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"Ghosts at the banquet"
moving towards aliveness : the anorexic client

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ATTESTATION OF AUTHORSHIP

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the qualification of any degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements”.

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ABSTRACT

The intention of this dissertation was to review the existing literature on the topic of movement from deadness to aliveness in the anorexic client and the countertransferential experience of this. Psychodynamic approaches recommended for this client group are reviewed through this directional lens. A literature review was conducted from a holistic framework looking at the approaches which utilise countertransference to integrate psychoanalysis, psychodynamic and mind/body psychotherapy. Although there is a wide body of literature relating to aliveness and deadness in the therapeutic space, it seems within the literature on eating disorders, the theme of death and deadness has been largely overlooked. It was found that clients with Anorexia Nervosa have complex presentations related to the puzzling pathophysiology of this illness. Improved outcome for the client may be enhanced by focusing the psychotherapeutic interventions to support the client to work through deadened states and access the self towards a more enlivened state and integral self.

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Chapter One: INTRODUCTION

Anorexia Nervosa has the highest death rate of any mental illness in the Western world and affects mostly women[1] (Neilsen, 2001). In their starving towards death this client group can frighten and frustrate loved ones and clinicians. The anorexic person seems to have separated psyche and soma into such different realities that she feels a sense of mastery in starvation, seeing "the illness as an extraordinary accomplishment" (Kaplan & Garfinkel, 1999, p. 669). Though much has been written, about the reason for such psyche-soma conflicts, less has been written about the state of deadness that seems to 'live in' the client and 'live out' in her relationship to others and the world. This deadness as a feature of the 'moment to moment' encounter is one I often meet in the therapeutic space with clients with Anorexia Nervosa, especially early on in treatment. It is this phenomenological landscape both within the client and intersubjectively experienced between the client and therapist that I am interested in exploring. This unsettling phenomenon of deadness gives an impression in the countertransference of what I have experienced and describe as 'a gap between the self and a never to be satisfied self'.

I will begin in chapter one with defining Anorexia Nervosa and the current state of definition for this disorder. This psychiatric condition is the focus of an ongoing, rapidly changing and complex clinical study and research, probably because it has the highest death rate of any psychiatric disorder,

[1] For this reason, the female pronoun is used to refer to the person with anorexia nervosa.

while still puzzling clinicians and researchers as to the understanding of the pathophysiology of this illness (Wagner et al., 2007).

In chapter two, I will outline the methodology approach I have used, a modified systematic literature review, and provide the rationale for its application to this dissertation.

In chapter three, I will explore the literature around the theme of aliveness and deadness in the therapeutic encounter, and how this theme affects and impacts on the clinical work. I will then relate this theme within the therapy encounter to experiences of life and death that reside within the anorexic client, and that confront the therapist and the therapy. By reviewing the literature around this theme, I hope to explore the potential for this to reveal material for a more enlivened exploration of the complexity around the dissociative and avoidant nature of this life threatening disorder.

In chapter four, I will investigate the countertransference as the guiding therapeutic tool for tracking the 'moment to moment' aliveness and deadness, and look to the various psychotherapeutic approaches and their treatment of the anorexic client. I hope that by reviewing the literature it will be clearer how the various ways treatment approaches may enhance motivation and growth within this client group, who are often regarded as treatment resistant (Kaplan and Garfinkel, 1999).

In chapter five, I will bring together the discussion of these themes of aliveness and deadness, countertransference and various approaches. I hope to highlight the approaches, interventions and features that support the focus of the therapist in engaging the client in their recovery and desire for their own lives.

It appears that the definition of Anorexia Nervosa is constantly being reviewed through a medical, biological, genetical, psychological and social lens. Though defined in the DSMIV (2000) as a refusal to maintain normal weight, a misperception of shape and weight and usually presenting with amenorrhea (the absence of at least three consecutive menstrual cycles), more recent literature is challenging this fixed definition. This would reflect the complex nature of this disorder, the current use of a multidisciplinary treatment approach, along with rapidly changing research data and scientific evidence, such as neuroimaging, that tracks this issue of a nature/nurture, mind/body response to starvation and the anorexic condition itself (Salbach-Andrae et al., 2008).

The clinical definition of Anorexia Nervosa in the "Handbook of Treatment for Eating Disorders" (2nd ed.) is the refusal to maintain body weight at or above a minimally normal weight for age and height. Usually what constitutes being significantly underweight is diagnosed in the DSMIV as being 85% less than the expected weight or having a BMI (body mass index) of less than

17.5%. However, this criterion is left to the clinician's judgment, due to the fact that a person can meet the criteria for Anorexia Nervosa without having a low weight (this situation is described as sub-clinical). Other than low weight, the other diagnosable criteria are that the person has an intense fear of gaining weight or becoming fat, a disturbance in the way they experience their body shape or weight which influences their self evaluation and /or denial of the seriousness of current low weight. The absence of menstrual cycles can also indicate the diagnosis and, for some women, this can occur before reaching a low weight as a result of physical and psychological factors (Garner and Finkel, 1997, p. 27).

According to Chassler (1994), the interpersonal theory of Bruch (1973, 1978) viewed the anorexic person as having major ego deficiencies resulting from disturbed mother-child interactions, isolating three areas of disordered psychological functioning.

1. A disturbance in body image characterized by delusional thinking so profound as to lead to a total denial of their emaciated appearance.
2. A disturbance in the ability to perceive and identify body stimuli.
3. A paralysing sense of ineffectiveness pervades their lives… eating is not an action performed by themselves but rather something which happens to them - an act over which they have no control (p.251-253).

The unknown etiology of anorexia and the lack of understanding of the pathogenesis have hindered the development of effective interventions (Wagner et al., 2007). More recently, Guisinger (2008) commended Wonderlich, Joiner, Keel, Williamson, & Crosby (2007) for an article in which

they acknowledged a "lack of progress in understanding, classifying and treating anorexia nervosa" and the need to refine diagnosis through the study of neural biology and its link to behaviour (Guisinger, 2008, p.199). Guisinger suggests there is a need for a new paradigm as it is usually impossible for an individual to maintain weight below normal, for any period of time. In this, the anorexic person is remarkable. He disagrees with Wilson, Grilo & Vitousek, (2007) and the more established view that assumes anorexia is "caused by a successful pursuit of thinness" resulting in restricting and excessive exercise and weight concerns, and attributes this to "putative faulty cognitions or disturbed relationships" (p.199). Guisinger (2008) believes the evidence shows that this is not volitional; but is instead a genetic vulnerability, and the restrictive behaviour results in cognitive and behavioural symptoms caused by weight loss not the other way around (Guisinger, 2008; Hebebrand, Casper, Treasure & Schweiger, 2004). Some researchers suggest that Anorexia Nervosa is an "unusual variant" of mood disorder to which the female population is particularly vulnerable (Salbach-Andrae et al., 2007). Other researchers such as Kaye (2008) believe the mood disturbance often predates the anorexia, with symptoms beginning in childhood and persisting after recovery, suggesting a pre-existing predisposition and the presence of traits that create vulnerability. Early studies from 1944 by Ancel Keys and colleagues to understand how to best refeed prisoners of war showed that, in food deprivation of normal men, a causal role of starvation and the onset of anorexic/depression were triggered in those who had a predisposition. Kaye et

