things. I was not healing because people were not hearing or seeing me.

7.5.7 It’s all about love: The free gift

I knew if I could focus on my own needs, if I could learn to love myself, my body, anorexia would feel neglected. My heart had to change, I had to start feeling differently about myself. Anorexia chooses to be with those people who do not love themselves. If I could love myself enough anorexia would no longer have a place to stay – he would be an unwelcome guest. If I made it unpleasant for a visitor in my house that person is not going to stay. However, if I do everything to make the guest comfortable, he or she may end up staying for months. My decision: do not give anorexia a house any longer, but make it difficult for him to stay! By not giving him a room in my house, I was limiting his power. At the same time caring for my self and my body meant I had to let go of him.

I discovered I could change; I was able to look after myself again. It meant taking time to listen to myself, asking myself what I needed and wanted in order to move forward; treating the self inside me. Healing meant walking away and leaving anorexia behind. This called for a high degree of self-awareness and becoming responsible in many previously neglected areas of my life.

Self-care was found in everything that brought me happiness and satisfaction. I had to be willing to spend time with people, to open myself to everything I valued. It meant looking for things to do, small things that made me feel I was doing something for myself, not for anorexia. My dogs Oscar and Lucy played a huge

part in my healing journey. I would often walk to the dam and sit there with them at my feet. When I was with them I was not thinking about anorexia, nothing reminded me of the illness. However, it was in these easily neglected moments I found more than I expected. It brought understanding, relationship-building and healing. When I went shopping with my mother for Christmas decorations, ornaments for the tree, it was so exciting because my mind was not occupied with voices. He did not like times like these – he missed the attention, it was my time to feel good! When I walked with my dogs, when I was with my mother doing exciting things, anorexia was left behind, there was no room for him. Oscar loved me; when I was with Oscar, I did not think about anorexia, nothing even reminded me of the illness. Our times together always brought a calming and relaxing affect that made me feel I was loved, I was special.

As I was reclaiming my own self and power, what I found amazing was the way in which my body responded to self-care. I was not just a shell, guided by a voice. I found satisfaction in little things; a bubble bath, washing and blow drying my hair. I developed an awareness to my life's circumstances. Whenever I felt unhappy or sad, often irritated, I reminded myself to watch out, not to give him any reason to return, rather to stop moping and get on with life. Often, refuge from anorexia was found simply through 'getting out' (metaphorically walking away and leaving him behind) where I experienced a sense of enjoyment and comfort, regardless of the nature of the activity. I could go places and have fun. I love nature, I love the outdoors, I could be me!

Becoming more involved also meant I got to know myself better. Today I understand that it is this connectedness of mind, body and spirit, that brings harmony and with it the ability to love the self and others. I searched for God, I had to find Him and connect with Him over and over to find purpose and meaning for my life, in my own unique way. I often had to push myself to become involved with my friends at school, my parents and family, but it was worth it.

Today I am so grateful to be alive. I write my reflections from a position of privilege as I consider myself extremely lucky to have survived the ordeal of having lived with anorexia. I make it my business to tell all those who are interested about the horror of living with an eating disorder. I offer my reflections

on the journey as an 'insider' to the illness, may it bring hope to those struggling like I did.

I come to the end of my story (for now) and have a beautiful poem (by an unknown author) that I would love to share. I think this is such an accurate explanation of the process of starting to love yourself again. It is short and sweet for a somewhat longer and more painful road. It is spot on for all the confusion and fear that anorexia brings, and the unknown that opens up before you, when you start loving your self again.

LOVE

Emotions bottled up inside

Each one telling me to die

Or cry

Or laugh

Or maybe just scream

I don't know

I can't tell what they're trying to tell me anymore

It's like I know they're there but that is it

That's as far as the connection goes

I'm crying and I don't know why

Is it pain?

Is it sorrow?

It is self-pity?

Or is it just me moving on?

Moving on?!

What a strange and foreign word for me

I never knew what it meant till now

I've managed to block that out for oh so long

Now I must pick up the pieces of my shattered life

And glue them back together

What's the point of staying in this hole?

When I can see the sunlight sneaking in

It hurts so much inside

Not sure why

*Did I bring this on myself?
Have I taken the wrong turn somewhere?
Is it something I deserved?
Another set of questions
Another set left on the shelf to be unanswered
I know what I must do
I must be strong
I must move on
I must say 'I'm sorry' to myself for once
I must forget my shadows behind me
I must learn to love myself again*

There is nothing more precious than loving yourself, particularly after many years of neglect. There is nothing more rewarding than feeling your body is being looked after and responding to the love it receives. There is nothing more special than being able to smile again, realizing that you are in touch with your own self again, feeling the one-ness of Spirit. Connecting the dots, is putting the team together, the team which plays the game of life!

7.6 MARISKA'S REFLECTIONS ON HEALING

It feels almost unreal that after so many years of struggling with my self-image, I'm eventually free. There is nothing more that holds me back, shuts me out and humiliates or demeans me. I can be just who I will. The person I am today I won't change for anything, particularly not for a thin body! What a waste of time! I threw away five years of my life trying to be something I could never be. In any event, I was never satisfied with what I was. What I wanted to be was laughable, unrealistic. I thought a slim, thin person was a perfect, successful person, and in the process I lost my self. I lost my freedom ...I became a prisoner, locked out from life. And that, just to have a thin body, I thought it would make me more attractive, IT DID NOT! It pushed people away and made men afraid. I was spiritually unhappy and very alone and lonely.

7.6.1 Conditioning a disabling spirituality

Today I'm well, but it wasn't easy. I think what was most difficult was to come to the point where I WANTED TO GET BETTER. For a long time it was nice for me to get 'psychological attention'. I enjoyed that my parents and friends were concerned about me. It motivated me to become even thinner. Because then I knew they were thinking about me. It also felt good that my boyfriend was concerned and anxious about me. It was my twisted way to keep him, for as long as I was ill, his attention would be on me. In any event, as a result of all this, I lost him. I think it was all because of the rejection I experienced from male figures from the time I was small.

There was a big gap in my life because I never had a stable, supportive father figure and I think I used bulimia and self-mutilation as a weapon, as security. As long as I was ill, no-one would forget me. In the process I forgot about Mariska, the most important person in my life. I didn't appreciate anything and I didn't see anything. I was dead inside. My spirit was dead and as long as I was spiritually dead, I was unable to heal.

7.6.2 Discourse and spirituality: discovering an enabling spirituality

I completely misunderstood spirituality. For nineteen years spirituality for me meant religion. And religion for me was the Dutch Reformed Church and all the hypocrisy that went with it. The church always made me feel guilty and God felt very far away. I thought that God expected me to prove myself to Him. How would that possibly have helped? I could never have got well had I not discovered my own spirituality.

For a long time I struggled to free myself from feelings of guilt about God. When I was ill, I felt He was angry with me. I couldn't understand Him at all. Now if I think back, I know why. I misunderstood God because others tried to tell me how I should experience Him. Joan changed my entire picture and image of God. Through her I learned to look at God in a completely different way. She gave me the freedom to search for God in my own unique way. Wow! That changed everything! I began to see God in everything around me, things that had nothing to do with religion or the church. I cannot remember when I was last in a church

and don't care, because I don't need a cold building to know God. He never expected it of me to impress Him. He only asks that I experience Him.

I started to open myself to spiritual experiences in order to get 'in touch' with my own self, and the moment that happened, I began to heal. That is why I know that eating disorders and addictions cannot be changed without the spiritual. My body, mind and spirit are ONE, the body cannot be treated as if it is separate to the mind or spirit. Bulimia, self-mutilation, alcoholism, obesity are all just symptoms of a broken self. And the self cannot become whole if the individual's mind, body and spirit are not connected. The one cannot be without the other. I could have seen another hundred psychologists without getting better, because not one of them would have understood what it was really about, what was missing in my life. I tried to get better without believing in anything other than my own strength, but it didn't work. I first had to understand the concept of spirituality and put it in practice. That doesn't mean that you must pray to God to become well. Spirituality is so much more. It's about connecting with yourself and the outside world as well.

The most spiritual things for me had actually nothing to do with God, but so much with humanity. It's a spiritual experience for me to lie in a bath with candles and bubbles, or to tell my little brother stories and watch how he laughs from his stomach, to read a beautiful book which touches me deeply and from which I learn something, to have an intelligent conversation, to philosophise about life, to enjoy a glass of wine with a good friend, to pick up shells on the beach, to try something new, to write a poem, to watch how a small plant grows, to see the excitement of my small dogs when I get back from the café, to listen to good music, to spoil myself.....the list goes on. THAT IS MY SPIRITUALITY and God's name is not even mentioned, though they are His gifts. It was these things that made me whole again. They filled me and made me feel alive. I am, however, comforted to know that God is all this and more. It did not help for me to try and get better myself. My mind was not strong enough. I had to come to a point where I simply had to focus on something bigger than myself. I had to start looking up, looking people in the eye, seeing things around me. God became a reality for me the moment I began to look for Him within my own life. I began to understand Him, started to appreciate nature and see the good in others. Spirituality was like the 'missing link' which I needed to help me to heal.

7.6.3 Living in two worlds

It was very difficult to distance myself from the lie I had been living. Most of my friends never even knew I was sick. I taught myself to be 'fine' when I was with others. I was leading a double life and somewhere I had to decide to make a change. It was incredibly 'scary'. On the one hand, I wanted to get well, on the other I was not entirely willing to give up my other life. I wanted to love myself, but I still wanted to throw up and cut myself. I tried to convince myself I could do both, but deep down I knew that at some time I would have to make a choice and I was scared to death.

I tried to drag out the whole therapeutic process just so I could be sick for a little longer. There is nothing as having to change your 'comfort zone'. I knew that as soon as I decided to get well, everything would change. I would have to fight with everything in me to get rid of Mia (Bulimia). I would have to face myself and put right all the damage I'd done to my body, spirit and mind. I didn't want to. I didn't want to admit to myself that I had completely wrecked my body but I knew I couldn't ignore myself for much longer. Somewhere down the line I would lose everything. People would start to give up on me and I would have to face my demons on my own.

7.6.4 The paradox of healing

For the majority of therapists, hospitalization is a good option. It's so easy to send a patient to hospital and pump her full of food. The patient goes back home weighing five kilograms more and the therapist is satisfied. BUT WHAT ABOUT THE PATIENT AS A PERSON? Nothing changes just because you weigh more; on the contrary, you are just more broken and the self more diminished. Your voice is taken from you and you are treated like an 'outcast', someone who doesn't belong. This is why the recovery rate is so low in the eating disorders – nothing is done about the brokenness of the individual. There's a very good reason for someone having an eating disorder. Something inside you is DEAD, God is dead; you stop living because altogether your faith and trust in others is severely challenged.

The focus should never be the patient's weight. Joan never told me I was too thin. She never focused on my physical appearance. What was important for her was what was going on inside me. Many times I walked into her consulting room with arms which I had cut to pieces. And I know she knew this, but this was never what she focused on. All that mattered to her was that I had to get rid of the pain inside me. She understood that I must heal from within; I am certain she was very concerned about my physical health, but she never threw it in my face all the time. I knew she cared deeply for the person inside me who had somewhere got lost.

I had to get rid of my fears and regain my voice back. Had Joan 'preached' to me at every session about what I weighed, or how bad my arms looked, I would have become even 'smaller'. She looked past my body and saw MARISKA, THE PERSON WHO SO BADLY WANTED TO GET WELL. If Joan had prescribed a whole lot of pills or suggested I should be in an institution I would have withered away. I would never have achieved what I have today!

Joan stayed completely away from any labels. Never did I hear from her that there was something wrong with me. She never made me feel I was crazy because I was hearing voices. These things inspired to get well, it was her way of working that made me feel WORTHY. She understood me and she understood the unbelievable struggle I was in. I knew I could phone her any time of the day or night if I felt I wanted to cut myself, and I did phone her, but every time we could put it behind us and look to the future. I could see in her eyes that she didn't judge me. And I never felt that she was sorry for me. I could see the empathy, but not the sympathy. That helped me more than she will ever understand. I never felt like a 'lost case' because she just never gave up. She always made me feel protected and I was never afraid that she would let me be locked away in a hospital.

After seeing Joan for quite some time, without any great improvement, I began to realize that only I could make the choice to get well. I tested her for a long time, I wanted to know that she wouldn't leave me, I wanted to be certain that she also didn't think I was crazy. It was almost as if there was something inside me which wanted to provoke her into saying I was crazy. I wanted her to say this so that I could write her off as just another therapist. She did not. She was there and

supported me and built me up....piece by piece. People I had seen before told me that I was crazy, that I was possessed with demons. But not Joan. She convinced me that there was nothing wrong with me. And said my illness is not who I am, rather a problem that I am struggling with, and that we would overcome it. Joan's perspective on mental illness and spirituality changed me dramatically.

7.6.5 The self in social discourse

I would have remained dead in spirit if I hadn't tried other options to get well. I could never have been a complete, mature woman. The world expects so much of us – or so I convinced myself. I wanted to be part of the unrealistic image which society creates for women. She must know her place and always look her best to keep her husband/man happy. Society shapes the thinking of girls and women from a very young age as to how to be the 'ideal woman'. Before we are three years old, our first Barbie doll is put into our hands. Barbie lives in a double storey house with Ken, the man all women desire. She has a sports car, the perfect body and perfect hair. Before we can even talk we listen to fairy stories where the princess is a gentle, stunningly beautiful girl with the prettiest clothes and hair. The bad characters in the story are always fat and ugly (in the eyes of society). We look at the pictures of the beautiful, thin princess and hear over and over how she attracts the prince with her perfect beauty. The message? The prettier, thinner and more submissive you are, the better your chances to claim the prince.

