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INNOVATIONS IN THE TREATMENT OF BULIMIA

TRANSPERSONAL PSYCHOLOGY, RELAXATION, IMAGINATION, HYPNOSIS, MYTH AND RITUAL

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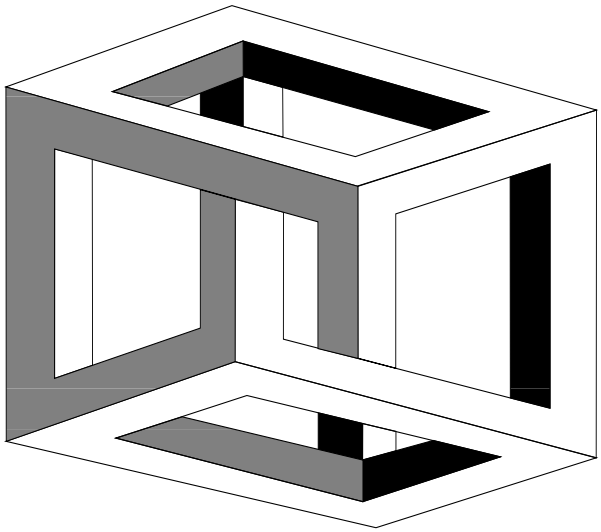
This paper is written for medical and mental health professionals who must help clients deal with the psychological dimensions of bulimia. It reviews bulimia's most obvious physical signs and symptoms, most apparent etiology, most frequent behavioral characteristics, and then considers innovative counseling approaches including Transpersonal Psychology, relaxation training, imagination, fantasy, hypnosis, myths and rituals.



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DESCRIPTION

The term 'bulimia' has become synonymous with binge eating, and the term 'bulimia nervosa' is now used to describe the full clinical syndrome (Giannini, Newman & Gold, 1990). The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM III-R) defines the syndrome thus (p. 67):

DIAGNOSTIC CRITERIA FOR BULIMIA NERVOSA

A.	Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time).
B.	A feeling of lack of control over eating behavior during the eating binges.
C.	The person regularly engages in either self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.
D.	A minimum average of two binge eating episodes a week for at least three months.
E.	Persistent over concern with body shape and weight.

Giannini et al (1990) suggest that binge eating and binge-purge behavior has been common throughout time. In ancient Rome, such behavior was widely practiced. Binge eating was also described in the earliest accounts of anorexia nervosa as a behavior associated with that disorder. During the 1970's, binge eating was reported as part of a syndrome in normal-weight women, and in the 1980's bulimia was identified as a distinct clinical entity (Giannini et al., 1990). Ware (1988) found that bulimia is prevalent in about 5% of the general population, and that 90% or more of patients who suffer from this disorder are young women.

Psychological Abstracts references no articles about bulimia before 1985. Since then, there has been a steady increase in writings about this syndrome, from 83 articles published in 1985 to 254 articles published in 1989. Because of the vast amount of information accumulating on bulimia, this article can only outline its more prominent features.

The following table outlines some of the major physical symptoms and/or effects of bulimia (Giannini et al., p. 1171-2; Ware, 1988, p. 82), expressed in layman's terms by Dr. D. Thomas (personal communication, November 9, 1990) so as to be understood by non-medical professionals.

PHYSICAL SIGNS AND SYMPTOMS OF BULIMIA

Abdominal distention
Abnormal heartbeat, atrial flutter or fibrillation
Anal tears and fissures
"Chipmunk-like" facies, due to swelling of the salivary glands
Constipation (mild or severe)
Dehydration
Electrolyte imbalances (potassium, chloride) possibly resulting in grand mal seizures, persistent spasms of the muscles in the hands and feet and kidney failure
Erosion of dental enamel and subsequent dental decay
Esophageal tears
Increased susceptibility to infection
Intense intolerance of cold
Low calcium levels
Metabolic alkalosis (drowsy, tired)
Menstrual irregularities
Postural hypotension (low blood pressure when standing abruptly)
Prolonged dull headaches
Scarring of the back of one hand
Weight fluctuating by 10 or more lb in one-month period with resulting abdominal striae (stretch marks)

ETIOLOGY

Research indicates there are many different reasons why young women engage in bulimic behavior. Ware (1988) suggests that the onset frequently begins in adolescence or early adulthood and is often preceded by a traumatic event, such as separation from a significant person. The relationships within families of bulimics have been characterized by Steiner-Adair (1986) as unempathic, emotionally distant, and enmeshed, which makes it difficult for bulimics to establish meaningful relationships with others. Negative interpersonal dynamics seem to be the major trigger of binge-eating and stress causes relapse (Wilson & Smith, 1987).

