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# Gestalt Approaches to Working with Clients Presenting with Bulimia

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**Abstract**

Bulimia Nervosa (BN) affects roughly 5% of Australians and likely many more who never seek help (Centre of Excellence in Eating Disorders (CEED), 2012a). The following paper critically analyses the therapeutic process of working with clients presenting with BN. The main focus of the paper, after briefly presenting DSM-V diagnostic criteria for BN, will be to reflect on this process and relevant interventions from a Gestalt psychotherapeutic framework. This will be done in light of Gestalt therapy's four pillars of field sensitivity, phenomenology, dialogue and experimentation.

## Epidemiology, Aetiology and Diagnostic Criteria

The reported incidence of BN in the Australian population is 5% (CEED, 2012a). However, due to the secrecy that often accompanies the illness, it is likely that many more people are affected (Wardetzki, 2001). The true incidence amongst students and women has been estimated to range as high as 20% (CEED, 2012a). Unlike Anorexia, where the low weight often is cause for alarm, many people with BN are of average weight and their condition may remain unnoticed. Frequently people struggle with BN for 8-10 years prior to accessing help. BN commonly begins after a period of extended dieting and a significant number of people with BN have a history of Anorexia Nervosa (Eating Disorders Association Inc., 2014). Whilst distinguished neatly in the DSM based on criteria of body weight and purging behaviors, clinical practice points towards a continuum of problematic eating with a variety of specific behaviours and weight ranges rather than neatly separated disorders (Black, 2000).

BN is considered a complex condition believed "to be caused by a combination of psychological, interpersonal, social, physiological and external factors" (CEED, 2012b, p.1). The diagnostic criteria for BN in the current Diagnostic and Statistic Manual for Mental Disorders (5th ed.; DSM-5;

American Psychiatric Association, 2013) are:

*A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:*

*(1) Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.*

*(2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).*

*B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.*

*C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.*

*D. Self-evaluation is unduly influenced by body shape and weight.*

*E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa (p 345).*

(Note the reduction in frequency to meet criterion C from 'at least twice a week' in DSM-4 to 'at least once a week' in DSM-5.)

From a Gestalt perspective "bulimic behavior is [the] creative adjustment to [the client's] current environment, the client's way of managing 'unacceptable' feelings and needs" (Gillie, 2000, p 98). Gillie (2000) argues that clients with bulimia are likely to have experienced significant ruptures in their intersubjective field through insufficient support for important needs leading to the emergence of shame whenever these 'unacceptable' feelings arise. The bulimic behaviour serves to temporarily push those shameful feelings and needs out of awareness, soon to be followed by increased levels of self-loathing and shame, creating a vicious cycle. Wardetzki (1995), a German Gestalt therapist, describes BN as a form of female narcissism, mostly experienced at the low self-worth end of the continuum rather than as grandiosity, but similarly rooted in a fragile sense of self-identity covered up by a 'false' self. She cites one of her clients: "Only during my binge-purge episodes can I be truly myself. No one tells me what to do or wants anything from me. I can finally be myself " (p 7, own translation). Many of my clients make statements about not knowing who

they would be without BN or being thin. Much of the work therefore addresses discovering disowned feelings, needs and values, experimenting with making these known, supporting differentiation in the here-and-now and regulating affect when experiencing self as different from the environment. Wardetzki describes this as, "enabling women to reconnect with their own selves, their potency, strength, power and identity in a healthy way rather than through [binge/purge] addiction" (p 7, own translation).

## Field Related Issues

There is enormous pressure on women to meet a prescribed beauty ideal, which is much thinner than the average healthy body weight. The influence of thinness promoting media has been documented in a number of studies, which have shown an increase of eating disorder behaviors following the introduction of western television to remote communities (Allen, 2002; Costin & Schubert, 2012). In Mission Australia's 2013 youth survey, body image, as in previous years, continues to feature among the top three personal concerns (Mission Australia, 2014a), with 42.1% of young women ranking body image as their main concern (Mission Australia, 2014b). According to Jasper and Brown, 60% of women in western society have started dieting by age 13; this increases to 80% by age 18 (Hollands, n.d.). While only some of these women develop more severe forms of eating disorders, many women expend vast amounts of emotional energy worrying about their body shape.

Support is an important factor in the recovery from BN and early therapy sessions may focus on exploring current and past supports, (re-)discovering unused resources and/or exploring options for additional support. Support groups and therapeutic groups play an important role in breaking the isolation, shame and secrecy that often surround people with BN (Black, 2000) and provide many opportunities for working with here-and-now interpersonal dynamics and experimenting with new, more authentic, ways of relating. When working with young people, it is important to involve the family at least in a psycho-educational capacity, if not therapeutically. Involving or resourcing partners of adult clients is also beneficial. Partners and parents frequently are at a loss when trying to make sense of their child/partner's behaviors and, with best intentions, can act in counterproductive ways if not well informed and supported.