Then we become teenagers and are exposed to pornography and the media. Again we are confronted with Barbie images. At the same time men are taught that this is the ideal woman. An evil cycle begins and women struggle their whole lives for this perfectionism. It's all lies. Why did I fall for this for such a long time? The harder I tried to fit in, the further I distanced myself. Those who really cared about me and didn't expect me to be perfect, had to stand and watch how I was throwing my life away. I missed so much and was so alone. My life will always be five years shorter than it should have been. I thought I had good relationships but I actually only had one friend, MIA (Bulimia). I lived past my own self. I thought I was special because MIA chose me, although I actually chose her. I believed she knew what was best for me because she led me to believe that nobody

understood me. I hate her and I'm not afraid to say it. She stole from me and I allowed it.

To all the psychologists out there who do not really try to understand, I just want to say that Mia really exists. For someone who is sick, she is just as real as any other person in your life. She was real for me and there is absolutely nothing wrong with me. My spirit got hurt, very hurt but that's all. I do not have dissociative personality disorder just because I struggled with voices. I was never crazy. You may disagree with me. But Mia exists, I know how she looks, how she smells, and the sound of her voice, what she wears. And if I had received the wrong counselling for much longer, I would have been sitting in a mental institution. I would have convinced myself that I was mad. I wouldn't have had any self-respect and my life would have been destroyed.

Every day I say thank you to Joan, my mother and brother who believed in me. And today I can take pride in an Honours university degree (a BA Hons Industrial Psychology), lots of friends and a full life. I am just wondering where my 'mental illness' disappeared to? I got well without ever seeing the inside of a psychiatric ward. That would have destroyed me! And I wonder how many people are in such places because therapists don't understand. It's so sad. Anyone who has not travelled this road will never understand just how difficult it is to live with an eating disorder. Joan really tried hard to understand, although a lot of what happened at times probably did not make sense to her, but she was never judgemental. She believed me when I said I was troubled by the voices, she believed in me and in my own ability to heal. She made me feel like a person and not an object. This is why I allowed her into my life and asked her to help me. The eating disorders do not belong in the DSM-IV.

7.6.6 A long road

The healing process was the most painful for me. It's unbelievably difficult to break away from everything you have created for yourself. The prison I had locked myself into was very difficult to break open. It was so difficult to let go all the habits I had taught myself over the years. A person's mind is so powerful and I convinced myself for a long time that I didn't know how to get well. This was not true. Actually I knew precisely. But I was scared of change. I knew I would have

to give up so many things. I would have to break down the castle in the sky I had built and start again from scratch.

Reflecting on those occasions when I was driving to Joan, there were times I literally could not breathe. So many times I had to pull off the road and wait for my anxiety attack to pass. Every time I was on the road (to her), she and my mother prayed that I would be calm and not overcome by fear. It was a big challenge for me to fight against those feelings. But every time I managed to arrive at Joan's I felt I had moved forward. Later I just continued driving on through the fear and began to realize that I was stronger than the feelings which tried to overwhelm me. Mia didn't want me to spend time with Joan. She always made me feel like a failure when I went to Joan. She made me believe that only a weak person seeks therapy and tried to convince me that I did not need Joan, that I was in fact wasting my time. Sadly, there were times Mia won.

I realized I had to be totally honest with myself and that was a very scary idea. I had to admit to myself that I threw up for two reasons. To get rid of the pain inside me, in other words throwing up and cutting myself had become coping mechanisms. I wanted to have a perfect body, something which I could never have had and which doesn't exist anyway. So what now? I had to quickly find something to replace coping mechanisms. I had always used writing as a release valve. Joan encouraged me to keep on writing. She felt that I was not sharing everything fully with her and that she could learn more from me if I shared my writing with her. This helped me so much. It was easier to say on paper exactly how I felt, because it was not necessary that I looked her in the eye. I was much more open when I wrote than during a therapeutic session. The writing gave me almost the same relief that I got from cutting myself. It definitely played a big part in my healing.

When I eventually started to really care for my body things improved. I had to give up everything that for years had been my security. For many years I ignored my body completely. Whenever I cut myself the moment would pass and I would not look at the cut again. My mind and body were completely disconnected. I could literally not see myself anymore, neither did I have any desire to do so. I never got dressed near a mirror or looked in a mirror. Today I realize just how

broken I was. How could I heal when I refused to look at my body? My mind, body and spirit were completely disconnected and I had stopped living.

7.6.7 Is it all in the mind?

It took a very long time to reprogramme my mind. For a long time I just had negative thoughts. I was attracted to the idea of becoming whole again and if I wanted to heal both spiritually and physically, I had to be positive and hopeful. I had to change my mindset. But I battled with overwhelming negative thoughts, particularly after I had eaten something. My 'sound' mind was telling me I had to start somewhere, but Mia was not just going to give up on me either. I had to constantly remind myself of my body's need for food and that I was not going to get fat overnight. I was petrified of picking up weight. For me it was a greater fear than even dying.

I must admit that even to today my own thinking patterns sometimes cripple me. I often also think how it was when I was ill. Sometimes I feel like making myself sick again particularly in times of stress, but I try and be strong. Not even throwing up once was worth it, particularly not if I look at my life now. The healing process was the most uncomfortable time of my life. Not for a moment will I believe anyone who says it's easy.

I began to put on weight and the old fears returned. The secret was that I had to come to the point where I didn't judge myself. This was the most difficult of all. I had to learn to accept myself. In times of relapse, I had to forgive myself over and over. I had to convince myself that I had not lost the fight because I threw up again. Every time I had to scrape the resolve together to start again and slowly but surely things started to come right. Today, I'm sure I weigh a lot more, but I'm happier than ever. I will always look after my body and never allow myself to become overweight, but I never again want to be the person I was.

7.6.8 Healing, spirituality and Mystique

My budgie Mystique brought life into my existence. One morning I was sitting on my bed and looking at the blue sky (something which didn't happen often because I was always looking down) and saw birds flying around. They looked so free and I wished I was one of them. And so I decided to get a bird for myself and

wanted him to be blue like the sky. While I was on my way to buy my bird, I suddenly realized how much I had changed. There had been nothing alive in my room for a very long time and suddenly I wanted to have something that could breathe with me. This was a sign of a big change from within.

I often spoke to Mystique and even taught him when I had to write an exam. I saw so much of myself in Mystique. He was a beautiful bird with so much potential, locked up in a cage, just as I had locked myself up in my own cage. He was alone, even if he didn't realize it. And he was very comfortable in his cage. He felt safe in the small space in which he lived. I had also allowed myself just a small space in which to live and was so afraid of a life outside my own 'cage'.

Mystique was part of my healing. Later I felt he should get a mate (at the same time that I had started a new relationship with someone) and so Mystique got a little wife. In the beginning they didn't like each other at all. It was difficult for him to get used to someone who wanted to share his space. Until he began to allow her to be part of his life. It was awesome to see how their relationship changed. Now they are very happy together and Mystique has learned that to be alone is not so nice after all. I also had to learn to let people into my space and just like Mystique I realized that it's 'fine' to have people close to you. The big difference between Mystique and me is that he will have to stay in a cage his whole life. He doesn't know anything else and wouldn't survive on his own. There are more and better things that wait for me.

7.6.9 Inner power

To heal requires self-confidence, determination and inner strength. It's amazing how much I learned about myself while I was getting well. I had never realized what a strong person I was. One of the biggest problems in my life was that I surrounded myself with people who made me feel negative about myself. H (a girl who I was friends with) was such a person. She drained me and made me feel powerless. I simply had to get her out of my life or I would never have been able to get better. A person cannot get well if you are powerless. I had to surround myself with people who really loved me and cared for me. People who were not sick themselves.

Today I feel strong and in control of my life. Although I can say that I am well, it is still a 'fight' to stay there. But I comfort myself because the fight is worth all the effort. And yes, it gets easier, much easier. I can eat ice cream without worrying about putting on weight. I also do not feel intimidated when someone tells me I have put on weight. Right now, I don't even know what I weigh, it doesn't matter. I can have my food and enjoy it. I do not have to eat quickly to rush down a glass of water in order to get sick. I do not have to make plans this summer as to how I am going to hide the scars on my arms from my friends. I like myself and therefore other people are comfortable around me. I am open to relationships and can share my heart with others. What did it help to be so thin, but so alone and lost?

7.6.10 Life ahead

I am very grateful to be able to sit here and write about a problem I can put behind me. There are still days which are more difficult than others and I know there will come times when I will feel discouraged and old feelings of 'sick' may return. I take every day at a time and try as far as possible to fill my life with positive things and positive people. My journey is a long way from being finished and there is still much I want to do. However, every day is for me a day further from sickness. I have to keep on reminding myself that bulimia and self-mutilation are weaknesses I need to avoid whenever I'm going through a difficult time. Fortunately I have learned that there are other empowering things which can support me during these times. My illness was not worth it, not even for one day!

7.7 HEIDI'S REFLECTIONS ON HEALING

Four years and another life later: Look at how far I've come.

Hello, I'm Heidi. My name isn't just Heidi, it's who I am.

I'm turning twenty-one next January, and I'm getting older, but I'm not growing tired. I'm studying and I love what I study [Heidi is a third year student at Stellenbosch University]. I'm spending time with people and I love the people I spend time with. I'm giving of myself, and I'm receiving. My head's no longer on top of my body, it's walking here beside it. I am present.

I am in control, because I am not trying to be. I am no longer trying to be.

It is very nice to meet you.

7.7.1 Healing

It's safe to say that of the hundreds of people I've met since I've been at university, only ten – if that many – know about my history of eating disturbances.

My parents and those who were with me through my troubled times doubt sometimes about whether or not I'm normal. Their radars are set on high detection and their hairs are always erect on the backs of their necks but here's the truth: I'm not that normal. I know I'm not that normal – I'll never be normal – but 'normal' is a utopian word that really just doesn't exist.

And so I don't blame them. And I don't hate myself.

My best friend asked me a couple of weeks ago if I was up to my old tricks. That every time we'd eat she'd see me disappear to the bathroom and had a suspicion I was throwing up again. And I didn't get defensive. A massive sign of healing. I didn't get defensive.

And I could talk to her about it, calmly and rationally – head on. That bond, that inexplicable hold that the eating disorder had on me, was nothing compared to the trust and connection I felt for my friend. I knew she loved me, cared about me. I knew she didn't want to take anything away from me. I could see old tricks that were trying to block up my headspace and I was able to swiftly and effortlessly block them from touching me at all.

It hasn't been easy to build up resistance. It's a constant road that I'm travelling and sometimes I feel discouraged. Sometimes I feel helpless and irritated and frustrated but it's a five minute feeling that I get over. It's a life feeling that everyone experiences from time to time, but you get over.

For the rest of my life I will have to be constantly aware of this eating disorder. During good times and busy times it's much easier to make as though I was

never ever sick, and not ponder. But during bad times – when relationships fail, when life disappoints, when things just don't go well – dark thoughts come creeping back in. I would be lying if I said they didn't, if I said I read the Bible a couple of times and it changed my life and now I'm in love with myself and I think I'm the best person ever.

It's simply not the case.

7.7.2 Sustained by faith

I had to look long and hard, stare at myself and retie those loose threads that had splayed all over the place. Find a way to tie them.

I had to deal with life and deal with myself and finding faith helped me do that. Faith.

Faith in life in general, and faith in my life specifically. I had to believe in something that could pick me up, that could rip me out of the sea I was drowning myself in and pull me to shore. And I got to shore. I found faith and I found purpose and I got to shore.

I know I was lucky – I know there are many other girls who find themselves too terribly wrapped up in the sinking sand of the sickness that there is no way out. For them. That they cannot possibly fathom an alternative existence. But I was hurting and I was lost and Joan offered me an alternative and I decided to try it, if not take it. And I tried it and after those first steps of getting to know life again, of getting to reconnect with things, I managed to learn how to pull myself out of situations. Stop coddling my heart and learn to open it, see warning signs, stop them. Fostering a deep and intense appreciation for all things living. For people, for animals, for nature. The coldness of the wind and the important warmth of the sun. The way that everything is so delicately balanced, and masterfully controlled. The way that a hand, somewhere, holds the strings that pulls the tides and patterns of the moon. The technical brilliance of my body, that heals and beats and shakes and shivers with cold and with laughter. My body. The commodity I used to hate, but was introduced to as a temple. As an object of

worth. As something worth protecting instead of discarding. As a means of enhancing my life rather than destroying it.

I came to the realisation that the hurt was there no matter what weight I was. Whether I weighed fifty or sixty kilograms was irrelevant.

I'm older. Perhaps my 'audience' is too. Those people I used to think were constantly judging and jeering at me no longer point fingers. But then again, I also no longer care.

I am preoccupied with myself, but healthily.

I think of myself, of my best interests, but healthily.

I am aware of the air that seeps into my lungs. Of the blood that runs through my veins, and, the aspect for which I am most incredibly grateful for, is the wholeness of my heart.

All of these factors amalgamated help me get through each day. My faith, my appreciation, my thankfulness, and my optimism. They help me get through each day, and give me excitement for the next.

7.7.3 Planning ahead

I have plans for my life. I have dreams and ambition and I feel I have potential. I am not restricted by my physicality, I have learnt to embrace it. It might not always be a love affair – everyone has 'fat' days – but it's a working relationship. A connected and budding and growing relationship that cultivates my sense of self-worth, my sense of aspiration. That relieves my anorexic and bulimic symptoms, because making myself sick or starving myself pales in comparison to the completion, stimulation and belonging I feel when I'm participating in Life. When I'm spending quality time with my friends, when I'm concentrating on my studies. There's no space for isolation, for secrets, or suspicion. There's no time, no place for the caging-in that the Eating Disorder causes. No need for that entrapment, that seclusion, that shutting out.