A second explanation suggests that the great importance placed on the physical appearance of women in today's culture, and an inflexible almost stereotypic definition of beauty, results in bulimic behavior (Steiner-Adair, 1986). These two factors cause a high amount of anxiety and discomfort about their bodies in many female teenagers. The freedom which has resulted from advances in contraception, greater access to professions and careers, and the impact of the feminist movement are also sources of conflict for many women, placing them in a kind of developmental double bind.

> Steiner-Adair (1986) says: Research shows that adolescent girls are primarily concerned with the establishment and maintenance of relationships but that neither they themselves, their male peers, nor the current culture at large condones and supports their concern... They have simultaneously been socialized to devalue the importance of relationships, and value independence and autonomy, toward which males are socialized (p. 99).

Perhaps eating disorders are also an expression and consequence of this double bind.

BEHAVIORAL ASPECTS

Bulimics are constantly concerned about weight gain, and the fear of fatness prompts the purge (Andersen, 1985). Meals and social occasions are carefully planned so that the bulimic can quietly exit after eating in order to induce vomiting. Binges are most likely to occur when the person is alone and, after bingeing, bulimics purge, diet, exercise to extreme, or use laxatives and diuretics. They feel guilty about these practices and go to great lengths to hide behavior which is either preceded or followed by a depressed mood and feelings of shame.

> Ware (1988) states that...difficulties in personal relationships and the desire to relieve anxiety and depression often lead to suicide attempts. As a result, suicide is the most common cause of death among bulimic patients--with attempts reported among 20% to 37% of persons with the disorder--and patients with bulimia have one of the highest suicide rates of all persons with psychiatric disorders (p. 82).

COUNSELING: BASIC CONSIDERATIONS

Clients need to understand the disorders from which they suffer, and therapy should help them gain this understanding and help them raise their sense of effectiveness and self-esteem (Gross, 1986). Since most bulimics are not very low in weight and are not subject to the starvation related problems of anorectics, they can usually be treated on an outpatient basis. However, if thoughts or intents of self-harm occur, the therapist should refer the person to inpatient treatment (Andersen, 1985). While the management of bulimia must deal with its signs and symptoms, counseling must be an essential part of any comprehensive treatment program, and there are many different approaches from which to choose.

COGNITIVE-BEHAVIORAL APPROACH

Treatment must address the beliefs, thoughts and fears that drive the disorder, and these cognitions must be changed for improvement to occur (Wilson & Smith, 1987). Alternative behaviors should also be offered to the patient to replace binging. For some patients, goal-directed, short-term cognitive-behavioral counseling is sufficient. Instead of being paralyzed by

the urge to eat, or responding to anxiety or depression with bingeing and purging, patients need to learn how to identify the causes of their urges and respond more effectively to them. Cognitive-behavioral approaches include developing supportive therapeutic relationships, self-monitoring, educational programs, nutritional counseling, cognitive restructuring, problem-solving, assertiveness training, self-control techniques, exposure and response prevention, and relapse prevention training (Wilson & Smith, 1987).

Some bulimics respond well to these programs. Others may have a clear intellectual understanding of their compulsions, fears, and sensitivity to the opinions of others but remain unable to change their automatic responses to them. Cognitive-behavioral counseling seems to be more effective than pharmacotherapy alone but not significantly better than other psychological methods (Wilson & Smith, 1987).

Counseling might be able to facilitate even greater transformational effects on the compulsive behavior of bulimics if more innovative methods were employed--techniques that explore deeper levels of the human unconscious or that awaken higher states of consciousness than simple rational processing (Gunnison & Renick, 1985). These transformational effects can occur by helping bulimics access and develop the functions of the right hemisphere of the brain.