al., (2004) showed obsessive compulsive disorder (OCD), social phobia, specific phobia, and generalized anxiety disorder most commonly precede the onset of anorexia, and Karawautz, Rabe-Hesketh, Collier and Treasure (2002) showed consistently that this also included more extreme behavioural constraint, avoidance of novelty and emotionality, regimentation, and perfectionism in early life compared with those without the illness. These premorbid features speak to the vulnerability and psychological risk but not to the risk of long term chronicity (Strober, 2004). Still further research by Wagner et al., (2007) has concluded that those who find little in life that is rewarding, besides the pursuit of weight loss, probably have an imbalance in their information processing with an impaired ability to identify the emotional significance of a stimulus; that is, they probably don't differentiate positive and negative feedback and therefore don't respond well to reward or the pursuit of pleasure or comfort. Further discussion around this ongoing psycho-biological debate occurs later in this dissertation.

The death rate of clients with Anorexia Nervosa is still recorded as the highest for any mental illness. This is figured at between 5-18% (Hsu, 1990; Steinhausen, 2002) and in some publications as high as 20% (Gura, 2008). Due to the treatment resistant features of Anorexia Nervosa, somewhere between 40-50% of sufferers never fully recover (Wilson et al., 2007; Gura, 2008) even after years of psychotherapy. Reviews of treatment approaches by researchers, such as Wilson et al., (2007) and Guisinger (2008), suggest psychotherapy is still the preferred current treatment for the illness despite the

lack of controlled research. This lack of controlled research is attributed to features of the disorder such as rarity, medical complications, long periods of treatment and sufferers having often ambivalent attitudes to recovery, which are an ongoing issue at nearly every phase of any research enquiry. This makes it difficult to recruit and secure participation and has consequences for follow up assessments (Agras et al., 2004).

Despite the crippling effects and the bewildering implications of Anorexia Nervosa, Strober (2004) proposes that its appeal for the sufferer lies in the solution it provides for unforgiving self-doubts, anxiety and perceived inadequacy. "A refuge from peril is ultimately sought in a life rigidly structured to avoid need, novelty, and impulse" (Strober, 2004, p.249). Strober notes that clinical observations have suggested that temperament may be more central to the pathophysiology and psychopathology than previously considered, with a range of mood, anxiety and impulse disorders resulting in an inferior sense of self and capacity for spontaneity.

Much has been written about the sensitivity and intuitive insight needed by clinicians working with this client group, partly due to their neediness and hostility, but also due to the reality of medical complications and potential suicidality (Franko & Rolfe, 1996). Strober (1997) writing about "consultation and engagement with severe anorexic clients" notes that although clients can be too malnourished and psychologically depleted for psychotherapy to proceed, most "retain the capacity for human connection" (p. 230). Strober

goes on to say that, although clients can be "incapacitated by their wasted state, or deemed treatment failures" and in need of urgent hospitalization, most remain emotionally responsive and later are able to make a commitment to treatment (p. 231). Strober places most emphasis on the therapist's readiness to create an alliance with the client and he says that this issue is rarely noted when discussing treatment, but is crucial to the life of the client. The approaching the illness from different perspectives means a therapist may "bring sense to non-sense, clarity to bewilderment, tenderness and compassion to ruthless discipline and self-abnegation" (p.231). This, Strober says, will be viewed by the client as "medicine of extraordinary power" (p. 231). The treatment of anorexia is time consuming and the stakes are high for which Strober suggests, not all therapists are suited (p.231). He states a therapist should not "undertake work for which your own nature is not well suited" (Strober, 2004, p.254).

As a psychotherapist, I am most interested in how the client responds during therapy, and how we might make best use of our relationship, given the presenting issues. The therapy setting calls on the client to express herself verbally or nonverbally. It is this therapeutic space which is therefore a re-creation of the psychic structure, and within that an expression of her psyche (Parsons, 1999). What is the experience of the negative (Green, 1986), the work of negation, and what helps the client to come forward to engage in a life promoting and sustaining relationship to self (mind/body) and to others? This

relates to my clinical question: *How best might the therapist attend to the issue of movement towards aliveness in the anorexic client?*

Through the researching and writing of this topic I have noticed a strong reaction by clinicians to my use of this deadness aliveness continuum. I have come to the tentative conclusion that it really speaks best to the life/death theme and subsequent anxiety faced by the clients, families and clinicians involved with this client group.

My interest in aliveness and *sense of self* in clients with Anorexia Nervosa led to the researching of literature around this concept. Of particular relevance is a recent study by Bers, Blatt and Dolinsky (2004) on "The Sense of Self in Anorexia-Nervosa patients: using the psychoanalytical concept of self representation to rate participants on four factors: agency, reflectivity, differentiation and relatedness." I am especially interested in the issue of Integrity (which they identified as a sub-factor of Agency) that is:

> the degree to which the self-description is characterized by a sense of integrity, from…(1) a **psychic deadness**, inner void and depersonalization, to… (5) an emerging ability to sense one's inner continuity and identity, to… (9) an emotional integration, **cohesiveness,** and satisfaction with one's life through both agency and relatedness (p. 295).

This research reviews the centrality of the self-system and the representational world as emphasised by self psychologist Goodsitt (1983) and points to other formulations focusing on the client's inner experience of herself in relation to issues of identity, fragile self esteem, fragmented self-perception, lack of self cohesion, continuity, strength and harmony (Lerner, 1991). Other

psychodynamic issues relate to the child's lack of control and autonomy (Wilson and Mintz, 1982), the absence of a soothing, calming parental presence (Goodsitt, 1983) and early failures in empathic connectedness (Geist, 1989).

I hope by reviewing selected literature and research that I get a greater sense of the integrity or wholeness that is compromised in the potential for *health* within the anorexic client. I ask what, in psychotherapy supports this translation and transformational process, to take a client from an inner void, depersonalization and rigidity to a more cohesive experience, a greater sense of self, agency and interrelatedness?