Who I surround myself with is important.

It's not pleasant being around friends who are insecure and calorie-counting and looking in the mirror every five seconds to check how much weight they've put on. I have so many friends who are in residence with me at university who start with these seemingly innocent symptoms, and I worry for them. Because that's how I started – conforming; some underlying issues there – not many, but more than enough to develop an illness upon and pack mountains on top of. This thing, it bites you like a pin-prick – you barely feel it, and next thing you know there's a black hole you're lying in with neither hope nor will to crawl out. If my mother had never taken me to Joan, I would've never wanted to crawl out. Never. And if I think back now, that frightens me. It chills my bones and that's okay because I want it to. My dad's words: 'My girl, what you're doing isn't normal.'

I understand them now. I understand. I'm standing in a courtyard with houses on both sides. Both have big windows, and I can see right in. On my left is me four years ago – the house is old and the windows are holes where planks used to block them up. Gaping pieces where burglar bars used to be. Where my secrets used to suffocate and constrict me and close me off from everything positive. Within it I see bare floors and paint creeping off walls. It's built like a house, but it's a jail. A jail that's been broken out of but still reeks of the anxiety and diffidence it once contained. Not quite threatening, but a solid reminder.

On my right is a white building. New windows, clean and open. Lots of light, pot plants, bed. Life and rest and peace of mind. A map on the wall – my future. There's space, empty space but that's potential. My room for growth. To continue growing, to develop, to expand, to experience.

I am standing in the interim space. It's a flat piece of lawn with weeds and flowers and bees that sting, but also serve to keep natural balance and pollinate. The jail-house is close enough for me to re-enter, but broken enough to prevent its rebuilding. I've burst its confines far enough open to keep them that way. With a tight and deep stronghold on faith and life and a God power there somewhere looking out for me, I can keep those confines open and walk back there, and reminisce, but never ever stay. It's the museum of my past.

The grassy space allows me breath. It allows me to recapture, recollect, re-attach and re-connect. It's a symbol of the process. The bees still sting but so does life. Everything happens for a reason, I am not debilitated by them. Even ugly things blossom, and I'm not ugly. I won't even say 'any more', because I realise I never was. My hurting was ugly. Distorted. Ugly. Untwisted, there's nothing standing in my way. That white house on my right has too many promises and things to look forward to for me to turn away from it. I have too much hope for myself for me to turn away from it.

7.7.4 Networking

My friend Joanna asked me the other day how I would react if my daughter had to one day show signs of having an eating disorder. Would I be protective? Encouraging? Forceful?

My own mother was difficult. But I understand that her position was difficult. I always felt as though she was accusing me, pointing fingers, disapproving without ever trying to understand. I'm glad she stepped in, but at the time I hated her for it. My mom really didn't do things in a productive way. I love her, and I know she just cared and worried, but she ear-marked 'Anorexia' in encyclopaedias for me, and left photocopies of magazine articles tackling eating disorders on my bed. I don't think that was the right way to do it.

What is the right way then?

If I had to deal with it one day, with my daughter, I'd try to keep her as busy as possible. Try and show her how much more there is to life than the little cage and isolation obsessing about your weight and self-worth puts you in. Try get her away from herself, so she can stop hurting herself. I'd do my best to boost her sense of self. To get her in the sun. In nature. Doing fun things – sports, activities, whatever she liked. Being around people as much as possible, showing her how most people in the world don't think twice about the natural necessity of food and eating it. Tell her about myself. Most importantly, tell her about myself. About how it doesn't make someone inhuman to suffer from an eating disorder. How it doesn't mean you're wholly dysfunctional, crazy or deranged. How pills

and force feeding can help relieve symptoms but will never cure the pains of the heart and the injured spirit that accompany the disturbed eating habits.

For everyone it's different, the causes are different, the hurt is different, but one thing's for sure:

It's never, ever worth it.

I cannot conclude this story, it is open ending. I can't promise where I'll be in the future, but I have trust in myself that I won't go back. That I've seen the glow of what lies ahead and above me, and so I no longer need to go searching for remedies beneath anymore. I honestly think I will live with an eating disorder for the rest of my life, by looking at how old ghosts still try to torment me at every given chance, but on the other hand, I also know that I am empowered. I am a step above it, and instead of it trampling on my head, I've got my foot on it.

No longer afraid, no longer ashamed, I can look back on my old broken and confused thoughts, feeling life, and be proud of myself.

I'm Heidi.

Look at how far I've come.

7.8 CHAPTER OVERVIEW

This chapter engages with the three participants in the recounting of their healing narratives. Embodied forms of knowledge, evident in different ways of knowing, seeing and being is linked holistically, to lay emphasis on spirituality as the life force orchestrating healing from within.

The chapter explores the participants' narrative experiences of anorexia nervosa/bulimia, how the illness first entered their lives, how it developed and became more powerful, how they coped with daily life and finally how healing was achieved. They relate how healing meant coming to love the self (spirit), an understanding of the mind, body, spirit relation and its role in structuring their own spirituality. These knowledge provide a continuum of illness experiences, providing insight into new strategies for growth and recovery, under-researched because of the elusive nature of the illness, making the role of story essential in providing an understanding of the illness.

In Chapter Eight I offer my own reflections on the participants' healing journey, staying close to the research questions. Their pilgrimage is initially marked by conflict and anxiety, evidenced in their lives as a disempowering spirituality. On the journey they came to know their own positioning in discourse and the vulnerability of the self or spirit, given the relation of body-self in the context of anorexia/bulimia. I underpin the importance of embodied knowledge in doing qualitative research. These knowledge provided the tools by which I came to enter the reality of the illness experience, in order to understand their construction of meaning in the context of the eating disorder. I also discuss the implications of the research findings and the effects of the qualitative inquiry on my researcher-self.

CHAPTER EIGHT

UNPACKING THE HEALING JOURNEY: LOOKING TO THE FUTURE

8.1 INTRODUCTION

In the first section of this last chapter I unpack and examine the healing process, based on insight from the participants' stories and subsequent reflective accounts. I tell a story within a story, and make use of their words to capture the 'metaphorical transference' (Austgard 2006:12) of the actuality of spirituality. At the same time, I examine the critical stages of recovery in terms of a common core narrative. From being stuck in a problem-dominated bind, indicative of a disempowering spirituality, the participants moved to a richer and more dynamic account of life, encompassed by a growing spirituality, with the process of healing best understood by the metaphor of an 'ongoing journey' (Ridgway 2001:337).

The second section is a discussion of the qualitative research inquiry. I situate it within the framework of spiritual care, a reflective approach to the creation of knowledge, based on various patterns of knowing. I highlight the role of emotions as central to qualitative research. I emphasise researcher sensitivity and flexibility in the creation of practical knowledge (as opposed to theoretical knowledge), acquired through interaction between myself and the participants, and the role of such knowledge in shaping the research process and the results I obtained. I use these results to argue critically for the acknowledgement of the subjective experience of illness, and make visible the barriers responsible for the marginalization of spiritual care in practice and education, given the current medical model.

I take the research further by applying the concept of a wounded self to chronic illness and disease, making visible the spiritual as the key dimension in holistic care. By highlighting spirituality as a 'neglected' dimension, I emphasise the categorization of illness in terms of the DSM-IV in order to stimulate further dialogue, given the divide existing between normality and pathology. I discuss the impact of the research on myself and the importance of the research alliance in qualitative research.

8.2 THICKENING THE PLOT: AN UNPACKING OF THE HEALING JOURNEY

In what follows, the healing process is portrayed as a journey, based on insights from the participants' stories and subsequent reflections, and in terms of the Recovery Model proposed by Ralph (2005:137). The journey towards healing entails a progression of stages, which folds back onto the research question and research objectives. Given the findings of the study, the participants' situatedness in discourse surfaces when their individual spirituality is described in terms of particular relationships and specific language, which ultimately shapes their spiritual identities.

Initially experiencing disruption in their lives, coupled with distress and anxiety, the participants suffered a loss of personal power, which was reflected in varying degrees of vulnerability. This state of helplessness or anguish was foundational to the first stage of recovery. Anguish is understood to be both a physical and moral experience. The physical dimension is symptomized by bodily pain and suffering, with the moral experience giving rise to feelings of sorrow, a heavy heart and a sense of desolation. This state of vulnerability is referred to by Cushman (1990:604) 'as an absence of personal meaning, manifesting as a hunger for spiritual guidance' with an underlying theme of 'disconnection'. In the context of healing anorexia/bulimia, this became the focus of the research inquiry and led to the formulation of the research question.

8.2.1 Anguish

Not in a position to fully understand the subjugation imposed by the illness, and with her life becoming dedicated to the rituals of the eating disorder, Mare-Lee provides a glimpse into the anguish experienced as she became trapped in two different worlds, uncertain as to the reality of either. She opens a window onto her lived experiences, her fear and anxiety in searching for the pre-illness sense of self or spirit when she states:

MARE-LEE: Mare-Lee is gone, I cannot find her.

The intensity of emotion escalates when she acknowledges that it was too late to find Mare-Lee, that she did not know where to start looking for her old self.

MARE-LEE: How does one describe yourself when the self becomes some-one else?

She shares how she experienced a self that was foreign to her, when she took on the persona of a 'glass doll', metaphorically providing a glimpse of a lifeless self or spirit, lacking connectedness, emotion and feeling. At the same time, she found it difficult to explain adequately what was happening to her:

MARE-LEE: I know that someone else lives in me now, but how do I explain this to others?

Anguish and a deficit of spirit experienced by Mariska is summed up in her words: '*Something died inside me....I began to realize that I was not well and needed help.*' Experiencing a sense of helplessness gave way to feelings of inadequacy, and she began to experience herself as inferior to those around her. Mariska acknowledges being overwhelmed and confused:

MARISKA: I do not know where things started to go wrong, I grab at empty thoughts, but I stare into nothing, everything is empty...empty.

The loss of self or spirit is eloquently portrayed by Heidi when she states:

HEIDI: But then I got to a point where I wasn't Heidi anymore.

Aware that somehow she is now different, she acknowledges her profound hurt and her helplessness to explain her predicament. Her experiences aggravate her confusion because

of a lack of 'absolute certainty where it stems from'. She attempts to share with the reader her intense suffering:

HEIDI: ...but it's a feeling, a sore and empty feeling which has no English name but lives real in my chest; sometimes in the pit of my stomach. A dull, aching sense of anxiety that can't be pinned down and simultaneously can't be ignored.

For Mare-Lee, Mariska and Heidi, the world became a dangerous place and they shared a heightened awareness of the presence of evil. Gone were their happy, optimistic, energetic spirits, now replaced by voices, mocking and demanding, stealing their resolve and reminding them of their own shortcomings.

MARE-LEE: Above all, I had a guide, I came to live by his voice. Best explained, I had a GPS taking me on endless roads. He provided the shortcut I began to know

MARISKA: I try so hard to get away from manipulating thoughts. Yet the fingers in my throat have become gods in themselves. I am not alone. There are voices in my head, fighting constantly and it's driving me insane! I don't really think I can fight them....

With the spirit violated, the participants came to experience emotions of fear, anger, pain and recrimination, presented in existential crisis states of vulnerability, social isolation and withdrawal. Viewed through the lens of Western science, the condition presented was one of mental illness. However, it is my contention that these eventualities demonstrate, rather, individuals being set apart through a deficit of the spirit.

MARISKA: Inside me I am all mixed up. Everything that is part of me is in the wrong place. It feels weird, but I am used to it, this is how I have been for as long as I can remember. I have never really figured out my purpose in life, I have always wondered who I am.

HEIDI: I was changing on the inside and I changed on the outside too. I died my hair black, I didn't recognize myself when I looked in the mirror. The lack of recognition, of association, helped widen the rift between my mind's image and actual image of myself even more. I didn't identify with my outward appearance. I was losing touch with my inner.

MARE-LEE: There I stood, in front of the high school gates, everything had changed so quickly. I was confused and kept asking myself one question, 'Why could I not stay 'that' little girl? I was outside the frame, alone, with 'nothing'. I had lost my self; my life, like a revolving staircase, began to move up and down.

In addition to experiencing and living an 'empty present' (Abma 2005:338), informed by no meaningful story of the self, both Mare-Lee and Mariska suffered the effects of a medical diagnosis. Although Heidi was never diagnosed, she too was fully aware of the stigmatizing nature of anorexia/bulimia. Her own words, '*anorexic bitch*', are a poignant reminder of the attitude of society. Through their stories, the participants provide insight as to how stereotypical attitudes regarding those considered 'mentally ill', given the stigma surrounding mental illness, also became relevant to them and part of their lives (Calabrese & Corrigan 2005:78; Markowitz 2005:89).

MARISKA: I carry all these labels around my neck....every day I try and convince myself that it is all a lie. I'm totally confused.....Some say it is a spiritual battle, others say it is a mental illness. I say, 'I don't care as long as you can make it go away!'

MARE-LEE: What was it about food? All I wanted him [the psychologist] to do was to help me account for the changes in me, it had nothing to do with food, I could not see the connection. I cannot make sense out of something I do not understand. The name [anorexia] means nothing to me and does not make any sense at all. It does not tell me how I got where I am, neither does it tell

me what I need to do to get out of what I am experiencing. It brought me despair more than anything.