SPLIT-BRAIN THEORY

There is an extensive body of research which indicates that, to a large degree, the left and right hemispheres of the brain have different functions (e.g., Galin, 1974; Hoppe, 1978; Ornstein, 1986). The left side of the brain seems to control the rational, logical, analytical and linguistic functions of consciousness. The right side of the brain seems to control the receptive, musical, symbolic and imaginative functions of consciousness (Brown, 1989). A comprehensive program of counseling would help patients both understand their disorder and make better use of a full range of psychological resources on a path toward greater personal power, enhanced self-esteem, better interpersonal relations, health and wholeness.

The chronic, persistent nature of bulimic behavior may result, in part, from an underdevelopment or underutilization of the symbolic, nonlinear, nonverbal systems attributed to the right side of the brain (Gunnison & Renick, 1985). Techniques which tap and explore these intrapsychic dimensions have proven to be of enormous help in treating bulimia.

Watzlawick (1978) analyzed the elements of therapeutic communication and concluded that the right side of the brain is the home of the individual's "world image"--the subjective way s/he imagines or constructs reality. He argues that techniques which stimulate right hemispheric activity (relaxation, imagination, fantasy, hypnosis, myth, ritual, among a host of others) seem to have tremendous therapeutic effect because they help patients access and transform their implicit world image.

TRANSPERSONAL PSYCHOLOGY

Important insights into the process of transformation are emerging from a field called Transpersonal Psychology (Tart, 1975; Walsh, 1980). In Latin, *trans* means "on the other side of," as implied in the word "trans-Atlantic"; or "above and beyond" as implied in the word "transcend." *Persona* means "mask."

To understand the process of psychological transformation, Transpersonal Psychology examines such unusual experiences as meditation and yoga, psychic phenomena, rituals, rites-of-passage, and altered states of consciousness of many different kinds attempting to distill from these experiences an understanding of the principles and methods which have a powerful and positive effect on the human psyche (Tart, 1986; Wilber, Engler, & Brown, 1986; Grof, 1988). Practitioners carefully employ these principles and methods to awaken and develop important human resources such as imagination, intuition, creativity, inspiration, and insight (Brown, 1989).

The innovative work of Transpersonal Psychology can help clients:

A. Understand how to get above their personalities so they can see them clearly, understand their origins and dynamics, integrate their functions, and transform them when possible;
B. Look on the other side of their masks, roles, and patterns to discover what is hidden, blocked, or defended within;
C. Develop latent human resources;
D. Consciously play roles in life that manifest their deepest values, bring into the world their best talents and abilities, and thereby live more meaningful, productive, wise and loving lives (Brown, 1986).

An explicit combination of exercises which can move people toward the experience of transformation can be found in a process called 'Fascinations' (Brown, 1989), "developed with the split brain hypothesis in mind in an attempt to stimulate, develop, and balance a variety of brain functions and human resources" (p. 52-54). Techniques employed in this 11 step process include deep relaxation, reflective and receptive thinking, visualization, mandala drawing, cognitive analysis, inner dialogue, symbolic identification, and the contracting of explicit homework assignments to ground and integrate the energies and insights derived from the process.

The readiness, motivation, and cooperation of patients are critically important to the successful use of such techniques, and the prerequisite is the capacity of counselors to create positive and caring relationships with their clients so they can begin to overcome their resistance to personal growth, psychological treatment, and change.

RELAXATION TRAINING

The use of deep relaxation is often the starting point on journeys toward transformation. Relaxation techniques can be very useful in helping bulimics begin to disidentify from their dysfunctional patterns of thinking and behaving and begin to tune into other levels of perception. Relaxation is

> a kind of awareness and reinforcement [process] that the bulimic person can employ to gain some control over her or his addictive patterns. Initially, the client is taught to relax by counting down 3-2-1, with 3 being the head, neck, shoulders, and arms; 2 the trunk of the body; and 1 the thighs, legs and feet.

> Through repeated practice the client can relax whenever he or she chooses (Gunnison & Renick, 1985, p. 79).

Instead of being paralyzed by anxiety or depression, or responding to them with bingeing and purging, clients can engage in a variety of relaxation techniques.