The introduction to this dissertation has briefly mapped some of the complexities for working with the client with Anorexia Nervosa. The difficulty in defining the disorder due to the puzzling aetiology and lack of understanding around the pathophysiology of Anorexia Nervosa, and also the changing scientific research which suggests the biological issues which predetermine the vulnerability to the illness. Research is continuing to show a causal role of starvation and premorbid features along with impaired ability to seek or experience pleasure. Neuroscience and neuroimaging are continuing to explore these correlations and to wonder about the ability of the brain to be flexible in adaptation to these issues. Due to the complexity of the new sciences, and the limitations of this dissertation, I am not going to review literature related to neuroscience and biology other than to point to it as an

important part of the information gathering and understanding for this client group for whom cognitive rigidity is often an issue (Davies & Tchanturia, 2005). For the purposes of this dissertation, I will focus on the therapeutic encounter and the 'moment to moment' experience that can inform the therapist and client to move towards integrity/wholeness and a greater sense of an enlivened self.

Chapter Two: METHODOLOGY

This dissertation is a modified systematic review using a qualitative approach appropriate to the context of evidence based practice commonly used in psychotherapy. As defined by Dickson (1999) "systematic review is the process of locating, appraising and synthesising evidence from scientific studies in order to provide informative, empirical answers to scientific research questions" (Hamer & Collinson, 2005, p.44).

The purpose of this research is to review the literature around what it is in the therapeutic relationship that supports and encourages movement towards aliveness in the client with Anorexia Nervosa. In defining the boundaries of what is known and what is not known it is hoped this review will support practitioners to resolve clinical issues. In this way a systematic review can aid in defining future research, though it is never a replacement for clinical reasoning (Mulrow & Cook, 1998).

Research question: *How best might the therapist attend to the issue of movement towards aliveness in the anorexic client?*

This dissertation follows the key components of a systematic review process as outlined by Hamer and Collinson (2005).

1. Definition of the research question
2. Methods for identifying research studies
3. Selection of studies for inclusion

4. Quality of appraisal of included studies

5. Extraction of data

6. Synthesis of the data

Step 1: Definition of the Research Question

My review began with a research question around states of deadness experienced by the therapist in being with the anorexic client and a wondering around how the therapist's approach might support the movement towards aliveness within the client. Initially, I searched literature to explore this question of the relationship between states of deadness, and in particular psychic deadness in anorexic clients and the relationship to the body, psyche and feminism (given this is largely a feminine issue). *How can states of deadness within the anorexic client inform the therapist in supporting the client towards a greater sense of self?* The literature on anorexia is vast but there is not a lot written on deadness within the anorexic client. I initially thought this feature might bridge the conflicts of language that have separated out feminism, psychoanalysis and Anorexia Nervosa. However what became more apparent through the literature was the potential use of the enlivened dynamic of the therapeutic relationship, with the therapist's transference as an informing intersubjective tool for aliveness and deadness, and the relationship of this to embodiment for the anorexic person. So I refocused my question to express this as a more clinically relevant issue.

How best might the therapist attend to the issue of movement towards aliveness in the anorexic client?

Step 2: Methods for Identifying Research Studies

The review was undertaken primarily using the Auckland University of Technology (AUT) library. Some 136 papers in total were located by utilizing electronic databases, books and the inter-loan services. Colleagues in the field also directed me to current magazines such as Scientific American Mind. The database searching on PsychINFO included some journals listed in PEP (Psychoanalytic Electronic Publishing); a separate search of PEP also extended the results that came up to include PEP articles not included within the PsychINFO search. These PEP articles were important in widening the relevance and definition of certain therapeutic interventions and features of the transferential experience for therapist and client. My search went on to look at countertransference and psychodynamic issues in attending to this theme of deadness and aliveness in the anorexic person and began to reveal saturation around certain key authors and themes such as psychic pain and the use of the body to communicate.

Table 1 shows an outline of keyword searches that identified relevant literature.

Table 1: Keyword Searches

Search Term		Number of Articles	Relevant Articles
PsychINFO	Anorex$	10770	
	Anorex$ and dead$	27	2
	Anorex$ and alive$	16	1
	Anorex$ and countertransference	67	13
	Anorex$ and psychodynamic	236	18
Proquest Dissertation / Thesis	Anorex$ and countertransference	4	1
PEP	Anorexia and deadness	37	7
	Anorexia and aliveness	35	4
	Anorexia and countertransference	239	14
Total		661	60

Step 3: Selection of Studies for Inclusion

The inclusion criteria captured literature that defined the transferential relationship associated with the practice of psychoanalytic and psychodynamic perspectives with clients with Anorexia Nervosa. Exclusion criteria included all material not published in English and those treatment approaches that went beyond the use of transference and countertransference, such as creative therapies and behavioural therapies. Given the medical implications of Anorexia Nervosa, I did include some research on neurobiology. With the complexity of these new sciences and the limitations of time and the length of this dissertation, I have not included a review of this. Other relevant and significant issues, such as gender related issues and cultural and societal influences were also not researched due to the enormity of information for this systematic review.

Step 4 and 5: Quality of Appraisal of Included Studies and Extraction of Data

The literature within the databases of PsychINFO and PEP has offered the clinical and empirical evidence for reviewing the research question. With little quantitative material used, it has been necessary to modify aspects of the review. As noted in the Psychodynamic Diagnostic Manual (2006), most clinical innovations in the history of psychotherapy have come out of clinical practice. For example, cognitive therapy emerged from the practice of psychoanalyst Aaron Beck, along with "converging observations" from fellow psychoanalyst Albert Ellis. Beck has integrated practice based evidence with applied research and a willingness to change theories and techniques when

"clinical and empirical evidence suggests the importance of doing so" (PDM, 2006, p. 750).

Step 6: Synthesis of the Data

In locating relevant literature around the keywords I began to reveal saturation around certain key authors and themes. This supported the synthesis of data.

My reading around Evidence Based Practice and Practice Based Evidence suggests that psychotherapy is a *research emergent* profession. Psychotherapy has been largely client-centred and foremost a "human endeavour….we do not yet know what is curative in psychotherapy" (Goodheart, 2004, p.2). As a profession, our relationship to research is developing as we continue to head towards a greater need for government funded therapy and healthcare. This is particularly important to clients with eating disorders who require both medicalised and psychological treatment within a multidisciplinary approach. "Research enhanced" or "research informed" decision-making are becoming more widely accepted terms. Evidence Based Practice is a decision making tool, rather than a rule that requires rigid adherence. It needs to take into account the critical thinking and interpretive paradigm in which the patient experiences illness (Ilott, 2004, p.348). Psychological therapies have long argued for a knowledge base in which each area of research has its place within an overall research model that complements the interdependent relationship of evidence based practice and practice based therapy.