Labelling Mare-Lee and Mariska anorexic/bulimic, (negative tags attached to their persona), portrayed them as deviant and morally inferior, accountable for their condition, whilst providing them with an ubiquitous form of identity. They came to accept themselves as 'other' and without hope. The process of labelling placed Mare-Lee and Mariska outside the range of 'normal' illness behaviour, and led to their being viewed and treated as 'bad patients'.

MARE-LEE: ...whilst looking at me with eyes which spelled out 'just get over your issues' I was stared at up and down. I wanted to escape these eyes, they did not have a clue what I was going through. If only they could give me medicine... I wished for an overnight cure'

MARISKA: Diagnosis makes people ill. To hear that you have more than one personality changes everything inside you, it made me fearful and anxious, and took me further away from recovery. The brain is powerful, mine made me ill.

At the same time, the stories of Mare-Lee, Mariska and Heidi also provided a window of opportunity to observe how powerful were the beliefs that they held. All three were unable to fully understand the extent to which anorexia/bulimia had become an obsession; their conditioning caused them to remain unaware of the negative effects of the illness, which kept them in a cycle of pain whereby they were inadvertently producing the illness symptoms.

MARISKA: I think it is fine to be different. I have managed my studies and all I set out to do, although I self-mutilate and let bulimia get the better of me. It is a secret, my secret. No-one knows about this. Do I have to give it all up?

HEIDI: I felt accosted. I was annoyed at the 'stigma' because I wasn't a hormonal little girl who didn't eat to get attention. I wasn't the freak they interviewed on 3rd Degree who is petrified of carbohydrates. I was just ... I didn't really know what I was, but I knew that was not me. I knew with all my heart that wasn't me.

MARE-LEE: My mom bought me a packet of jelly tots which I decided I would have for lunch. My mother was upset telling me what I was trying to do was wrong. A part of me was already making plans how to skip lunch.....

From the participants' stories it becomes clear that not one of them could identify the connection between dieting and rigid control of body shape on the one hand, and being controlled by the illness on the other. Without their realizing it, they were moving away from 'normal' eating behaviour to becoming involved in something sinister and bizarre, trapped by something from which it proved difficult to escape. They regarded weight loss as a form of personal achievement, but they also realized that their lives were spiralling out of control, as they became more isolated and distrusting of people. No longer connecting to the self or to others meant disengagement from reality and what was happening around them. The real danger becomes evident in this lack of emotional and spiritual balance, something which further exacerbated the power of the illness.

Accordingly, the real issue no longer centred on food, but on the necessity of becoming more fully aware of the fundamental issues underlying the eating disorders, staged in this thesis as a form of addictive behaviour with anti-spiritual properties. Healing for Mare-Lee, Mariska and Heidi meant coming to terms with their own vulnerability and, most importantly, understanding how the position they found themselves in ruthlessly compromised their freedom to act, leaving them wounded in explicit ways. Heidi's comment below shows that she was no longer free.

HEIDI: But it became obsessive, the point counting (Weight Watchers). It became addictive, watching the scale dial move down. Fitting into smaller clothes. The compliments – there was a glamour about it, a shimmer, a sparkle, that I've never experienced before.

At the same time she acknowledge retracting into a world tyrannized by anorexia/bulimia:

HEIDI: A tremendous power, force, voice of some sorts within me absolutely, by all means, forbids me to let anybody know, or let anybody in. People hurt you. You couldn't trust them.

Her words manifest a woundedness of spirit, compounded by a vulnerability to remain trapped in the illness:

HEIDI: I honestly thought that nobody liked me – how could they?

Withdrawing from her friends, teachers and parents she became more isolated and under the control of anorexia/bulimia. Mare-Lee opted for being busy, especially with exercise:

MARE-LEE: I signed up at a gym, something which made me feel alive and happy with myself. But even this healthy pastime changed into an ugly obsession. I could not miss a single day from the gym.

Being driven by this obsession, self-care was compromised.

MARE-LEE: There was no time for friends, 'outings', movies, eating cake or even just chatting. I was caught up in a routine that was stealing my life, I was no longer living. I began to realize that my 'comfort zone' was actually a tiny, empty black room; a black hole from which I couldn't escape.

Mariska also withdrew, driven by a sense of not being what she ought to be:

MARISKA: I feel powerless, but also in charge! It feels good to know that I have a secret inside me that all the strange faces on campus do not share. I still need to lose more weight until I feel good about myself. In my head I have a picture of what I should look like and I know that I can do it.

With Mariska not fully understanding the extent to which she has lost control to the illness, her telling provides 'insider knowledge' regarding the 'other side' of anorexia/bulimia and the anti-spiritual power of entrapment:

MARISKA: Sometimes it feels as if I want to be sick. All the pain, the attention, the dark side of it, it pulls me like a magnet. I am so caught up in the pain of 'sick' that it actually fills me. The cuts on my body, the fingers in my throat, the dark conversations, this is what keeps me alive. One gets used to the voices in your head, so much so that you feel lost without them.

If, during my interaction with Mare-Lee, Mariska and Heidi, I had focused on food, their weight and what they ate, both they and I would have remained fixated on the technical and scientific issues of the illness. I would have had them eating 'normally' again in order to 'repair' the body. But the thinness of their bodies was not the problem. Anorexia/bulimia was only the symptom of something much deeper, something disquieting, a form of 'dread' to which I myself did not have the answers.

Altogether, it was the physical *presence* of the participants that I found emotionally disturbing – the way in which they carried and presented themselves, cold, sad and distant, lacking any form of intimate connection or feeling, something I found challenging to my experience of life and reality. What touched me most were the extremely withdrawn personalities, eyes without any sparkle, the bold yet aloof attitude, determined to keep everyone at a distance. I was intrigued as to what they were thinking, how they made sense of living day by day. I did not believe that they welcomed the condition they were experiencing. They acknowledged that something had gone terribly wrong in their lives, something had usurped their control, a power they themselves did not understand. Clearly they were no longer at peace with themselves, with the world at large and their Creator.

Ochs (1983:99) observes that inner peace is achieved by having a sense of being in harmony with reality. The participants found it difficult to experience peace due to the confined and restricted boundaries set by anorexia/bulimia – being in conflict with reality was due to an inability on their part to give up on the eating disorder. For each of the participants, the most important step in the process of healing was to establish a belief in the self, in the inherent power of the spirit. They needed to know that their lives were worth living and that hope was to be found from *within*. The therapeutic process was but a means of helping them to reach within themselves to find self-acceptance, an awakening to their own uniqueness and individuality. They needed to reclaim their ‘otherness’, assisting them to arrive at the boundary situations that contributed to a new, empowering spirituality.

8.2.2 Awakening

Ochs (1983:124) reports that the period of awakening is usually preceded by a long time in which the self (spirit) is divided. She states that awakening is usually marked by an event that, while it may seem precipitous, actually concludes a long process of transformation. Within this framework, the participants came to occupy a position *alongside* body weight and eating behaviour, rather than living *inside* the illness. This meant that during our interaction, technical aspects of the illness were ‘set aside’ to make time for somehow getting to understand what is meant by Spirit/spirit, maybe touching it some times through our conversations, with issues of voice and personal power becoming all-important.

Furthermore, the process of awakening required coming to discover what is meant by both health and illness. It meant coming to terms with their suffering – an acknowledgement that their suffering was not just physical, but also spiritual and emotional, that the self or spirit was affected by the way they treated their bodies (Corbin 2003:258). It required recognizing that being held in bondage to the demands of anorexia/bulimia resulted from their own limited perspectives, overpowering emotions or values.

For the participants, becoming spiritually aware meant becoming aware of their own conditioning, their choice of a ‘life’ which diminished their sense of self. Awakening signified a growing awareness of how confining were their perspectives on issues regarding choice,

personal agency and voice, how living a disabling spirituality had crippled a sense of meaning and purpose in their lives. Looking within, Mare-Lee, Mariska and Heidi could come to understand how this conditioning negatively affected their chances of living a life of fulfilment.

The active, conscious process of coming into relationship with their own bodies and selves, reflecting on their experiences in terms of what anorexia/bulimia was taking from their lives, was the beginning of finding and developing their own enabling spirituality. At the same time, it brought home to them a spirituality that was silent on structures, doctrines and hierarchies, but focused instead on the transcendent power of their own experiences. This form of spirituality, available to all, signified the uniqueness of each of the participants, whilst also re-emphasising the value and significance of the world outside the self (Ochs 1983:9).

Once they understood that their behaviour and attitudes were contributing to the problems they faced, Mare-Lee, Mariska and Heidi came to view themselves differently. They had to understand and believe that they had the power of choice instead of being passive recipients to the demands of anorexia/bulimia and their voices. Most importantly, believing that they could do something about it became empowering, motivating them towards recovery.

They began to recognize that there was a reality other than that defined by anorexia/bulimia. At the same time, the self was 'dethroned' as it came into contact with a reality larger than itself. However, coming to think about themselves differently also required a new approach in confronting anorexia/bulimia. Which voice was the voice of authority? Why were their own voices not being heard?

In the process of awakening, the participants became the most important players in the therapeutic relationship: they were empowered to be partners in the healing process. No longer victims, but experts in their own right, they were knowledgeable about their own experiences, needs and preferences and they were acknowledged to be the ones best able to identify what would be helpful in promoting healing.

However, in order to awaken to new perspectives, Mare-Lee, Mariska and Heidi had to risk leaving the familiar for the unknown. It meant developing a new consciousness, becoming in tune again with themselves and the world around them. It called for a willingness to go the distance, no matter what the cost, in search for new knowledge that would sustain and strengthen the self in its journey towards healing. Ultimately, it was the willingness of each of them to become the 'architect and engineer' of the healing process (White et al. 2005:237), which stimulated an awareness of the self and responsibility towards caring for the body.

MARE-LEE: I was led to re-discover my own self, to try and fight anorexia's 'say' in my life. It was here where I truly discovered that there still lies a 'self' inside that is not being looked after, and not given the time and attention to 'be'. This was a very eye-opening experience. I had to decide which way I wanted to go. Everything changed from this time onwards. For the first time the focus was on me, not on anorexia. Anorexia's title was taken away, and time, help and love was given to me. Soon I discovered that there was much more inside me than others could see. I realized that there was still a 'me' that wanted a say over who I am, where I go and what I do.

MARISKA: The last conversation with Joan is the one that stays longest in my mind. It is the first time after a consultation that I really thought so much about what was said. Perhaps it was the first time that I really heard her. It also helped me so much to get used to the idea that I am not a bulimic but that I have a relationship with bulimia. I so wish people had previously put it like that. She asked me to reflect on the plans bulimia and self-mutilation have for my life. And she asked me whether I thought bulimia became a god, acquiring a spirituality of its own. This is true and these things become gods that you worship, because they swallow your identity, they take the place God should have. God is so abstract, untouchable, invisible.

It was very difficult to distance myself from the lie I had been living. On the one hand I wanted to get well, on the other I was not prepared to give up my other life. I wanted to love myself, but I still wanted to throw up and cut myself. I taught myself to be 'fine' when I was with others. I was leading a

double life and somewhere I had to decide to make a change. It was incredibly 'scary'.

HEIDI: Finally there was something I could deal with. Someone was asking about my feelings. Not about how much I was eating or when or why. There was nothing wrong with my head – my heart was the problem. Yet she wasn't encroaching on the secret, my secret. She was just asking about my heart! It was a long journey, the experience of discovering myself, who I wanted to be and could be. I was advised to try and take a stand against the 'eating disorder'. To try and personify it, give it a name, treat it as an external entity. I had never thought of things in such a way before.

Moving from awakening to the next stage, that of gaining insight, meant that Mare-Lee, Mariska and Heidi felt more hopeful, more positive about new choices and opportunities that they had not known before. However, although they harboured fewer negative emotions, the three participants still experienced a sense of emptiness, which stood against attaining an enabling spirituality and healing. Also, although they were capable of intimacy and connection, they still had difficulty in experiencing these emotions, because their spirituality was not contributing to their own wholeness.

In view of their experiences and difficulties, initially spirituality was an empty concept for the participants, with two of them responding to the term with aversion because they regarded spirituality and religion as synonymous. If spirituality was seen as synonymous with religion, it also meant that spirituality had no special meaning unique to each one of them, no subjective identity. In order to gain insight, Mare-Lee, Mariska and Heidi needed spirituality to be presented in a manner that their hearts could understand – experiential as well as cognitive, relational and rational. Given that new relational experiences were foundational to their creation of a new sense of self, the question about the character of God became crucial when it came to structuring their human lives (Poling 1991:89). In this regard, Griffith and Griffith (2002:124) believe that an awareness of the presence of God can be a way through which new meaning enters. It requires introducing God's presence into the dilemma, a way of moving away from that which is culturally prescribed to accommodating images now personally chosen (Griffith & Griffith 2002:71).

8.2.3 Insight

The participants held certain views on spirituality. Hence, arriving at an awareness of the tensions and conflict in the narratives they held made critique of those narratives possible. A 'de-stabilization' of the hierarchy of meanings the participants held on spirituality brought about a new understanding, which rendered spirituality contingent, individualized and open to revision with the availability of other interpretations. The journey pivoted on their own free will, the freedom to choose, to convert their own uniqueness into personal action, strengthening their decisions about how they would live their lives. Acting on this freedom of choice meant claiming their potential and power in the face of the control exerted by anorexia/bulimia.

HEIDI: Then spirituality came in. Joan taught me I did not have to feel the way I did. I didn't have to feel cut off and inaccessible. I didn't have to feel confused and hopeless and failing. That there is something bigger than me, something stronger than me, and by implication too, something stronger than the ties that kept my heart in such bondage. There are ways to get back in touch with myself. Ways of getting to know myself again, associate with myself again. It was my thinking that made me confused, more wrapped up in myself, more tangled. I needed to try and spend more time with people. Made a concerted effort to notice things – notice nature, notice seasons changing, notice the weather. Feel the wind, smell fresh air, taste, touch. Pamper myself – take pride in myself.