> The idea is that one may not be able to change the mental state preceding the binge by act of will, but one can take charge of what *is* under personal control, the amount of tension of the voluntary muscles, and can thereby indirectly change the central mood state (Andersen, 1985, p. 125).

IMAGINATION

When clients relax and let go of their obsessive rational thinking patterns, they are more able to tune into their inner depths to discover the many powerful dynamics operating within them. "Urges, drives, desires, and emotions tend and demand to be expressed" (Assagioli, 1974, p. 60) and this is never so clear as when clients begin to connect with imagination.

> Imagery integrates diverse energies in a way the rational mind cannot do. Where once they were viewing elements within them as separate and discreet, and in opposition to one another (mind, body, emotions, spirit), now they can see how they fit complementarily together. With such insight they can take into account all the dynamic forces within them and act to meet their needs in a wholistic way (Brown, 1978).

> In a sense it is a complete system of ingathering, storing, transforming, and finally of utilizing energies. The normal succession of the psychodynamic efficiency of the symbol is that of attracting psychological energies, storing them, subsequently transforming them, and then utilizing them for various purposes--particularly for the important one of integration (Assagioli, 1965, p. 178).

IMAGINAL DESENSITIZATION

In a technique called Imaginal Desensitization (McConaghy & Blaszczynski, 1988), clients provide descriptions of four typical scenes in which they are stimulated to carry out a bulimic behavior. The descriptions are used to define the feelings and reactions leading up to binge-eating but ceasing before the undesired behavior begins. Clients are then trained for five minutes in a relaxation procedure. When they have reached a relaxed state, they are asked to visualize the first of four scenes. The following scenario might be typical:

> You are driving home from work after a stressful day. The thought of driving to a particular shop to buy some cream cakes comes into your mind. You turn the car toward the shop. As you drive toward it you start to think you will be binge-eating again, putting on weight and unable to eat normal meals. You realize your urge is not so strong and you can resist it. You turn back and drive home without buying any food you use for binge-eating (McConaghy & Blaszczynski, 1988, p. 80).

The scene is described and clients are instructed to signal when they have imagined it while in a relaxed state. After about a minute of relaxation without visualization, the next of four scenes is recounted, and so on, for about 15 minutes. Two such sessions are given on day one and three on the subsequent four days. This technique has brought about significant improvements in patients for whom prolonged psychotherapy had produced little change.

FANTASY

Fantasy exercises can be used to help patients symbolically confront their fears. In a technique called the Fantasy Door Approach (Gunnison & Renick, 1985., p. 80), patients are asked to imagine looking behind a door to confront the block, fear, or irrational self-image and world image associated with their addictive pattern.

Giles (1988) provides a case transcript in which imagery was used to help a patient who suffered from severe bulimia and who was terrified of the thought of weight gain and the social disapproval she believed would result. In a relaxed state, she was asked to imagine looking into a mirror to see her body, focusing on her arms and progressing to her thighs, hips and stomach, and report what she saw to the therapist. She responded well to this approach and after 20 sessions could "fearlessly imagine all the previously feared images. This was accompanied by diminishing numbers of occasions of feeling fat. She no longer suffered depressive episodes. She also stopped 'seeing' herself as obese" (p. 146).

HYPNOSIS

Hypnosis is "a sleep-like condition psychically induced, usually by another person, in which the subject is in a state of altered consciousness and responds, with certain limitations, to the suggestions of the hypnotist" (Webster, 1982, p. 691). It is clear that hypnosis is similar to the relaxation and imagination work mentioned above. The use of hypnosis in treating eating disorder patients has reported success rates varying from 50 to 80% (Pettinati & Wade, 1986). Through hypnosis, patients can be given suggestions to help them develop deeper values in life, better eating habits, a more realistic perception of body image, and more assertiveness in interpersonal relationships (Gross, 1986).

Since the issue of control is central to the symptomatology of bulimics, patients must be helped to understand that hypnosis is an experience that is under their control rather than being a treatment that is imposed on them which requires them to surrender control to the counselor (Pettinati & Wade, 1986). In fact, all of the techniques mentioned above can help them gain more control over their lives. In this light, many clients are willing to learn self-hypnosis as a way to confront and end their addictive behaviors of bingeing and purging (Gross, 1982).