Alternative Research Methodology

My interest and the subsequent development of a clinical question for this dissertation came from my subjective experience and interest in phenomena such as my countertransference with clients with Anorexia Nervosa. Given this, it could be argued that my question may have been best answered through the use of a *Single-Case Research Methodology.* Case study research is ideal for bringing an understanding of a complex issue, and can extend experience or add strength to what is already known through previous research. It is an "empirical enquiry that investigates a contemporary phenomenon in real-life situations; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used (Yin, 1984, p.23). This methodology is more often used in psychoanalysis and is the kind of research that involves not only an exploration of the client's personality but also the need to look at the therapist's psyche as well (Meadow, 1984). So the therapy session exists as the laboratory where the life history of the client unfolds in relationship with the therapist (Lief, 1992). This would have developed the use of my clinical phenomenological experience; the area of gestalt that may have developed would have been a greater emphasis and depth of exploration into 'the shared mind' and within that intersubjectivity the "creation of mind" (Symmington, 2007) and movement through "emotional thinking" to reach the inner activity of the client and therefore support the inner mind-building activity" (p. 1410). However the

decision was made to use the systematic review process to explore the chosen clinical question.

Ethics

Ethics approval has not been sought for this dissertation as no clinical material has been formally collected. The use of typical situations that occur in psychotherapy is spoken to so as to demonstrate what might occur within the therapeutic session. This is for strictly illustrative purposes only, and does not include research evidence of clinical cases, thus no approval is required.

Conclusion

I have discussed the use of the systematic literature review as a methodology approach, provided rationale for it application to this dissertation, and discussed the scope and limitations. The next chapters extend the literature review process and interpretation of the literature.

Chapter Three: ALIVENESS AND DEADNESS IN THE THERAPEUTIC ENCOUNTER

In this chapter I will outline the theme of aliveness and deadness as written about and as experienced in the therapeutic context. My intention is to shed light on this theme and to point to it as a pervading and "lived experience" for the therapist and client. In particular I am interested in this 'moment to moment' (Ogden, 1995) encounter as a revealing and informing state, rich with information that can be enquired into creatively through the psyche, mind/body, verbal and nonverbal interactions. I hope that in reviewing this theme it will be revealing of the place aliveness and deadness has in the healing context of psychotherapy and in particular in working with the anorectic client and their unfolding potential and movement towards an embodied sense of self. I am using the term deadness here as simply 'a lack of aliveness'.

According to Clayton (1992)

> There are two dynamic forces which exist in an uneasy and volatile relationship. One of these dynamic forces is a desire to live fully, to experience purpose and meaning and to create ideals and live by them, and to love. It is this desire to live fully that is experienced as an inner urge to move out, to feel, to be and to make. A second dynamic force is the desire to stay secure. This desire for safety and security is demonstrated by all those powerful forces which hold back the impetus of growth. (p. 1)

Axis of Experience: Deadening to Enlivening

Much has been written about aliveness and deadness in the therapeutic space (Ogden 1995, Korner, 2000, Eigen 1995, Malan, 1997: La Mothe, 2001). It seems that theorists traverse a vast landscape on this topic when discussing the enlivening to deadening axis of experience (Korner, 2000). Along this axis in terms of deadening experience, theories move from the mystical, to destructive, murderous and suicidal intent. Eigen (1995a) writes:

> The sense of being dead has become a popular clinical theme. More people than in the past seek help for feeling dead. Although feeling dead is a central complaint of many individuals, it is not clear where the deadness comes from or what can be done about it. (p. 277)

Therapists note that a sense of liveliness relates closely to "activity within a system of interpersonal resonance….. and that sudden shifts towards experiences of deadness are a matter of concern in psychotherapy" (Korner, 2000, p. 231).

Psychoanalysts such as Ogden (1995) value the theme as a measure of the 'moment to moment' process of therapy saying that every "psychopathology represents a limitation that is specific to the individual's capacity to be fully alive" (p. 696). Ogden, like Winnicott (1971), sees the goal of therapy as an experience of aliveness as a quality in 'its own terms' beyond the reduction of symptoms, enhancement of self understanding, and increasing sense of personal agency. Lifelessness in the client is enacted in a sense of lifelessness in the therapy which Ogden terms the "entombed" experience. Goss (2006) describes the lifelessness as an internal waiting. This could be viewed as

similar to what the 'matriarch' of eating disorders, Hilde Bruch (1978), called the "golden cage". Bruch's description pictured the anorexic caught in her home (like a bird in a cage), deprived of the freedom to be and do as she truly wanted. Strober (2004) likens her to an existential recluse, with "being in life" being too much for a temperament which avoids emotionality and unwanted experiences.

Consider a client who experiences the world like this and therefore the following scenario:

> *Cl: I feel encased?*
> *Th: Encased? Say more?*
> *Cl: Like a museum piece, archived in a glass box. I can see the world but I can't be of it or in it.*

Ogden (1995) suggests the anorectic symptomatolgy of food restriction and rigorous exercise is a way to ward off intense anxiety; a feeling of being "powerfully untouchable in her isolation…and immune to human vulnerabilities….such is the need to control everything with and outside of her" (p.706).

The Experience of Deadness

The extreme experience of a pervasive sense of deadness when meeting an anorexic client is due not only to the skeletal presence of the client (striking at the life-death instinct of the therapist) but also to the void of feeling and the destructiveness of the negation of life that confronts the therapy relationship (Eigen, 1995a). In this way Eigen notes that "something transpersonal" seems

to be occurring, and the analyst may feel unable to move or breathe in the force field of this antigrowth (p. 289). Eigen gives an illustration of an anorexic client who, through her body, symbolizes what he says is the force of Freud's death drive and "is herself an embodiment of death" (p.289). Eigen (1995b) views the death not as a passive falling apart, but as an active breaking down. In Eigen's discussion of 'maximum –minimum states', psychological defences can act as a barrier to dampen and regulate an overwhelming stimulation resulting in a blankness of nothing. In this way, he refers to the "destructive force within" and of a part of psychic deadness being tied to the ego's attempt to do too much (p.605). Klein also places Freud's death drive at the centre of psychic life but sees the ego defences of splitting, idealization, maniac denial, projection and introjection as attempts to defend against psychotic anxieties, where as Eigen's focus is more towards psychic deadness. Emotional deadness is seen by Klein as a measure of unconscious anxiety. The conflict/anxiety model means that the work to be done is to help the client to bring inner and outer worlds together so as to bring them back to life. Klein, would seem an obviously relevant theorist for this eating disordered client group, given her theory of earliest development around the primitive psyche, separation and boundaries and early defences. Warren (1996), exploring death themes in Anorexia Nervosa, includes Klein and her theory in relation to reparation of the damage that can occur in the early phases of life.