MARISKA: I think I understand now for the first time what spirituality is about. It makes me feel far more positive just to know that I need not seek and worship God like everyone around me. I also realize that I will have to decide about my future. I do not want the illness in my life but it is also difficult to have a life without it. I know that I am going to fall back and that I will have to fight again. This is what I fear most, the very big disappointment if and when it happens.

In view of the above, for the new changes to be lasting, change had to be something the participants desired. Insight for the three participants necessitated an openness and willingness to engage with a new spiritual language and narrative. Once they came to understand their spirituality as something unique, a shift in the illness relationship became possible, with their spirituality becoming evident in their own power and voice.

Firstly, a change in life-narrative had important biological consequences in how it coordinated the physiological states of the body. A relaxed body also meant a body that was no longer anxious, subjected to control by anorexia/bulimia. Furthermore, discovering their own spirituality meant acknowledging their own connectedness, not only with the self, but with all outside of the body. They came to feel they were part of something larger, promoting not only their own well-being, but also feelings of intimacy, community and connection, factors which proved paramount in their healing.

MARISKA: For a long time I struggled to free myself from feelings of guilt about God. I couldn't understand Him at all. I misunderstood God because others tried to tell me how I should experience Him. It did not help me trying to get better by myself. I had to come to a point where I simply had to focus on something bigger than myself. I had to start looking up, looking people in the eye, seeing things around me. God became a reality for me the moment I began to look for Him within my own context. I began to understand Him, started to appreciate nature and see the good in others. Spirituality was the 'missing link' which I needed to heal.

HEIDI: I was unfamiliar with the Bible in the beginning of my healing stages. But I needed to believe in something higher. Stuck at the level I was in, the only thing I managed to accomplish was self-degradation. And I tried hard to love myself but it didn't work. I came to figure it out. I had to find for myself purpose and meaning and in doing that I had to find God, only He could be the combatant of what I was going through, self-hatred and severe dislike of myself.

Entering their lives as something non-abrasive, but healing and empowering, their newly discovered spirituality, found in a relatedness with God, opened possibilities which had not been experienced previously. Because this relationship had dimensions of power and intimacy, the participants were able to address the issues of isolation, loneliness and loss of voice they were all experiencing. They spoke of transcendent experiences which transformed their lives and the joy and pleasure of participating in life again.

HEIDI: I started to talk to God about things, connecting in that way, reading my Bible when I felt sad. And I fell in love with the idea of having someone or something in my life that promised not to let me down, that had been believed in by millions for centuries, that claimed it could love me and heal me and protect me unconditionally. Because that's what I craved so dearly. I took up my parents' offer of support and tried my best to speak more openly about my sickness. My problem. And eventually the intense feelings of hurt and constriction began to subside.

MARISKA: Something happened to me. I did not look for it, it just happened! For the first time for as long as I can remember, I see things around me bright and clear; almost as if they were not there before, completely out of my sight. I see nature, I feel it in my body, I see the autumn leaves, so bright and beautiful it hurts my eyes. I stand in the pouring rain and just let it come, although I am getting wet, it doesn't matter, I want it! For the first time I knew what it was like just to feel... everything around me was so extraordinarily beautiful. I was taking it all in and was overwhelmed, it was too big, even if I tried, the simplest forms of expression eluded me!

MARE-LEE: When I closed my eyes I was filled with energy, a creative energy filling my body. I felt differently, I knew it was there, that it was up to me to grow or not. I sang with focused attention; never before could I sing with so much commitment. I was searching for a connection with God, I experienced something like a surrender but also a transformation, my thoughts and behaviour changed from myself wanting to be in control to just being one with everything sacred.

The participants came to look for the 'good' in their lives, and to understand that 'good' in the context of practices which promoted their spiritual growth and well-being.

8.2.4 Determined commitment and well-being

Davidson et al (2005:153) maintain that recovery entails what a person *does*, and not something that can be done *to* a person by others. The participants also had to assume responsibility for their own healing. The ways in which they managed their symptoms differed substantially, and although the complete remission of symptoms was not a pre-requisite for healing to occur, the participants reported that being able to manage the symptoms in some way empowered them, which assisted them in taking an active role in their own healing (Davidson et al 2005:152). In order to develop coping strategies according to their own needs, the participants became investigators in an active self-discovery process; and the practice of intensive self-discipline with self-care became crucial to healing (Ridgway 2001:338). Taking back control over their lives from the hold of anorexia/bulimia and the dictates of voices reduced feelings of helplessness and perceptions of victimization, while increasing their own sense of self-worth.

MARE-LEE: I had to continue discovering the pleasure and purpose in life, rather than fighting the elements that took it away from me. It became an everyday challenge, I trained myself to search for the good in every hour of every day, and not to give in. I had to work towards my own good and not against myself. Anorexia had to realize that I was no longer his blank canvas, where he could just paint his symbols of pain and torture. I had to find a way of wiping that away and allowing others to also see me in my new colours...I had to keep on looking how to connect the dots, mind, body and spirit.

MARISKA: I learned that my imagination created my whole world and the only way to change that was to take control over my imagination. And...this proved much more powerful than being controlled by voices! I had to make an effort to start seeing things happening around me. I had to colour in my dull and grey world. And I did. This is where things started to change for me.

In order to overcome the stigma of 'mental illness' and feelings of 'otherness', the participants' immediate social context played an important role in helping them to develop a renewed sense of self and identity. One point of transformation came for the participants when they chose to turn away from destructive people in their past and sought to bring new, healthier relationships into their experience.

MARISKA: To heal requires self-confidence, determination and strength. It's amazing how much I learned about myself while I was getting well. I had never realized what a strong person I was. One of my biggest problems in my life was that I surrounded myself with people who made me feel negative about myself. H (a girl whom I was friends with) drained me and made me feel powerless. I simply had to get her out of my life or I would never have gotten better. A person cannot get well if you are powerless.

HEIDI: Who I surround myself with is important. It's not pleasant being around friends who are insecure and calorie-counting and looking in the mirror every five seconds to check how much weight they've put on. Pills and force feeding can help relieve symptoms but will never cure the pains of the heart and the injured spirit that accompany the disturbed eating habits. For everyone it's different, the causes are different, the hurt is different, but one thing's for sure: it's never, ever worth it.

We learn from the participants' reflections that they often had to push themselves to move beyond social withdrawal and into relationship with others. According to Deegan (1996:97), responsible action includes being 'willing to try and fail and try again,' to involve oneself in life. As the participants internalized new relationships characterized by love and support, earlier traumatic experiences faded, and new relational experiences created a new sense of self. It brought a sense of belonging in the world that they had not known for a long time, and within this new space of belonging, the participants experienced an enhanced sense of competency which gradually became the centre of power in the 'emerging self' (Poling 1991:99).

MARISKA: Since that time on the campus when I really felt God's presence, it is as if I am constantly looking for more, wanting to experience more. Because of what I felt, even when I did not look for it, I know it is there, I now go out searching for it. This past week I have made a constant effort to look at people's faces on the campus, and to carry a face with me all day long. I often see God in people. I think He sends people to me. Particularly faces of people who do not want me to hurt my body.

The participants' stories also indicate that finding hope and support did not always involve other people – comfort was sometimes found in animals or pets. They also emphasise the importance of their having faith in God when life was at its bleakest.

MARISKA: My budgie Mystique brought life into my existence. While I was on my way to buy the bird, I suddenly realized how much I had changed. There had been nothing alive in my room for a very long time and suddenly I wanted to have something that could share my life. This was a big change from within.

MARE-LEE: Spending time with my dogs always had a calming and relaxing affect that made me feel loved again. I had to connect to God for inspiration to find purpose and meaning in my own unique way. Without the connectedness of relationship one is not only unable to love who you are but are also unable to love others, animals and God.

Feeling supported, hopeful and committed to and capable of healing, the participants were also drawn towards involvement in meaningful activities and the development of social skills. This also afforded them a sense of purpose and direction in their lives.

MARISKA: I know that I am busy healing. It becomes easier to notice the beauty of life. I also had to learn to let people into my space...I realized that it's fine to have people close to you.

I am much more aware of my own self. I am beginning to appreciate the uniqueness of Mariska. I begin to believe my music teacher when she tells me that I have extraordinary talent. I begin to like my sensitive nature.

Becoming mindful of the self created a spiritual energy which brought change at every level. Caring for the body and spirit became synonymous, as was the care and love for friends, nature and God. At the same time, the participants were no longer storying their experiences through a body victimized by recurring symptoms. Instead they developed self-narratives that became protective, healing and soothing for the body (Griffiths & Griffiths 1994:135). In this way, each participant learned to take direct responsibility for the physiological state of her body.

Healing meant a coming together in order to make whole, so that the dividedness between the body and the self so evident in the eating disorders was now attenuated by the participants' beginning a routine of self-care. Self-care includes caring for the self (spirit) both physically and emotionally, and may also include asking for help (Ralph 2005:138).

MARISKA: After I have had a taste of all the 'good' in my life, it is as if I am compelled to look after myself in a very special way. Definitely more so when I go out with friends. Sometimes when I have had too much wine, old feelings return. What I can say now is that I have learned not to cut myself any more when I feel down, and this has been a tremendous step in my journey towards healing. Although I can say that I am well, it is still a 'fight' to stay there. But I comfort myself because the fight is worth all the effort. And yes, it gets easier, much easier.

MARE-LEE: As I got closer to connecting the dots, mind, body and spirit, I discovered change. I was starting to look after myself again. I was willing to put some time aside to listen to myself, to ask myself what I needed and how this could be achieved. It was the little things I started to appreciate again.

Having hope and believing in the possibility of a renewed sense of self and purpose, makes possible the next essential step on the journey, that of empowerment and healing.

8.2.5 Empowerment and healing

With a new awareness about their own spirituality and a growing feeling of security, Maree, Mariska and Heidi were empowered to exercise this new spirituality in all areas of their lives. Gaining self-power (as spiritual power) was evidenced in transcending the bondage imposed by anorexia/bulimia, through growing and becoming more. This meant the active development of new counter-practices, new habits and ways of thinking so that they no longer participated in the destructive stories they held about their lives. Escaping the influence of the problem story meant that it had to be challenged where it existed, in the participants' lived experiences – in the *practices* of their daily lives that *embodied* it (Griffith & Griffith 1994:132).

MARISKA: 'All healing is self-healing'. This is what Joan told me probably a hundred times. But I chose not to understand this. I wanted her to make me better. Or anyone else. As long as it was not up to me. This meant that I had to decide for myself whether I wanted to get better. And this is the truth. Because this is the only way to really achieve healing.

No longer distanced from the needs of their bodies, healing became synonymous with improved health and functioning. For the participants, it meant a process of retrieval (regaining what was lost to the illness and its treatment) and a process of discovery (moving beyond the illness and its limitations (White et al 2005:235). At the same time, healing became transformational, with a deepened insight regarding the self in relationship to the illness. It became a witnessing experience which fostered nurturing of the self and the body. Having regained a sense of inner peace, the participants were now more likely to make and maintain lifestyle choices that would be life-enhancing rather than destructive. The process of healing, as coming to understand and live an enabling spirituality, became a personal reality in which the participants worked towards re-establishing meaning and purpose in their lives.

MARISKA: The voices in my head are almost gone because I decided I will no longer give them the space. I also am no longer drawn to writing about the darkness and unhappiness which for such a long time occupied my life and

thoughts. I know that for someone reading all this it may sound too good to be true. Sometimes I too wonder about it all. I am vulnerable, but times when I do feel in control I appreciate with everything inside me. I hold onto what I now have. Sometimes I fall back but I get up from the dust and remind myself of just how good it is to live without voices in my head! I know that life does not have to be bad and that it gives me so much power to be in control of my body; not bulimia, not self-mutilation. Only me!

Additional efforts that participants made in their own recovery are seen within the framework of reconstructing an effective sense of self as a social agent (Davidson et al 2005:160). Recovery was fostered through discovering the potential of the self, the perception of who they could be free from anorexia/bulimia. It called for an examination of the strengths and weaknesses of the self, given the challenges presented by the illness. This new, developed sense of self became the bulwark against anorexia/bulimia and toxic social discourse.

MARISKA: There are still days which are more difficult than others and I know there will come times when I will feel discouraged and wish I could go back. I take every day one at a time and try as far as possible to fill my life with positive things and positive people. My journey is a long way from being finished and there is still much I want to do, but every day is for me a day further from sickness. Fortunately I have learned that there are other empowering things which can help me through a crisis. My illness was not worth it for even one day.

HEIDI: I had to look long and hard, stare at myself and retie those loose threads that had splayed all over the place. Find a way to tie them. I had to deal with life and deal with myself and finding faith helped me to do that. Faith. Faith in life in general, and faith in my life specifically. I found faith and I found purpose and I got to shore.

I have plans for my life. I have dreams and ambition and I feel I have potential. I am not restricted by my physicality, I have learned to embrace it.

It might not always be a love affair – everyone has ‘fat’ days – but it’s a working relationship. ...making myself sick or starving myself pales in comparison to the completion, stimulation and belonging I feel when I’m participating in Life. There’s no space for isolation, for secrets, or suspicion. There’s no time, no place for the caging-in that the eating disorder causes. No need for entrapment; that seclusion, that shutting out.

In order to give effect to the research questions, in this section I have reviewed the healing journey as it was experienced by the participants. A progression of stages and a number of particular themes were identified, emphasising the evolving nature of the participants’ spiritual growth on the road to healing.