MYTHS AND RITUALS

Myths and rituals are also increasingly being used in the strategic treatment of bulimia. Myths can help patients access and express in an imaginative way the ideational plane of beliefs, values, and affects. Rituals, on the other hand, access the material plane, the patient's observable behaviors and repetitive patterns (Van der Hart et al., 1988).

In the first stage of counseling employing myth and ritual, clients tell a story about their negative experiences in terms of a myth. The myth tells how the accident, the affliction, or disorder originated and why it remains. The issues or problems are expressed in a symbolic manner (Van der Hart et al., 1988).

> In terms of bulimia, Andersen (1985) says: The patient must be helped to recognize the urge when it occurs and to give it a name. Often the patient experiences a vague sense of emotional discomfort, but the urge to binge is not recognized. By making the urge a neutral symptom rather than a source of blame, and by giving the urge a name and a description, the ability of the patient's "observing ego" to recognize the urge and to make decisions about it is strengthened. The idea is to route the dysphoria through the ego, rather than directly into the symptom relief of a binge. This eventually allows choices to be made regarding the urge, and frees the patient from impulsive responses (p. 124).

Rituals are symbolic and repetitive acts unique to the individual which focus awareness and action in positive directions. In the second stage of counseling employing myth and ritual, symbolic actions are performed by patients to eliminate or improve the negative cognitions they expressed in the original mythic story. Rituals can help transform patients' inner experiences and the social relationships in which they are an integral component (Van der Hart et al., 1988).

Protinsky (1987) cites the successful use of ritual with a college student who had binged and purged on the average of three times a week for five years. After a good therapeutic rapport was established, and the patient had developed the expectation of a positive outcome from the ritual, the following procedure was employed.

> Whenever Sara was experiencing the type of guilt that she knew would lead her into depression and then into bingeing and purging, she was to walk from her dormitory to the local grocery store (a distance of two miles), where she was to purchase $10.00 worth of canned goods. She was to take the food and walk an additional mile to the synagogue. Once she was on her way to the synagogue she was to allow herself to experience her guilty thoughts and depressed feelings as much as she was capable. As she experienced guilt and depression, she was to notice how heavy the bag of canned goods felt and how difficult it was to walk with that extra burden. As she approached the side entrance to the building, she was to stop a few yards from the door and spend another five minutes experiencing her guilt and depression. She then was to place her bag of burdens at the door of the synagogue and slowly walk back to her apartment, noticing how easy it was for her to walk without that bag. She was also to imagine how easy it would be to take future walks without carrying that weight.
>
> This particular ritual was to be carried out anytime she experienced the guilt that preceded bingeing, no matter where she was or what time of day it was. Sara honored the contract by performing the ritual three times the first week after its prescription and two times the second week. She reported that she felt a great sense of relief each time she placed the bag of groceries at the door, and that her walks back to her dormitory were enjoyable and her spirits upbeat. By the third week her guilty thoughts and depression had subside/d, and she had no desire to

> binge or purge. She was seen for three more months with therapy focusing on self changes in her family of origin. During those three months she performed the ritual only two times and experienced no desire to binge or purge. A one-year follow-up revealed that she did not experience her bulimic symptoms and reported improved relationships with her parents (p. 70).

CONCLUSION

Bulimia is a severe disorder with profoundly negative symptoms, causes, and effects. Bulimics are often lonely, anxious, and depressed people who need very special help to recover from this disorder. Counseling must help bulimics understand the nature of their disorder; it must help them examine, explore and transform the intrapsychic dynamics which underlie the affliction; and it must provide ways to help them develop more effective and satisfying lives.

Cognitive-behavioral counseling can help bulimics understand their disorder through a variety of educational interventions. The split-brain theory, however, suggests that reason alone is not sufficient to transform it. Transpersonal Psychology is an emerging field which attempts to understand and facilitate the process of psychological transformation through the use of techniques which awaken and develop important human resources such as imagination, intuition, creativity, inspiration and insight. Specific techniques mentioned in this article which help to do this include deep relaxation, imaginal desensitization, fantasy, hypnosis, myth and ritual. These techniques have proven to be of tremendous benefit to treatment-resistant bulimic patients, and deserve further research, application, and evaluation.