According to Klein (1953):

> The breast and its product, which first gratify his [sic] self-preservative instinct as well as his sexual desires, come to stand in his mind for love, pleasure and security. The extent to which he is psychologically able to replace this first food by other foods is therefore a matter of supreme importance (p.90)

It is interesting to note that in my search around anorexia and deadness/aliveness and countertransference, Klein's work per se did not appear amongst the article searches. However, her reference to the death instinct and psychic development was referred to by other authors and researchers. I point to this because Klein's theories are not in the foreground of the literature as might be thought obvious in this dissertation.

The unspoken anxiety of being annihilated has been an area of exploration for many psychoanalytic writers. Farber (1997), Grotstein (1993), Krueger (2002), and Tustin (1990), refer to the fear of losing one's self, of being engulfed, abandoned, devoured, penetrated, or mutilated as an overwhelming terror of falling into a terrible black hole. Bion (1970) was the first psychoanalyst to describe the "infantile catastrophe" as a "black hole" such as described in astrophysical terms, where a set of events causes a massive collapse of a dying star. "Everything is dragged back by the gravitational field, producing a region of space-time where infinitely strong gravitational forces literally squeeze matter and photons out of existence" (Penrose, 1973, cited in Gribbin, 1992, p. 142). Hurvich (2005) considers annihilation anxiety as central in the development and maintenance of severe pathology. Likewise, Modell (1994)

in commenting on the notion of the "black hole", mentions that the feeling of deadness can be modified when people come in better contact with themselves. He believes that some, who lose out in terms of psychic attunement with their mothers at crucial stages of development, may need to "maintain contact with somebody who can process their affects", (p. 376) and states that given environmental influence and biological issues some of these factors contributing to temperament and the ability to process affects may not be reversible in psychotherapy.

Winnicott located the source of vitality in the psyche-soma and in the intersubjective field. This contrasts with what Freud spoke of as instinct; psychic energy directed as libido towards a life instinct. The issue of the death instinct as a force working against change is a kind of "psychic rigor mortis" that drives the personality to guilt and punishment through an "unpleasure principle" (Eigen, 1995, p. 287). Freud (1937) thought antigrowth forces could also be located in "the original death instinct of living matter" (p.243); that is as soon as a cell is created it begins to die. Therefore, resistances to growth were viewed "not primarily from top down (superego against ego against id) but from bottom up" (Eigen, 1995 p. 287). Eigen notes it is important for the therapist to be in touch with her own antigrowth tendency so as not to become fused or polarized by the patient's "force field". He notes that the therapist in being aware of her own tendencies towards this antigrowth state is able to make room for the client's antigrowth state. This is an uncomfortable challenge that allows the countertransference to make conscious the deadening

aspects so as to bridge the sense of discontinuity and make use of the therapeutic relationship as a resource for the "dead side" rather than have it be a drain that could kill or strangle the therapy (Goss, 2006).

Unconscious Destruction and Aggression

The research of Farber et al.(2007) view the "dissociative processes that compartmentalize and separate psychological and somatic experiences" as the most destructive factor in the psychopathology of anorexia (p. 289). In their research they related the dissociative defences to psychic trauma and the compromising of ego functioning that leaves the anorexic with poor affect tolerance. Farber et al., go as far as to say that the child seeing food cut up by the mother and then eating it develops a cannibalistic notion of being eaten or of eating others, thereby connecting the experience of eating as a confrontation with death. They refer to Garrett (1998) who notes that the anorexics confrontation with death forces a choice of life to be made more conscious, and that the failure to recognize or make a choice develops as a compromise formation (Freud, 1957) in which they deny death but reject life (Bachar et al., 2002; Jackson & Davidson, 1986).

According to some researchers (Bachar et al., 2002; Farber et al., 2007) the theme of death has been significantly overlooked in the literature on eating disorders. Perhaps it is due to this fear of having death so close, embodied and enacted in our relationships to eating disordered clients that makes this 'rejection of life' difficult to write about and to conceptualise. In a published

study on anorexia, murder and suicide David Malan (1997), best known for his model of short-term focal psychotherapy, considers these three issues to be "among the most difficult, dangerous and alarming conditions therapists are likely to be confronted with" (p.1). Malan relates this 'pull to death' as a particular self destruction that also offers the greatest opportunity for a pull to life, that is, if the therapist can align with the needs and wants of the client. Malan is not talking here of an exploration with the client but a clear awareness of the psychiatric issues for the client and a requirement of the therapist to act in accordance with the clients survival.

For clients who are not in immediate danger, some of what the client and therapist face are unconscious issues that unfold within the therapeutic space. Farber et al., (2007) relate this to unspoken family messages, such as the mother's murderous wishes towards her child and that life might have been better for the parent if the child did not exist. By developing a false self, the child may be able to extinguish herself physically and emotionally. The false self is linked to the experience of deadness is related to that part of the self which feels dead and is initiated from experiences of impingement and deprivation (Winnicott, 1971). Increasingly, the child longs for death and may become a sacrificial offering to the family. This can be highlighted at the time of adolescence (often the time when young anorexic clients present) around this process of separation - individuation which may mean the symbolic death of the family (Farber et al., 2007). Self-psychologist Arthur Crisp (1997) cited in "Handbook of Treatment for Eating Disorders", also points to the

unconscious death that lives at this developmental stage and says, at a level of psychopathology Anorexia Nervosa is construed as a "phobic avoidance disorder" (p. 249). The phobic objects are described as normal body weight and shape seen as becoming fat. For those clients who face anorexia at the developmental stage of adolescence, the anorexia may be a desire to maintain a subpubertal body weight in the face of impending puberty. Crisp describes this as a major and unavoidable life event , our "first brush with the full extent of the real world and personal mortality", and says even though a client may show a degree of trust in accepting treatment, therapeutic interventions run the risk of being perceived as "invasive, persecutory and destructive" (p.270). While Crisp sees this as an unconscious response to life's transitions, it seems Farber et al. (2007) are more focused on the anorexic person's preoccupation with death. Others such as Warren (1997) would look to ask of the meaning behind the behaviour. How does the behaviour reflect an attempt to deal with the anorexic person's world? Warren raises the counter argument to Farber et al. (2007) and Jackson & Davidson (1986) in stating that the theme of death may be salient in some cases, but that in others, feelings of powerlessness or thwarted growth to selfhood is more prominent. This tone, the threat to life, continues to permeate such descriptions of treatment and therapeutic approaches with the anorexic client.