8.3 HEALING ABRIDGED

In Section 8.2 the participants’ autobiographical accounts are reflected on and reconstructed in order to present the re-storying of three lives, experienced by the participants as a ‘re-awakening of hope after hopelessness’ (Ridgway 2001:337). Given the non-linear nature of recovery, the healing journey captures metaphorically the spiritual growth in the lives of the participants. Having lived a disabling spirituality marked by anguish and fear, they grew into the richness of relational life, embracing the spiritual on the road to self-empowerment.

During the initial stages of the journey, anguish and despair best described their being-in-the-world, which was living a spirituality marked by vulnerability, with feelings of inadequacy and unworthiness. There is a sense of deficiency in spirit, a ‘sense of disconnection from a source of nourishment and continuity: a tear in the sense of simple going-on-being’ (Todres 2004:4) There is a feeling of something missing, a reaching out to what may come, so that the healing journey progresses to a renewed sense of hope, where the participants assume primary responsibility for their own healing.

After the hopelessness caused by a medical diagnosis and the power with which the eating disorder enforced rigidity and control, the healing process also captures the inherent strength

in a newfound, empowering spirituality that challenges the false claims of anorexia. The participants have come to learn how to control the symptoms which have crippled their lives and to build important support systems in order to deal with the illness proactively. Moving from a problem-dominated story to the re-authoring of an empowering life narrative, the healing journey is the epitome of a life-story that has been reformulated, creating space for a renewed sense of meaning and purpose, in which self-care becomes caring for the body and spirit, achieving unity and wholeness of mind, body and spirit.

Whilst healing remains a very personal and private experience, some common denominators have been defined and are evident in the process of healing. These are discussed below.

8.4 HEALING: COMMON DENOMINATORS

Based on the participants' first person accounts, in what follows I emphasise common themes which capture the essence of healing. As people journey to find new sources of self-empowerment and worth, and new ways of defining achievement, the participants' stories provide innovative ways of viewing the healing experience.

8.4.1 Healing: embracing spirituality, relationship and connection

Reflecting on the qualitative research process, healing became the embodiment of those entities that constitute our humanity, the unity of mind, body and spirit, standing against the incoherence of the self. In terms of the research question, healing implied making whole the wounded self or spirit, which suggests that healing could only be an inherently spiritual process. Hence healing was not directed towards seeking a desired wholeness, but towards coming to know the integrated self in harmony and acceptance.

The healing process may be understood as a journey of progress through various levels of understanding. Thus it signifies the 'coming together' of that which was missing in order to achieve a life of fulfilment. This implies that healing cannot be separated from

transcendence, from an enlarging of the self. For self-transcendence to take place, it was important that the participants shaped their destinies from within, that they themselves became the creators in order to gain the necessary freedom to change. Simultaneously with healing from within, self-transcendence became 'a process of change that originates in the heart, begins with a vision of freedom, with an "I want to become" (Wheelis 1973:105). Accepting the responsibility for making personal choices as their greatest resource, their spiritual growth became evident in their reconnection to life and the world. The participants' stories provide testimony to lives that were miraculously touched when they started to feel the power of Spirit. Having felt powerless, isolated and out of control in a bleak world that was incomprehensible to them, healing brought insight, new ways of seeing, being and understanding, because they were able to position themselves differently in discourse.

Reflecting on the participants' stories, gaining an understanding of and integrating an enabling spirituality, simultaneously placed relationships at the centre of awareness and responsibility. Therefore, the healing process did not occur in isolation, but embraced connection and participation, orchestrated from within, moving outward to include other people, nature and God. Spirituality, as embodied existence, became the vehicle manifesting connectedness through relationship, with the emphasis on relatedness emerging as a primary feature of spirituality (Griffith & Griffith 2002:16).

8.4.2 It's about the person, not the problem

Based on the outcome of this research, our definition of healing (as the human experience of recovery) differs from the notion of recovery from anorexia/bulimia propounded in clinical research, which involves the alleviation of symptoms through the repair of the body. The participants came to recognize the multi-dimensional nature of the spirit, which is capable of choosing and pursuing personally meaningful goals and aspirations, even though they continued to experience the side effects of anorexia/bulimia.

This suggests a new approach in the treatment of anorexia/bulimia: it is the person struggling with the illness, rather than the illness itself, that should be the subject of scientific inquiry. This entails further consideration of the individual's role in her own healing and recovery,

both within and outside the context of formal therapeutic treatment. This approach signifies a break from traditional models of psychological research, with a new emphasis on the spirituality of the person as upholding and giving effect to subjective experiences felt in the spirit.

8.4.3 Healing: an ongoing and personal journey

According to the reflections offered by the participants, healing should not be understood as what Deegan calls an 'end product or result' (Davidson et al 2005:150). Nor is it synonymous with curing (White et al 2005:233). Instead, healing presents itself as a dynamic, lifelong process that involves an indefinite number of steps in life's domain. Scotti (2009:845) refers to this process as having to 'learn to live life all over again', a process that occurs in small steps over a long period. For this reason, the healing process may be seen as a uniquely personal process that embraces a particular way of life (Davidson et al 2005:150). The experience of healing was inevitably a very different process for each of the participants. Because healing cannot be measured, it was also impossible to formulate one set of essential ingredients that will hold true for everyone (Ralph 2005:137). However, the process of healing does reveal several common denominators which are highlighted in the reflections offered by Mare-Lee, Mariska and Heidi.

8.4.4 Healing is standing up to self-doubt

For the participants, overcoming self-doubt was about coming to honour and love themselves again. Life took on new meaning and purpose when they came to value themselves, believing they could make an important contribution to others and to their communities (Ridgway 2002:339). Over the course of the healing journey, a renewed sense of self emerged, a more positive sense of self that existed beyond the disorder.. Attainment of a more positive sense of self did not mean that the challenges they faced were ignored or forgotten. In fact, acceptance of certain personal limitations or vulnerabilities became a valuable aspect of their recovery (Ridgway 2001:339). At the same time, active coping required a high degree of self-awareness, including acute attentiveness to both sources of stress and positive resources in their environment. The participants learned to actively self-

monitor their own state of mind by attempting to keep in touch with their feelings and attend to difficulties immediately.

8.4.5 Healing is determined commitment and well-being

Most of the narratives point to the fact that healing or recovery is not a sudden conversion experience. Instead, it is a slow process that takes substantial ongoing commitment. Nor is the journey linear. Rather, the journey is made up of a succession of stages and accomplishments. It is an open, (r)evolving process, marked by setbacks and relapses, often causing disappointment after periods of positive functioning (Ridgway 2001:339). The participants regard the process of healing as encompassing well-being rather than health, and although healing was orchestrated from within, they also acknowledge that they could not go the distance alone, expressing their appreciation of a network of people who provided ongoing love and support in coping with the demands of anorexia/bulimia.

8.5 HEALING FROM WITHIN

In Section 8.4, I indicated that there were some similarities in the personal narratives of the three participants in reflecting on their experience of healing. Given that healing is a highly individualised and personal process, it poses challenges for treatment approaches which administer healing from the outside. The outcomes of this study suggest that the healing process emanated from the spirit, confirming the personal nature of healing. Moreover, it places emphasis on 'seeing' the whole person in the context of illness, rather than becoming fixated on the 'problem' brought to therapy.

For healing to take place, the participants had to reconnect to themselves. This meant restoring and achieving unity of body and spirit, previously experienced as a state of disassociation brought about by the illness. Abuse of the body placed the spirit in jeopardy so that the body, ill and in pain, withdrew from living and relatedness to adopt a position of social withdrawal and alienation. Healing therefore implies a deeply spiritual process, with the participants having to re-discover their own spirituality, a personal and ongoing process

from within. This further underscored the need for the participants to take responsibility for their own healing. Evident in the healing process was the introduction of various coping skills, for example, actively engaging in everyday activities or avoiding the 'wrong' company, always being mindful of people and circumstances that might cause a return of the illness symptoms. Essential in the healing process is the extension of the self, with the self growing and evolving to become more.

The growth of the self which can be observed in the lives of the participants goes hand in hand with connecting to and participating in their worlds again. A changed relationship with the illness opened possibilities for 'other' more empowering ways of being, new ways of participating in life. The healing process includes the re-establishment of relationships that had become broken, and is accompanied by a different happiness. Thus they have a new appreciation for the smaller things in life. Also, no longer dominated by voices, the participants were able to experience a calmness and serenity which the illness had denied them.

I now move to reflect and describe the qualitative inquiry by paying attention to the embodied engagement within the therapist/researcher-participants' face-to-face encounters, in order to demonstrate how the positioning of our lived bodies affected experiences which determined the results obtained in this study.

8.6 STAGING THE QUALITATIVE INQUIRY: AN EPISTEMOLOGY OF EMBODIMENT

In the following sections, I unpack the qualitative journey which was a combination of both therapy and research, so that I write from the position of both therapist and researcher. The research I undertook was about spirituality and spiritual experiences in the context of eating disorders. The focus on spirituality was not limited to the participants only, but importantly how my own spirituality, embodied in the relational interaction between myself and the participants, shaped the construction of meaning and impacted on the outcome of this study. Spiritual care is inseparable from physical, social and psychological care, because together they form a whole – it is in the *connection*.

Experiencing the effect of diagnosis and feeling they had somehow lost hold of reality, the participants were very scared and emotionally fragile. Feelings of disembodiment had caused their particular self-stories, as these had been projected into the future, to become broken. They experienced pain in their ways of being in the world, creating estrangement in their sense of embodiment, giving rise to illness experiences very different to mine. Most importantly, the participants could not sense or experience the physical world unless they too were physical – unless they had the capacity to touch and be touched by those around them. The ways in which I participated with Heidi, Mare-Lee and Mariska became central to the process of healing; and these ways established the heart of this inquiry.

I situated the inquiry within conceptual frames of reference for patterns of knowing, so that my positioning drew on these broadly defined forms of knowing, directing me in authentic and ethical ways of being and doing both therapy and research. Accordingly, different forms of embodied knowledge provided epistemological significance and shaped the means by which I came to ‘know’ and act. Feeling and being connected positioned the participants and myself in ways which anchored the research inquiry within the framework of a ‘spirited epistemology’, an epistemology grounded in humanity (Vella 2000:7).

8.6.1 Spirituality and pastoral care: a spirited epistemology

Spiritual care began with ‘seeing’ the other person. It had to involve looking past the physical if I was to connect with her inner spirit. The ability to ‘see’ the wholeness and vulnerability of the person in front of me allowed me to look beyond the confines of anorexia/bulimia. It meant that the quality of the *engagement* between myself and the participants became a matter of crucial importance, rather than any emphasis on difference or otherness evident in the emaciation and social withdrawal of the body. Hence, caring did not mean objectifying the body, but rather embracing their bodies as vulnerable and in need of healing. This meant seeing and experiencing anorexia/bulimia in a new context. Todres (2004:1) states that it is in the existential task of having compassion for vulnerability that the potential of a ‘wound’ connects us empathically with others. It follows then that the impulse to care does not necessarily depend on the participation of the one that is ill, but on the unfolding of the caring relationship (Montgomery 1993:83).

Caring happens when two people 'experience union at the level of spirit, giving them access to a greater energy that serves as a source of self-renewal and healing' (Montgomery 1993:33). Montgomery (1993) brings to light the invisible aspects of caring communication and explains the power of these moments. The most important behavioural manifestation of caring is to empower patients/clients to mobilize their own resources. The 'focus is not on what the caregiver does to 'fix' the problem, but rather to facilitate the patient's (or client's) own inherent capacities for healing' (Montgomery 1993:52). Moreover, healing did not mean that I was seeking a desired wholeness for the client, but rather for Mare-Lee, Mariska and Heidi to know as well as appreciate their inherent wholeness, which illuminated their potential for understanding and created possibilities for action.

Following on from the above, healing can only occur when caregivers are sensitive to and respond to the humanness of the situation (Montgomery 1993:44). Byrne (2007:123) argues that spiritual care calls for a hard, and often painful, process of self-emptying to make space for others. In ministering to the spirit within the person, a deeper connection allowed me to transcend judgments and to connect with the client who is unable to respond in the therapeutic situation. The challenge was to juxtapose feelings of connection with those of isolation, with the concept of connection and relationship coming into play as central in learning to care for the spiritual needs of the participants. The difference between a caring and a non-caring confrontation is that, in providing care for the participants, I was motivated by the desire to stay in the relationship – no matter what, to stay involved in ways that would be helpful to them. It was vital to create the space needed for human feeling and connectedness to emerge, and to suspend the need to suppress, control and regulate this process (Montgomery 1993:129). It meant appreciating the uniqueness of their being – in essence, who they were in mind, body and spirit – in order to make possible the exchange of a healing energy, a transferring from self to other.

8.6.2 An embodied encounter

The body constitutes the main resource for creating knowledge in qualitative research. This distinguishes this form of inquiry from positivist science. Because the body is always present, it participates, shapes and informs who we are and what we do. The body is itself influenced by the interactions taking place between a researcher and those being researched, in this

case, myself and the research participants. In this sense, fieldwork can be nothing but an embodied activity with an embodied awareness of the 'other', structuring the inquiry towards new knowledge that stimulated the research, built theory and practice, with our bodies becoming essential for the practical accomplishment of the field inquiry (Seymour 2007:1191).

Within the broad framework of knowledge construction, I used various activities and situations which structured ways of *being* and *doing* in the context of providing care. In order to be flexible in my practice, I had to be sensitive to the circumstances of every situation, whilst paying attention to the uniqueness of each individual. My interaction was therefore characterized by particular ways of *being* with the participants, that is, how I found myself in each particular situation in order to arrive at *understanding* (Lykkeslet & Gjengedal 2006:81).