REFERENCES

American Psychiatric Association, 1987. Diagnostic and statistical manual of mental disorders, Third Edition Revised. Washington, D.C.

Andersen, A. E., (1985) Practical comprehensive treatment of anorexia nervosa and bulimia. Baltimore: The Johns Hopkins University Press.

Assagioli, R. (1974) The act of will. Baltimore: Penguin Books.

Assagioli, R. (1965) Psychosynthesis. New York: The Viking Press.

Brown, M. (1978) In search of fire. Unpublished master's thesis, Sonoma State University, Rohnert Park, Ca.

Brown, M. (1986) Transpersonal psychology: Exploring the frontiers in human resource development. Pathways: A resource guide to the Baltimore and Washington D.C. area, 9(3), Washington, D.C: Yes Educational Society.

Brown, M. (1989) Transpersonal psychology: Facilitating transformation in outdoor experiential education. Journal of Experiential Education, 12(3), 47-56.

Galin, D. (1974) Implications for psychiatry of left and right cerebral specialization. Archives of General Psychiatry, 31, 572-583.

Giannini, A.J., Newman, M., & Gold, M. (1990) Anorexia and bulimia. American Family Physician, 41(4), 1169-1176.

Giles, T.R. (1988) Distortion of body image as an effect of conditioned fear. Journal of Behavior Therapy and Experiential Psychiatry, 19(2), 143-146.

Grof, S. (1988) Human survival and consciousness evolution. Albany: State University of New York Press.

Gross, M. (1986) Use of hypnosis in eating disorders. New Directions for Mental Health Services, 31, 109-119.

Gross, M. (Ed), (1982) Hypnotherapy in anorexia nervosa. Anorexia nervosa: A comprehensive approach. Lexington, Ma: Heath, 119-127.

Gunnison, H., & Renick, T.F. (1985) Bulimia: Using fantasy-imagery and relaxation techniques. Journal of Counseling and Development, 64(1), 79-80.

Hoppe, K (1978) Split brain--psychoanalytic findings and hypotheses. Journal of American Academy of Psychoanalysis, 6(2), 193-213.

McConaghy, N., & Blaszczynski, A. (1988) Imaginal desensitization: A cost effective treatment in two shop-lifters and a binge-eater resistant to previous therapy. Australian and New Zealand Journal of Psychiatry, 22, 78-82.

Ornstein, R. (1986) The psychology of consciousness. New York: Penguin Books.

Pettinati, H.M., & Wade, J.H. (1986) Hypnosis in the treatment of anorexic and bulimic patients. Seminars in Adolescent Medicine, 2(1), 75-79.

Protinsky, H. (1987) Rituals in the strategic treatment of bulimia. Family Therapy, 14(1), 67-71.

Steiner-Adair, C. (1986) The body politic: Normal female adolescent development and the development of eating disorders. Journal of the American Academy of Psychoanalysis, 14(1), 95-114.

Tart, C., Ed. (1975) Transpersonal psychologies. New York: Harper and Row.

Tart, C., Ed. (1986) Waking up. Boston: Shambhala.

Van der Hart, O., Witztum, E., & de Voogt, A. (1988) Myths and rituals: Anthropological views and their application in strategic family therapy. Journal of Psychotherapy & the Family, 4(3/4), 57-79.

Walsh, R. Ed. (1980). Beyond ego. Los Angeles: J.P. Tarcher.

Ware, M.R. (1988) Pharmacotherapy and psychotherapy for bulimia nervosa. Family Practice Recertification, 10(11), 81-94.

Watzlawick, P. (1978) The language of change: Elements of therapeutic communication. New York: Basic Books.

Webster's New World Dictionary, Second College Edition (1982). New York: Simon & Shuster.

Wilber, K., Engler, Jack, & Brown, Daniel (1986). Transformations of consciousness. Boston: New Science Library; New York: Distributed in the United States by Random House.

Wilson, G.T., & Smith, D. (1987) Cognitive-behavioral treatment of bulimia nervosa. Annals of Behavioral Medicine, 9(4), 12-17.

This article is dedicated to the memory of Elizabeth Stewart, the first client suffering from bulimia with whom the author worked, who died from the effects of this disorder.