The Dialectic Structure of Life-Death

The dialectical structure of opposing forces and concepts such as life and death, ties with what Ogden (1992) and others discuss as the dynamic

relationship of life. The ever changing relationships within this dialectic of life are reflected as creating and preserving, informing and negating. "The dialectical process moves towards integration, but integration is never complete. Each integration creates a new dialectical opposition and new dynamic tension" (p.208). As Israelstam (2007) notes, as opposite as life and death are, they are also defined by one another "They are so close, sharing opposite sides of the same coin, yet never fully integrate" (p.592). At the edges of the dialectic experience is generated an experience that can alert the therapist to the vital presence of an edge to be worked with. In facing into these dialectical edges, there is the phenomenon for creativity (Ogden, 1992) and in this potential space (Winnicott, 1971) there is an opportunity for the client's imaginative life to expand. Israelstam (2007) believes this is the space Winncott referred to as the "inherent" capacity that lies between dialectics of "life-death, hope-despair and creativity-collapse"; a creative reflective space (p. 605). Israelstam points to the fact that if "we allow our minds to associate from life-death to other dialectics we might notice how they are all interconnected…notably 'meaning and mortality', 'attachment and separation', order and change, ritual and spontaneity" (p.593) and notes that these gestalts provide the necessary tension for the generation of creative symbolic thought. However, what remains most difficult for us as therapists is to remain present to the client within the threat of this "danger area", this moment when the edge of life-death is present for the client and anxieties and tensions arise for both the client and therapist. At times like this, it can be hard

to remain present and to "mentally and emotionally function in the collision of opposing and interdependent forces" (Israelstam, 2007, p. 596).

Both Winnicott (1971) and Bion (1962) emphasise the need for holding and containing through this demand and point out that it is in this tension that frustration can lead to new useful information. Israelstam notes this is a gestalt where "the state of tension, anticipation, frustration and anxiety" means that "no closure acts as a rich recourse of creative thoughts" (p. 595). Similarly, Eshel (1998), relates this 'existing analytically around deadness' as a serious dilemma for the therapist; to be "in the neighbourhood" especially around deficit, likened to a "devouring world of deadness" (p. 1125). Eshel says that, in surviving together, a change can occur in one person and cause a change in the other, so that the psychic work can be redone. Little (1981), relates this therapeutic journey "to go back to a not-yet-personalised state… to allow time for the psychic work to be done, which means experientially going through annihilation and death and coming forward again, but differently" (p. 152).

Winnicott (1971) has noted the object usage and survival of the therapist and client through these spoken and unspoken demands, as an important continuity within the intersubjective field. Within this is the potential for space but also for reenactment. This seems particularly pertinent for the anorexic person for whom Bruch (1977) considered anorexia as an expression of confusion, a desperate effort to ward off panic about powerlessness and their vulnerability at being retraumatised through power dynamics.

Protection through Preserving Emptiness

The ability to desymbolise, to preserve emptiness and foreclose, to bar entry of any psychic input from others so as to protect against pain or over stimulation, has been studied by Freedman & Lavender (2002) and theorised by Williams (1997). Freedman and Lavender focus on "the breakdown of the symbolic", the need to evacuate so that "the most powerful nonverbal message comes in the physical stature of the patient who seizes strength from having no desire" (p.184). They relate this to the phenomenon described by therapists and clients of erosion and barrenness of inner landscape.

Consider a client who experiences the world like this and therefore the following scenario:

> *Cl: When I was at my most severe anorexic weight, the world looked lifeless and grey, like a fallow wasteland.*
> *Th: This matched how you felt. Nothing nourishing.*
> *Cl: Yeah, in fact, I was repulsed by anything that was full of life. I was repulsed by pregnant women, by plump and cuddly things such as pet rabbits.*

Here it seems important to emphasise the role of the therapist in containing repulsive or overwhelming phenomena and experience. Ogden (1995) makes use of Bion's (1962) notion that the therapist/mother keeps alive and brings to the client/infant projected aspects of self through the successful containment of projective identification. Grotstein (1993) notes this sustaining and existing presence as a 'background transference', meaning that, though the therapist might be unimportant in her own right, she serves an important function similar to Winnicott's (1971) 'holding environmental object'. Both Ogden and

Winnicott note the collaborative process for potential space where the therapist is a "good enough", vitalising object for the client.

Attraction and Repulsion to Life: Self Psychology

The self-psychological understanding is related specifically to the issue of the client's rejection of life and the anorexic person feeling and behaving as a selfless human being who serves the needs of others (Bachar, 2002). The therapeutic issue is how to regrow a basic sense of self (Guntrip, 1969) or how to integrate and differentiate a stable consistent self–representation (Kernberg, 1976). According to this 'selfless' theory, the client is liable to feel self-guilt (Goodsitt, 1997) whenever she promotes her own interests. It was by using Orbach & Florian's (1991) instrument of 'attraction to life or attraction to death', and their own Selflessness Scale that Bachar et al. (2002) concluded that clinicians should not focus directly on death preoccupation. Rather they should try to reduce the client's self-guilt or guilt at promoting self-interests. This appears to be in line with therapeutic techniques recommended by Bruch (1975) for treating clients: to develop a sense of competence through a self respecting identity. Bruch and self psychologist Tolpin (1980) acknowledge that the connecting of bodily experience is at the essence of one's psychological being; leading to a self experienced through a sense of wholeness and aliveness through 'time and space'. This is important to the theory of self psychology, with the human caretaking environment providing calming and sustaining functions so that external provision fosters an internal psychic structure of the self (Geist, 1989). Geist, like Winnicott (1971),

acknowledges the importance of "corrective developmental dialogues" which "lead to internalizations that transmute experiences of failures for the child, by the parent" (p. 10). Recovery of an emotional experience enables the child to build up their own capacities, and to experience a reliable empathic environment with shared meanings, and where realness and one's aliveness becomes actual. According to Geist (in self psychology terms) eating disordered clients, lack the psychological connectedness due to a lack of empathic resonance, and experience a trauma not in a rememberable event but in what Winnicott (1974) states as "nothing happening when something might profitably have happened" (p.106). This experience of "nothing happening" is, as Geist (1998) notes, common to the feeling of "emptiness or nothingness" in the therapeutic transference with the anorexic client (p. 13).

Geist (1998) gives an example:

> *Cl: I would rather be dead than know myself is not all there, that's what's so unbearable, knowing myself is not there, nothing inside of me.*
> *Th: The deadness is a way of coping with the agony of the break up of your self when you were very young (p.13).*

Geist summarises this experience of deadness in relation to the self:

> Total loss of psychological oxygen that keeps the self alive…. a depleted and dying self in the context of the desiccation of its sustaining ambience…. a withering of that creative living where feelings, moods, and events can be communicated or symbolically represented, played with, and actualized; and they begin to lose the capacity to comprehend what they are experiencing and to integrate it into an aspect of a more completely experiencing self. (p.13)

The Place for Emptiness

It seems a lack of self sustaining support has the self lose its feeling of aliveness, and so there is no way to modulate intense affective states. For whatever reasons, the infant is unable to borrow the strength of the parents. Losses experienced (for example a loss of friendship in adolescence) leave the self highly vulnerable to disintegrating anxiety and the fear of emptiness. In defence of this, the self will organize a controlled emptiness by not eating, or ruthlessly fill up with a greediness that is compulsive and feels "mad" (Winnicott, 1974). Winnicott (1974) and Green (1986) both note that emptiness is an essential part of psychic development and, if not experienced at the beginning of life turns, up as a state that is feared, yet compulsively sought after. Geist (1989) reflects on this, saying eating is related to emptiness and so the adolescent, in trying to defend against self depletion and feelings of emptiness, symbolically recreates the activity most closely related; eating. The anorexia, therefore, is a symbolic recreation within the symptom; both the danger to the self and the efforts at self-restoration. This concept of concretization, expressing inner perceptions through the body, has also been noted by Atwood & Stolorow (1984) and McDougal (1989) who saw the life threatening nature of anorexia paradoxically used in the service of psychic survival".