The dimension of being is understood in terms of what it means to be human, in other words, understanding my own existence and the relationships of living. The being-dimension also accounts responsibility for a particular kind of *presence*, understood as *being connected* and *being understanding*, where I remain open to 'perceiving and sensing, feeling and living-with the other person' (Lykkeslet & Gjengedal 2006:84). Collaboration at this level constitutes ethical and authentic ways of being. It also provides an opportunity to train oneself to know more and to know with greater insight and openness through feeling. Acknowledging our connectedness is an attitude, a way of being present.

Doing took place in the context of cultural and social discourse, where participation in certain practices suggested my own positioning in discourse, and thereby my knowledge about the world. Beveridge (2002:101) agrees with the well-known comment by Anaïs Nin that 'we don't see things as they are – we see things as we are'. Therefore whatever I do discloses my thinking and assumptions. The construction of knowledge necessitates ways of being that are open to changing circumstances, which involve an exploration or discovery of new themes or ideas that would bring about new realities and ways of experiencing (Lykkeslet & Gjengedal 2006:86). It follows that knowledge co-constructed through forms of being and doing are evolving, open and flexible. Positioning myself as the research instrument, I now discuss these forms of knowledge construction.

8.6.3 Being understanding

Referring to myself as a relational 'I' means that all the knowledge I have about myself and the world is constructed in relational ways of being. No understanding can take place outside relationship. My experiences, thoughts, feelings and ways of acting or not acting constitute the relational understanding between my own body and self, as well as the way in which being in relation with the participants also constitutes selves.

In order to arrive at an understanding of the condition or situatedness of each of the participants in the context of anorexia/bulimia, I had to 'read' the participant, something I did each time I met with her. Reading the participants required me to use my senses: I observed, listened and touched to establish understanding and knowledge about the particular condition (James et al 2010:1507). I had to 'see and sense' each participant in a specific context, which also enabled me to know if she needed extra support and care. An openness to 'reading' the participant meant I was alert to any changes in her condition, to whether she was feeling depressed, tired, withdrawn or sad. I was also required to be on the watch for any subtle communication that she might need special support, where I might be called upon to act at short notice. It is a commitment which brings about a different form of understanding. It is not merely observing, but rather a kind of 'participation and presence' that is open to 'interpretation and re-interpretation'. Knowledge construction is an ongoing process, depending on shifts in our relationship (Lykkeslet & Gjengedal 2006:85).

The most important elements which constituted the construction of knowledge towards understanding were founded on an openly explorative attitude, and an ability to adapt to the circumstances. This openness is a prerequisite for being able to assess different situations and obtain greater understanding (James et al 2010:1508). Reading the participant generates a broader understanding that becomes 'skilled know-how' or embodied knowledge (James et al 2010:1508). This assisted me greatly in assessing the effects of anorexia/bulimia and the likely course of the illness. Making decisions to act quickly, when necessary, suggests involved action from intuitive, hermeneutic experience which is derived from theoretical knowledge (episteme) and practical knowledge (techne). Both these forms of knowledge are incorporated in meaning-making strategies (James et al 2010:1508). Flexibility in my practice was necessary, moving away from the one-size-fits-all approach of

the biomedical model, to considering each new situation on its own merits, so that the flow of our dialogue was never interrupted and the construction of self-knowledge remained new and unique.

Caring depends on the particular context in which it takes place. It is a participatory act in which the focus is the empowerment of the patient/client rather than on control over or the outcome of the results achieved. When the relationship is conducive to both parties, there is a flow of harmony, with both the caregiver and the patient being affected (Montgomery 1993:74-76).

8.6.4 Adaptation

To obtain knowledge, there is a need for openness, both in dialogue and when assessing different situations. Being open involves acquainting myself in sensitive ways with the reference points of others and in that way learning from them (James et al 2010:1503). My helping and caring role had to be adapted to the circumstances the participants and I found ourselves in throughout my interaction with them. It had to be based on 'fact', on my 'reading' where the other person was in a given situation (James et al 2010:1503). Inevitably, I bring my own life and work experiences into every situation, together with different perspectives from my professional background. This basis, which can be called knowledge of 'forms of life', becomes the foundation for negotiating different circumstances. What is known and understood influences what will be seen and understood in every new situation.

The dimension of being was explored in terms of what it means to be human, that is, understanding my own existence and the relationships of living, so that the being-dimension also took responsibility for a particular kind of *presence*, my being at all times connected and empathic (Lykkeslet & Gjengedal 2006:86). I remained aware that physical closeness could threaten the ill person's integrity, so behaving appropriately was always a balancing act (James et al 2010:1509). It was a challenge to position myself with regard to being intimate, but not too intimate, getting involved but not too deeply involved, being caring but also being able to let go, being personal but also professional (Lykkeslet & Gjengedal 2006:86). This form of knowledge is always flexible, emerging through negotiation within the space of

therapist/client, researcher/researched relationship. It is a matter of professional self-understanding, striving to be professional and personal at the same time.

8.6.5 Creating space

The space in-between us was important. Maturana and Varela (1992:246) write about *love*, or the acceptance of the other person beside us in our daily living. I believed the participants when they told me how difficult it sometimes was to cope with the voices. Although I did not understand much of their experience, I sought to be with them in ways that could be healing. Isolation served the interests of the voices, my presence indicated something else: it was a presence they could sense and feel. It was important to create a space in which they would feel safe to talk about the voices, while I had the opportunity to learn more from them about the voices and the power of anorexia/bulimia. Finlay (2005:278) adopts Churchill's term 'empathic dwelling' to describe the situation where a researcher, in staying with the participant's description, becomes ever more open to what is being communicated. Finlay (2005:278) adds that such 'empathic intuitive understanding' requires practice, skill and talent. It is about leaving behind one's own context to project oneself into the other's situation in an attempt to see the world through the other's eyes (Finlay 2005:278).

Reynolds, Scott and Austin (2000:236) observe that to be morally there for participants requires an 'affectively rich responsiveness to others' as the basis for an active engagement, in order to make a positive contribution to their lives. According to Reynolds et al (2000:236), this is an attitude which Dillon terms 'care-respect'. It involves profoundness of feeling, rather than an absence of feeling. The act of connecting, along with openness and commitment, formed the very core of the inquiry, helping the participants to develop an enabling spirituality to withstand the demands of anorexia/bulimia. Accordingly, in an attempt to understand the impact of physical and spiritual injury on the embodied self caused by the illness, I directed my attention to the body, not as an 'expert knower' but as a 'caring other' (Carr 2010:1387).

Care and its ethical implications are essentially embodied possibilities that can only be fully understood when we take into account the body's response to care. Everything we do is a structural dance in the choreography of co-existence (Maturana & Varela 1992:248). For this

reason, contexts, relationships and affective knowledge all became significant as contributing to the embodied practices of ethical care in this study. The body became the research site; and embodiment became the subject of analysis (Seymour 2007:1192).

8.6.6 Discovery

I always aimed to be with the participants in healing ways. The knowledge constructed through sensing and seeing a participant and being open to new possibilities brought discoveries that could assist us in bringing about healing. Everyday small-talk, being curious about her life at home, pets, progress at school or university, was restful and could divert attention from the illness whilst creating a sense of community. It also served as a means to create space between the individual and the illness, which could be used for thinking about and expanding into new and more hopeful realities. Becoming emotionally involved in her life-world meant getting an increased understanding of the illness relationship, whilst at the same time providing an environment of trust and safety.

Making the participants alive to their own self-worth played an important part in their healing. Remembering their birthdays, buying a small present, being interested in their lives, all helped to build self-esteem. Also, being worthy of sharing my feelings – when Sasha died (our old dog and good friend), I shared my sadness with them. Perhaps in so doing they were encouraged to share their feelings too. Given the course of this research, most of the understanding was gained through ‘serendipitous experiential learning’, through becoming mindful of spiritual experiences, with knowledge becoming context-dependent. Based largely on discovery, such a process can never be linear. Instead, I became more knowledgeable as a benefit of the insight I acquired when I came to understand and practice what I experienced. In unfamiliar practice situations, deliberate reasoning helped to guide my decisions. Often I was led to completely new perspectives, not theory-driven ones, but founded on some form of understanding which sustained connection and confidence in my caring practices.

8.6.7 Unknowing

Adopting an unknowing or not knowing position constitutes an approach by which each new situation is appraised with openness and a readiness to make room for all possible types and sources of knowledge. The condition of openness underscores all knowledge as open and evolving, instead of knowledge being fixed, an end in itself. Being unknowing suggests an ignorance on my part regarding the subjective experiences of the participants, in order to arrive at collaborative interaction in the construction of new knowledge.

At the same time, connecting with the participants as a means of learning and discovery inevitably included many affective experiences which shaped the inquiry in many ways. It meant that I often found myself shifting between opposing positions of give and take, commitment and withdrawal. Under these circumstances, what became crucially important was the identification of diverse contexts within which spiritual coping strategies could be developed and given meaning. This made it possible for the project to be continually regenerated and redirected in terms of how each research participant perceived the 'other'. It was this dynamic of interaction that shaped the context and the content of what transpired and further uncovered the processes underlying spirituality and its relationship to mental and physical health (Gockel 2009:227).

8.6.8 Challenging times

As mentioned earlier, during the journey with the participants I often felt physically and emotionally drained. I remained critical about my own practice of care and was often confronted with difficult decisions regarding the best way forward. Journeying with the participants and occupying the role of therapist and researcher was, at the best of times, like trying to piece together an ever-changing puzzle (James et al 2010:1513).

Although my strategy was to focus on the person rather than the eating disorder, there were times when I had to intercede when family relationships became strained, mostly because of ongoing conflict at meal times. This was difficult for me, because I had noticed 'other' habits

that were very empowering for the participants. For example, one of the participants had started to connect with her family and school friends again, yet the family remained concerned because she was still not eating what they felt was sufficient.

There was also the problem of self-mutilation. I was concerned; what if the participant accidentally cut too deeply? On occasion, one of the participants was unable to manage bulimic behaviour. These situations were not always easy to cope with, because I had to show concern but not alarm.

It was very important that I dealt with each participant in a unique and personal way. I had to remain flexible in order to accommodate their differing needs and circumstances. Embarrassing episodes in their lives, when people stared or made judgemental comments, broken relationships – all impacted on the illness, delaying recovery and the re-establishment of wholeness. However, our struggle together against the illness undoubtedly brought us closer.

Anyone embarking on such a journey must be willing to be involved in the various stages of healing in the client's life. My body, as I experienced it in the research context, was often 'hard-driven' because of the unruly nature of anorexia/bulimia, and the dilemma of how best to work with the participants. This was compounded by the fact that available literature was not of much help. I think what helped me to maintain equilibrium was the fact that I was always optimistic about their achieving healing and that I lived that reality. Also, I have a strong support system in place in my own family, with my husband and children, together with the fact that I maintained my own interests and gave myself space between counselling and my private life.

Although we experienced conflict at times, it was more a loving struggle for the common good of the participants. Through conflict, new perspectives were formulated through which deeper knowledge was obtained (James et al 2010:1504).

8.7 THE ETHICS OF CARE: CONSIDERING THE 'OTHER'

The above discussion emphasises care as practice. I discussed how the engagement of new practices also gave rise to new knowledge, embodied in particular ways of *being with* the participants in helping them to achieve healing. In the context of providing care, emphasis was placed on our mutuality as human beings rather than on any expertise, suggesting practice as the medium by which moral values were articulated (Graham 1996:98). My positioning and situatedness in terms of being with the participants in order to be able to connect with them expressed a particular kind of 'in-between' space referred to by Buber (1937) as the I/Thou. This in-between space and the way in which it is used determines whether the patient/client is perceived as embodying 'Thou' or 'it' and has significant implications for the treatment of the eating disorders.

It is not possible to listen outside a relationship. The relationship is a given, and through interaction is transformed in one way or another. This has implications for touching. To touch an ill person does not refer to the physical only. They are touched when someone is seeing, hearing and witnessing their illness stories ethically and empathically, making room for them to articulate and make known *their* particular reality as they live it. If their reality is denied, they remain recipients of treatment and services rather than becoming participants in empathic relations of care (Frank 1995:109). This suggests that much illness behaviour can only be understood when the 'would-be interpreter is able to enter imaginatively into a world *without* purpose' (Frank 1995:107). Furthermore, intuitive and embodied knowledge were repeatedly held up as critical sources of knowledge for therapeutic benefit. Through the processes of reflexivity and reciprocity, individual subjectivity and embodied knowledge were repeatedly used to contextualize and bring forth the creation of new knowledge (Broom 2009:1053).

In order to accommodate the needs of the 'other' more fully, this research project cannot emphasise too strongly that treatment of the eating disorders requires ways outside the medical for looking at, understanding and being sensitive to the one that is ill, something which poses significant challenges for all those in the caring professions.

8.8 THE WAY FORWARD – IMPLICATIONS OF THE RESEARCH FINDINGS

As long ago as 1982, Pellegrino (1982:157-166) wrote about the needs of the individual as a result of the experience of serious illness, and the moral and ethical requirements of a fully authentic healing relationship. Pellegrino further drew attention to illness as something highly personal, not open to be experienced by someone else. This individual response to illness challenges the present-day treatment of patients, given the objective/subjective divide which persists in the Western medical model.