## Analysis of Manifesting Phenomenology

Gillie (2000) describes "the phenomenological experience of the majority

of bulimic clients … [as] focus[ing] on other's expectations, rather than on their own felt needs" (p 99). Any experience of not being able to meet these expectations can quickly lead to the very familiar experience of shame, a sense of unworthiness and not belonging, accompanied by the urge to disappear (Shure & Weinstock, 2008). This may manifest in sessions as a frozen quietness, a shrinking body reaction or a sense that the client has suddenly disappeared. Alternatively, it may be expressed through anger at the therapist, contempt or envy (Joyce & Sills, 2010). An active, sensitive exploration which supports the client to slowly re-establish contact is important in either case (Shure & Weinstock, 2008). To be supported to remain in contact, to be met and accepted even though the unbearable, and generally experienced as incredibly shameful, need has become known and seen begins some of the healing.

**Dialogical Challenges Including Ethical and Relational Issues**

"The development of support is in and of itself an essential healing process" (Kepner, 2003, p 15). Working dialogically provides opportunities to experience person-to-person relating in new and healing ways. "It generates the internalisation of a healthy and functional interpersonal field from which other self-structures can grow and be tested" (Kepner, 2003, p 15). The notion of support is often a foreign and frequently scary concept and some clients describe BN as the only relationship they can count on. BN thus may fill the role of reliably providing the pseudo-meeting of one's relational needs, promising nourishment, nurturance, companionship and acceptance. But the shameful needs can only be met in secret and after a fleeting moment of peace and satisfaction one has to quickly rid oneself of the shameful substance to return to the outer facade of being in control/autonomous. Many clients with BN come to therapy hoping to achieve complete emotional independence, hoping to therapise, meditate or medicate the overwhelming emotional needs away. This makes sense as a creative adaptation to an early environment in which relational needs were insufficiently met. Gestalt therapy's dialogic approach allows for an embodied experience of attunement and the co-regulating of overwhelming levels of affect as clients' disowned relational feelings and needs can, with sufficient support, come to awareness. This opens up the possibility of owning one's relational needs and experimenting with strategies to meet these.

Dialogic work centres on working with shame, beginning to notice sensations, feelings and needs and supporting action based on these in the here-and-now and outside therapy. It involves the therapist's interested engagement in meeting the person as a whole, including disowned parts, to facilitate a fuller, integrated sense of self and agency. Feelings, once feared alongside the urge

to binge or withdraw due to shame, become barometers which indicate the importance of attending to one's needs.

Dialogic work also allows for the important task of learning to regulate affect, often a key difficulty due to not having experienced sufficient validation and soothing/co-regulating support (Gillie, 2000). Resembling a mother's attunement to her infant the therapist acts "as an affect regulator of the patient's dysregulated states to provide a growth-facilitating environment for the patient's immature affect regulating structures" (Schore, 2003, p 264). This will, over time, enable clients to employ both interactive and non-interactive forms of affect regulation first within and then beyond the therapeutic setting (Schore, 2003; Ogden & Minton, 2000).

A range of duty of care issues can arise when working with clients with BN. Amongst other medical complications abnormal potassium levels as a result of purging can lead to sudden death due to heart failure if unmonitored (Black, 2000). Regular medical check-ups therefore are important and psychotherapists ideally will network with, and provide referrals to, experienced and supportive General Practitioners (Black, 2000). Self–harm, suicidality, drug and alcohol abuse and other risk taking behaviours may co-exist alongside BN and can put clients at significant risk. Duty of care policies and limitations to confidentiality need to be discussed transparently from the beginning so clients can be informed and involved whenever possible in ensuring their own and others' safety.

## Experimentation

Gestalt-based experimentation with clients with BN can take many forms. Denham-Vaughan (2004) has presented a model based on the cycle of Gestalt formation, proposing a range of experiments related to common contact interruptions as part of bulimic processes. I recommend her paper to the interested reader. For the purpose of this essay I have chosen to present two experiments from my own practice context.

The following experiment emerged in a session with one of my clients dealing with long-term BN when she spoke of feeling spacey, not connected to her body, and her sleep being disrupted with early trauma memories. We had been working on remaining more present to her binge/purge episodes and she had reported a decrease in frequency following this, but suddenly everything felt out of control again. We contracted to do some work involving sensing her body and body boundaries, feeling herself here in her body. Support was provided for her to initially trace the surface of her skin (hands, arms, legs, face) through gentle surface touch, stating, "here I am, these are the outer surfaces of my body." This was followed by sensing some of the deeper layers (muscle,

tissue, bones) through firmer pressure, massaging hands, arms and feet. My client slowly appeared to be more present, but also began to look quite agitated.