Green (1986) in "Private Madness", notes that the absence essential to psychic development finds itself in the potential space between self and object. In this way, Green takes Winnicott's position, stressing the importance of the use of

an object through identification. Green notes that the abandonment of the object sees the client aspire towards nothingness; this he relates to the death instinct. Though Green considers maternal deficiencies aid this cathexis, he questions whether it creates it. He thinks the question of therapy being possible for such a client lies between the borderline state (splitting) and the decathexis (striving for the zero state), so that the dilemma is between delusion and death. LaMothe (2001), in exploring the vitalising process of therapy, says that it is the interactional processes which give the sense of being alive and real. Within this, he notes that vitality is experienced and organized throughout the life cycle and developmental stages, and is therefore implicit in the client and therapist transferential reenactments in the therapy setting. He notes that vitality may be considered a legitimate and valid structure in the human mind, and that developmental phases grow and change due to genetic function. Perhaps psychoanalysts such as LaMothe, who see developmental tasks as important for developing vitality and who consider these "phases as epigenetic" (p. 320), are more in line with neuroscience and biology. This seems, in part, to relate to what Kaye (2008) cited in Gura, (2008) is pointing to; that "eating disorders are biological illnesses and better treatments will come from biologically based approaches" (p. 62). Kaye notes that life for the anorexic person is not rewarding but instead is an existence built around avoiding negative emotions.

Research in the area of neuroscience and psychiatry explored by researchers such as Kaye (2008), now reveals the support for what psychoanalyst Arnold

Modell (1994), mentioned, in the light of a premorbid temperament. The anorexic person has difficulty in differentiating positive and negative feedback due to exaggerated activation of the caudate, a region in the brain involved in linking action to outcome. It has been hypothesized by Kaye and others "that individuals with anorexia nervosa have an imbalance in information processing, with an impaired ability to identify the emotional significance of a stimulus" (Wagner et al., 2007, p.1842). This reveals further information related to the question of aliveness and deadness. Interventions informed and approached from the "bottom up" can address the body, taking into account the biological/genetic make up of the client and her vulnerability predisposing her to Anorexia Nervosa. This may also relate to their inability to respond to reward and to what neuropsychotherapy calls the approach-avoidant evaluation so necessary for motivational work and therapy (Grawe, 2007). For some clients this sounds like the unbudgeable rigidity Freud thought was rooted in psychic life and in the very nature of matter (Eigen, 1995a). Freud (1937) believed it was part of the inherited equipment; that depletion of plasticity and psychic inertia and entropy, which he thought as a force, could not be mapped. Freud's sensitivity to rhythmn had him think that death work probably sees "some alterations of development in psychical life not yet appreciated" (p. 242). Grawe (2007) notes that in neuropsychotherapy, mental pleasures include the joy of one's own competencies and that psychic entropy is the opposite of Csikszentmihalyi's (1990) flow concept and therefore "exerts a negative influence on mental health" (p. 245). "Entropy implies

increasing disorder….a psyche working in reverse" (Eigen, 1995a, p. 289). On this lack of plasticity and "movement between states between selves and between worlds" (Eigen, 1995a, p. 297), it would seem that the science and phenomenology of psychoanalysis and neuroscience have continued to agree.

I began this chapter outlining the literature and interest in deadness as experienced in the therapeutic setting. Sekoff (1999) notes death is a subject that does not sit well with "attachment, sex or the self" and says Ogden (1995) and Green (1989) have drawn much criticism for using "too grim a vocabulary when other less exaggerated descriptions would do" (p. 120). Sekoff wonders if this has to do with the reduction in death's presence due to public health measures now available to the fortunate. It seems, in reviewing the literature, that Anorexia Nervosa remains outside this modern solution (still rating the highest death rate of any psychiatric illness), and that much of the lack of exploration around the aetiology of death in Anorexia Nervosa is due to the confrontation of it's presence, not only in the clients embodiment of it, but also in her attraction and dissociation to death. In the following chapter I will thread this theme into the 'moment to moment' encounter with the anorexic client and how the psychodynamic use of countertransference can inform and guide approaches to assist both therapist and client.

Chapter Four: COUNTERTRANSFERENCE AND TREATMENT APPROACHES

In this chapter I will define countertransference and then outline the presenting factors surrounding it, as experienced and used in the therapeutic setting with clients with Anorexia Nervosa. Countertransference is one of the phenomenological and subjective tools used by the therapist to inform them in understanding the client's world. In considering a variety of treatment approaches, I will review how psychodynamic approaches to countertransference, in the context of 'deadness to aliveness' and the 'movement towards a sense of self' within the anorexic client, might be used to indicate the 'moment to moment' process and motivational direction of the therapy. Davies & Tchanturia (2005) note that "the major focus of therapeutic work currently for Anorexia Nervosa is cognitive behavioural therapy, cognitive analytical therapy, interpersonal therapy, dynamic therapy, motivational enhancement therapy and family therapy" (p. 311).

The unspoken communication conveyed by the client and felt and experienced by the therapist, is a strong feature of the therapeutic relationship with anorexic clients. In summarizing this experience, Wallin (2007), observes that, "That which we cannot verbalise, we tend to enact with others, to evoke in other, and/or to embody" (p. 121). More often, what is openly expressed by the anorexic client is the experience of a negative self scrutiny, which accompanies depressive and anxious features (Bers, Blatt & Dorlinsky (2004). Bers, Blatt & Dorlinsky's (2004), research showed self judgment is a core

issue of Anorexia Nervosa. It is this core self judgment that lives powerfully in the transference for the therapist and client. It is this that has led me to want to understand this state of psyche, soul and embodiment and how to best make use of approaches that inform the "principle that psychotherapeutic interventions should be tailored directly to psychopathological processes" (Skarderud, 2007).