The findings of this study suggest that for those living with an eating disorder, the struggle is not primarily about food. Instead, anorexia/bulimia appear rather to be symptoms arising from a vulnerability to develop the illness. This is something which is not only significant for an understanding of spirituality as a key dimension of well-being, but calls attention to the prevailing notions of normality and pathology as defined within the medical model. If the condition of an underlying vulnerability gives rise to a wounded self, leading to the development of chronic illness and addiction, then greater emphasis should be placed on the subjective or the spiritual in order to arrive at a better understanding of the person's situatedness in such illness or addiction.

For the ill person, it is the spiritual, subjective experience of being wounded which calls attention to the need for spiritual and moral care from those who profess to heal. However, caring responses and responsibilities to others are formed and habituated in our bodily openness to the 'other's' experience of illness. A need to understand something of the 'other' as a living, lived body reflects the existential and ontological nature of illness which directs practices and care responsibilities within the realm of care ethics (Pellegrino 1982:157-166).

At the same time, the study highlights existence as situated in the inter-relatedness and interdependence of mind, body and spirit, as subjective and affective experiences proceed from the spirit. My focus on spirituality as this sense of embodiment, which is essential to understanding the existential dimension of illness, transcends the dichotomous ways of thinking that have restricted Western thought for centuries, because spirituality as embodied

existence, lies at the juncture of some of these fundamental dualisms – mind/body, nature/culture, public/private.

I believe my argument is relevant to the current debate in the field of mind/body medicine. Physicians acknowledge that something is happening in this relationship which has an impact on the physiology of the body. With the potential for improved health care, some disregard the issue as a ‘mystery that is beyond our capacity to solve’. Such a statement is indicative of a perspective shaped by an epistemology uninformed of the capabilities of the self (spirit) to heal. The current debate is not merely a topic of scholarly interest, but seriously affects how those in helping professions ultimately care for their patients (Beveridge 2002:102).

In summary, the objective/subjective divide of Western science, appropriately labelled ‘*Descartes’s Error*’ by Damasio, according to Beveridge (2002:103), has sparked opposing views from many because of its dehumanizing approach to patient care. The question that is raised is whether the time has come to abandon this divide (Beveridge 2002:101-103). If medicine is both an art and a science, together with the newly emerging interest in the medical humanities, there is some urgency in seeking how the ‘arts’ can assist clinicians in attaining a deeper insight into the problems of their patients. It calls for an individual understanding of the patient, attending to the whole person, rather than perceiving the human being as consisting only of signs and symptoms (Beveridge 2002:102).

Whether or not this is achievable remains open to debate. I am of the opinion that it is not about the objective/subjective divide *per se*. When it comes to empathic witnessing, it takes a whole (embodied) doctor to hear a whole patient. For a clinician to be ‘whole’ requires ongoing reflexivity and awareness of practice which incorporates both the professional and personal realities of ‘being there’ for the one who is ill. It calls for a willingness and openness to actually ‘see’ the patient, somebody whose life has been affected by illness, somebody who has a story to tell, somebody in need of care. It is this ‘space between’ which is of critical importance, where people’s stories can be heard by those who profess to care. It calls for an intersubjective, dialogical approach which is inherently ethical, before any collaborative work can begin. Such a positioning provides the patient with an opportunity to be listened to, and

to communicate his or her needs and feelings. In addition to being heard, there also seems to be a co-equal or even deeper wish of being understood.

The fact that clinicians have the opportunity to work in the space between the world of medicine and the world of the patient is encouraging (Watson 2007:1285). Then again, these parallels are not simply incidental; they speak to a common process. Spirituality is embodied existence. It affects the attitudes and perceptions of both the healer and the patient, thereby influencing the healing process, the process of making whole. Compassion, humility and faith have their origin in the spiritual dimension and are difficult to experience outside this context. Awareness of this dimension automatically draws attention to the clinician's own spiritual resources, which together with developments in modern physics, suggest possible avenues for reconciling the medical and spiritual paradigms. It is therefore important that those who profess to heal should assess their own attitudes and perceptions to ensure that these are consistent and ethical, and do not compromise the healing relationship.

This qualitative inquiry challenges prescribed ways of thinking in current medical practices pertaining to the treatment of anorexia/bulimia, questioning the attitudes and beliefs generally held by professionals and society regarding the illness. The inquiry, being open and reflective of new knowledge, endeavours to investigate what constitutes and sustains spirituality as embodied practice. It is hoped that this will stimulate further dialogue that will promote the rationale for spirituality as a key element in healing, particularly in the treatment of anorexia/bulimia, as well as other forms of addictive behaviour.

8.9 TAKING THE RESEARCH FURTHER: THE AGE OF CELLULAR INTELLIGENCE

With the social constructionist movement came the idea that as humans, our lives are constructed in and through relationship, by means of language and social interaction. In a recent article, Gergen and Gergen (2006:118) posit that changes in human behaviour are always understood as distinctly psychological, but should be interpreted in terms of relational action. However, I would suggest that the term 'relational action' is meaningless without referring to the biology of the human being. Pellegrino (2001:570) is of the opinion that all, except the most absolute mechanistic materialists, acknowledge the realm of the spirit, that we all have a spirituality (or spiritual component).

Opposing the reductionist approach of Western dualism, recent scientific studies into single cell intelligence now point to embodied forms of knowledge, rather than the brain, controlling much of what we do. Ford (2009:358) explains that 'while we are taught that the brain controls all our bodily functioning, in fact most of the body's cells are invisible to the brain and are indifferent to its regulation. They do not even know that it exists'. If relatedness is the core concept on which spirituality rests, one cannot but consider the same relatedness and consciousness existing in single cell organisms like the amoeba, which displays both intelligence and awareness. With spirituality giving effect to embodiment and relatedness, awareness of the amoeba is exhibited by the life-force within it.

Ford's (2009:350-365) work suggests that cells in the human body have both intelligence and memory. He describes cellular activity after surgery when individual cells in some inexplicable way detect what has happened and start repairing the body, as an immediate response to the injury the body has sustained. For me, this brings to mind the sacredness of the human body and all life forms which Western dualism has chosen to ignore. Ford (2009:356) suggests that every cell, invisible as it is to the naked eye, contains in itself the 'creative, reproducing, repairing and recreating qualities, determining the future of the body in which these cells reside'.

In this study I have argued for the body, that we live through the body, that our emotions are embodied, that we relate through the body, that our spirituality is expressed in embodiment. Interestingly, with the age of cellular intelligence upon us, Ford (2009:358) writes: 'Our brains help us to rationalism, communicate, coordinate and interact, but brains are not the origin of the senses. We are who we are, not simply as the result of cells acting in concert, but as the coordination of a property inherent within each single cell' (Ford 2009:364). The question I ask is whether there is a spirituality present in the cells of our bodies, providing the potential flow to existence through the intelligence and memory capability inherent in the millions of cells that provide structure to all life forms.

8.10 IMPACT OF THE RESEARCH ON THE RESEARCHER

Ceglowski (2000:96) writes that doing research *is* relationship, agreeing with Noddings's view that a caring relationship assumes a sense of connected knowing, a knowing that, in Noddings's words, 'carries with it an intimacy that presumes a sharing of Self and Other'. Richardson (1992:136) states that as qualitative researchers, 'in writing the Other, we can (re)write the Self', so that the qualitative inquiry exemplifies the possibility for 'authoring' one's self (Neumann 1992:200) through a confrontation with others and different worlds.

Gerkin (1984:157) argues that 'to enter with another into hermeneutical examination of the deep issues of that other's soul requires a level of personal involvement and interpersonal engagement that taps the deepest vulnerabilities of the soul of the counsellor at a number of different but related levels.' Similarly, Pellegrino (2001:570) is of the opinion that the highest good which must be served in the clinical encounter is the good of the patient as a spiritual being. If being there for someone in need is a gift of the self (Byrne 2007:118), then perhaps the real challenge of spiritual care is that it not only affects practice but ultimately lives. Our journey together has changed me, my life, my views in a profound way. The inherent suffering caused by anorexia/bulimia has brought the participants and me closer, it has redefined our lives. Reflecting on our journey, I am at peace. For me, the greatest consolation lies in the changes of the lives touched, lives that are a testimony to spiritual experiences, lives that have rediscovered inner peace.

Although we were off to a difficult start and travelled many a rough road, I have found my work with the three participants richly rewarding. It brought me much encouragement and sustains my belief in the ability of individuals to retake control over their lives. Through our time together, I am challenged to work with others who struggle with an eating disorder. I have learned that I can go further than I thought, and that 'compassion for vulnerability' (Todres 2004:1) in the 'other' has made me open to one of the most important tasks, to work with and witness illness stories. Through my involvement, my strength has been tested in difficult situations. It has made me more aware of life's problems and a more caring person.

I have learned many things on our journey together. My life was enriched by the knowledge co-constructed and benefited hugely in challenging the power of the illness. Hence, I must acknowledge Mare-Lee, Mariska and Heidi as the 'experts'. At the same time, I am left with a

tremendous respect for the three participants who opened their hearts and souls to strangers, sharing their lives so that others might come to know healing.

8.11 SAYING GOODBYE ...

The aim of qualitative research is to bring about meaningful differences in the lives of those we work with and write about. This research inquiry has established a circle of wholeness between Mare-Lee, Mariska, Heidi and myself, as well as changing each of us in unique ways. The world, and our place in it, has been transformed. Our journey was a process of learning, of growth, with the participants finding a voice and power to share, to heal and be healed.

As a last word, we offer T S Eliot's (1969:104) moving poem to you, the reader, because we believe that it captures something of what the journey has meant for us.

Journey of the Magi

All this was a long time ago, I remember,

And I would do it again, but set down

This set down

This: were we led all that way for

Birth or Death? There was a Birth, certainly,

We had evidence and no doubt. I had seen birth and death,

But had thought they were different; this Birth was

Hard and bitter agony for us, like Death, our death.

We returned to our places, these Kingdoms

But no longer at ease here, in the old dispensation,

With an alien people clutching their gods.

I should be glad of another death.

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APPENDIX A

OF HUMAN BONDAGE: INVESTIGATING THE RELATIONSHIP BETWEEN ANOREXIA NERVOSA/BULIMIA, SPIRITUALITY AND THE BODY-SELF ALLIANCE

INFORMATION SHEET FOR INVITED PARTICIPATION

Thank you for your interest in this project. Please read this information sheet carefully before finalizing your decision to participate. Should you have any questions regarding this information sheet, please do not hesitate to raise them with me.

THE AIM OF THE PROJECT

This project is undertaken in fulfilment of the requirements for a Doctoral study in Practical Theology with specialization in Pastoral Therapy. In terms of what we have discussed, ideas regarding the aims of the project are as follows:

1. to emphasise the difference between healing and curing in the context of anorexia nervosa/bulimia
2. to promote the health promoting possibilities of spirituality in health and healing so that through this research project, greater empathy and understanding will be created around the illness, with new options, inspiration and hope for those afflicted and their families, as well as for healthcare professionals.
3. to focus on feminine subjectivity and its relation to the female body. The project is committed to understanding the broader political and ethical movement, as it affects the lives of women. The autobiographies serve to give 'voice' and inspire resistance to this life-threatening illness in an attempt to foster positive social change.
4. To assist you in writing a novel in which you wish to make known your struggle with the illness. You expressed a keen interest to use your autobiography for the project as the stepping stone to a heart-felt goal.

WHAT WILL BE REQUIRED OF YOU AS PARTICIPANT

No financial reward or any other form of payment will be made for participation in the study. Should you agree to participate in this project, you will need to provide written consent for the

information obtained during our therapeutic interactions to be used in the research report. I will also provide you with a consent form.

I have explained to you that you are a co-researcher and the emphasis of the research project is on our collaborative interaction during therapeutic conversations. I have kept written notes of our conversations. We have agreed that we would write your autobiography from your own journal notes and any other poetic presentations as well as from my notes made during our sessions. As we complete sections of your story, you are invited to comment on and discuss any further thoughts and ideas. Every written piece will be qualified by yourself and you are also free to change anything related to you or your family. The research report will be written in English as will the summaries and other correspondence. At your request these can also be translated into Afrikaans. You are also free to withdraw from the research project at any time.

CONFIDENTIALITY

The completed autobiography will be discussed with my promoter and will be used in the project. Only my promoter and I will have access to the written work and our therapeutic interactions.

RESULTS OF THE STUDY

The results of this project may be published. At your request, details (names and places) will be changed to ensure your anonymity. You will have the choice of using your own name or a pseudonym. A copy of the completed report will be made available to each participant.

APPENDIX B

**OF HUMAN BONDAGE
INVESTIGATING THE RELATIONSHIP BETWEEN ANOREXIA NERVOSA/BULIMIA,
SPIRITUALITY AND THE BODY-SELF ALLICANCE**

CONSENT FORM FOR INVITED PARTICIPATION

I have read the Information Sheet concerning the project and I understand its scope and objectives. All questions have been answered to my satisfaction. I understand that I am free to request information at any stage.

I understand that:

1. My participation in the project is entirely voluntary.
2. I am free to withdraw from the project at any time without disadvantage.
3. I understand that all written notes and journals with my personal information will be kept confidential and destroyed on conclusion of the project.
4. I will receive no payment or compensation for participating in the study.
5. I am aware that Joan's promoter will have access to all relevant material.
6. I am willing to participate in this research project.

.....
Signature of the participant

.....
Date

.....
Name of the participant in capital letters

.....
Signature of witness

Student number: **469-349-3**

DECLARATION

I declare that OF HUMAN BONDAGE: INVESTIGATING THE RELATIONSHIP BETWEEN ANOREXIA NERVOSA/BULIMIA, SPIRITUALITY AND THE BODY-SELF ALLIANCE is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



.....
JOAN ELIZABETH COLLETT

DATE: 28 February 2011