T. "What are you aware of?"

C. "My hands, they look so old…"

T. "Take some time to stay with your hands, feel each finger, look at your hand..."

C. "It's like I don't want to be here, don't want to feel my body… I always thought it was about being fat, needing to be thin, but it's not that, it's that I'm disgusted by my body, I hate being in this body, no matter what size…" (starts crying)

T. "Being in this body, feeling and noticing your body hasn't been very safe."

C. "No… (crying). I always thought it was about my weight."

We stay with her hand a little longer. More meaning emerges and it becomes clear that in the context of her ongoing early abuse adopting a place of hating and mistreating her body, and through this disconnecting from feeling and body sensation, was the only way to survive; the only way to split off the horrific pain and the knowledge of her dear father inflicting it.

The session ends with the woman wishing to inhabit her body more, wanting to be able to care for herself, nurture herself, but also stating, "if I allow myself to feel, the pain will tear me apart". She requests support to slowly, over the next sessions, continue to make contact with her body. We agree that over this next week she will try to look at and feel her hands a few times and journal about what comes up, monitoring herself how much of this she can do and drawing on some of her identified self-soothing or relational support strategies as needed.

The following excerpt highlights the importance of noticing signals of shame and providing sufficient relational support so the client can move through the impasse. It also demonstrates the use of phenomenological exploration to heighten awareness, which alongside the relational support opens up possibilities for new/different experience and action.

T. "What does the critical voice say? Is it ok to share some of that with me?"

C. "Yes…" (seemingly uncomfortable – squirming, than leaning forward, tense, resting elbows on knees, fingers and forearms tensed, looking down).

T. "What's happening right now?"

C. (Sitting back up) "Ohh…."

T. "You're kind of hunched over, bracing yourself…?"

C. "Yes."

T. "Are you curious about that?"

C. "Yes."

T. "Come back there once more, I'll try it with you. What is it like holding yourself like that? What's good about it?"

C. "I'm tensing, getting ready to protect myself… I'm also shrinking, hoping I might not be noticed…"

T. "What happens as you tell me this?"

C. "I'm feeling sad, noticing how much hard work it is for me to put myself out, how hard I try to get it right, say the right things…" (starts crying)

T. "It's really hard work…."

C. (nodding, still crying softly)

T. "I'd like to offer you a sentence, see if it fits. And I'd like you to use your breath to support yourself as you say it, it looks something like this: (deep breath in, sigh breathing out) 'It's hard to put myself out.'"She readily tries this out, I breathe with her:

C. "Aaahhh… it's hard to put myself out" She has energy for this and stays with it for a bit until eventually coming to rest looking at me.

T. "What are you aware of now?"

C. "I'm really tired..."

T. "If you let your body guide you in what to do next, what would it be?"

She rests her head on the side of the couch, I encourage her to follow her body's impulse in finding the right position and offer cushions for her support. She spends some time resting deeply while I speak with her calmly letting her know that I am still with her; that even as she is putting out nothing at all, I am still present with her. She leaves the session feeling tired and calm.

The following week she reports back that shame is a very common experience of hers and that she generally withdraws to avoid feeling further shame. She reports that this was a first experience for her of staying with this feeling long enough to be able to "come out the other end" and that "it wasn't too bad". She is now curious to explore feelings and needs further, but also shares her long held belief that feelings are not real, need to be overcome and that it feels dangerous to have feelings or needs. We agree to move slowly and check in often. I also assure her that we are not working to reduce the great strength of her rational self, but rather want to equip her so that her rational self can be informed by her emotional needs instead of working so hard at suppressing them. As she has spoken about not knowing who she is without the eating issue, she now also becomes interested in whether her feelings may give her access to a more authentic self which integrates feelings and thoughts.

In this moment we both feel excited at the adventure ahead!

## Conclusion

BN can be seen as an attempt to regulate overwhelming affect (Van der Kolk, Perry and Herman, 1991), an attempt to manage "'unacceptable' feelings and needs" (Gillie, 2000, p 98). Gestalt therapy through its dialogic, field-sensitive and experiential approach directly addresses some of the core challenges of clients with BN and provides opportunities for healing in the here-and-now. Working phenomenologically and experientially facilitates an embodied awareness which allows for disowned feelings and needs to emerge in the session. Through sufficient relational support affect is co-regulated and unbearable feelings, usually pushed out of awareness through shame/binge-purge, can be experienced, named and shared. With sufficient support these feelings can be contacted and remain in awareness long enough to inform the person of their needs, wishes and wants. Over time with an enhanced sense of self these needs, wishes and wants can be expressed more confidently and translated into effective action – BN as a way of coping has been outgrown.

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