Definition of Countertransference

The term countertransference has changed in meaning over recent decades (Franko & Rolfe, 1996). Transference was originally introduced as a concept to describe phenomena occurring in the therapy setting which inhibited the client in free associating. What Freud (1910/1957) learned from this was that in the patient reliving psychological experiences, they often acted "as if" the past experiences belonged to the present and therefore responded to him as if he were like the past (love) object.

Freud's (1910/1957) understanding later led to countertransference being used to describe the emotional reaction of the therapist to the patient's transference. This was sometimes viewed as unresolved needs and conflicts of the therapist. In this way, transference and countertransference were described as an obstacle to the therapy and then through further enquiry, transference was later described as being an asset to better understanding the client's world and therefore a powerful tool, if the therapist could be in touch with the transference and work with it with the patient (Racker, 1988).

The Role of Countertransference in Informing the Therapist

Feiner (1982), suggests that, if we take the client's affective state and behaviour as triggering our own inner processes, we are then able to differentiate our response from that of the client, and therefore are able to go on and explore the question: "What is there about this person that elicits this from me, that is, the way I am right now (hopeless, angry, defensive, guilty, withdrawn, sexy, humorous, etc)?" (p.407). This, Feiner suggests, helps to metabolise and process our experience and, as Wallin (2007) concludes, this allows the client to be more available and more accessible to herself. Part of the difficulty is in "the anxiety of influence" (Feiner, 1979) exerted by the client and experienced by the therapist by way of countertransference, as the client faces into their fears. At these times, Wallin (2007) notes that the therapists subjective experience is both a resource and a resistance that can enhance or inhibit the therapy.

In noting the similarities of therapist and client, Racker (1988) says that, while both have "internal and external dependencies, anxieties, and pathological defences" (p. 132), there exists the difference in objectivity; that the therapist in true objectivity can form an internal division that enables the therapist to be alive to her own countertransference and subjectivity, and ideally to remain relatively objective towards the client. This reflects the shift of psychoanalysis; namely that, on one hand, the therapist is not seen to live without anxiety or anger but also at the other extreme is not 'drowning' in the countertransference. Part of this shift, is also due to the influence of

intersubjectivists such as Mitchell (2000) and Stolorow (1994), who relate the phenomenon of transference as a "system of reciprocal mutual influence" (Stolorow, 1994, p.42). Taking into account the contrasting 'mutuality' of the relationship where the client's role is to be responsive, while the therapist is responsible for the therapy (Aron, 1996). What most therapists report, as the following research will show, is that this is easier said than done.

Studies of Countertransference with Anorexic Clients

Today, countertransference is considered more broadly as "all those reactions of the analyst to the patient that may help or hinder treatment" (Slakter, 1987, p.3). In using this broader definition, Franko and Rolfe (1996) studied the emotional reactions and feelings evoked in the therapist in response to their anorexic clients. They note that empirical studies in the countertransference of this client population are few but that some, such as Herzog, Hamburg and Brotman (1987), suggest that intense countertransference reactions to these clients are due to their medical complications, neediness, potential suicidality and hostility, and that this requires "more forbearance and self-questioning" by the therapist than other psychiatric conditions (p.549). Kaplan and Garfinkel (1999) parallel this, reporting that these clients are experienced as "difficult" due to the negative countertransference that they evoke. The earlier studies by Rampling (1978) concluded that the therapist treating a client with Anorexia Nervosa must be prepared to accept frustration and failure. Therapists may also be fearful because of the potential for death through suicide or starvation (Zerbe, 1992), alongside the negative feelings generated by the life-threatening

behaviour sometimes perceived as intentional (Brotman, Stern and Herzog,1984); all of which can recreate a sadomasochistic relationship with the therapist (Zerbe, 1992). Other factors such as gender issues; feelings of envy and competition towards a female therapist may interfere with the therapeutic alliance (Zerbe, 1992).

Franko and Rolfe (1996) surveyed clinicians and found that "eighty percent were psychodynamic in their orientation, with the remaining twenty percent identifying themselves as both psychodynamic and cognitive behavioural" (p. 111). The mean number of years of the study population working with eating-disordered clients was seven, making most respondents experienced clinicians. This study concluded that therapists with a greater number of clients with eating disorders reported feeling more frustrated and angry as well as tired and manipulated, when compared to those with a fewer number of these clients. They showed that anorexic clients evoked more intense negative feelings than bulimic clients, and that "therapists reported feeling less connected and successful, as well as more frustrated, hopeless and helpless with anorexics than bulimics" (p.113). The study also showed that as therapists gained experience, they were better able to cope with the anorexic behaviours. Left in doubt, following the study, was whether the years of experience influenced the efficacy of therapy with anorexic clients. However, what was clear was that, though experienced therapists reported negative feelings in response to their anorexic clients, the awareness on the therapist's part of their own feelings and ability to deal appropriately with countertransference benefited both therapist

and client. Safran & Muran's (2000) study correspondingly highlighted the importance for therapists to attend to countertransferential feelings, and they showed poor outcome resulted in cases with complex interactions and hostility linked to negative interpersonal processes between the therapist and client. This study highlights the need to contain and process powerful affective states (Zerbe, 1992) so that the therapist doesn't take the needs of the client and act as if they were their own (Nunn, 2007) and therefore using the client's therapy for their own psychological problems (Ogden 1979). The danger of negative and complex interactions between therapist and client is that a repetition of early pathogenic interaction may result in a recapitulation of the narcissistic parent remet within the therapist. This can happen if the therapist's own self-object needs to be mirrored or validated are intensified when the client negates her need of the therapist (Goodsitt, 1997).

For individuals who have not had the experience in childhood of having caretakers remain present to them during bursts of anger, the capacity to hate as well as love is a developmental achievement that has not been integrated (Winnicott, 1965). Therefore the therapist's containment and the ability to work with the negative transference, to be the "bad object", is an opportunity for developmental repair for the anorexic (Zerbe, 2007). At times, this demand can feel assaultive and, if the therapist can attend to this demand, part of the integrative process of positive and negative transference can be processed as required, resulting in a reworking of the client's internal object world (Zerbe, 2007).

Goodsitt (1997) says the psychological issues presenting in the anorexic client mean a therapist is at risk of over or under managing the treatment due to the following issues:

1. A patient exercises tyrannical control over her world, including the therapist
2. A patient is committed to defeating hope and the therapy
3. A patient does not relate to others, including the therapist, as separate human beings
4. A patient adopts the psychological position of selflessness and engages in "selfless transference"
5. A patient engages the therapist as withholding, omnipotent other (this pattern is more of bulimics) (p.224)

Working with Issues of Countertransference

Meyer and Weinroth (1957) say that a favourable outcome has less to do with offering psychological insights and more to do with the therapist's warmth and ability to meet the attention that the client seeks. Part of the pressure exerted on the therapist is in relation to projective identification[2], another subjective tool available to the therapist for information and insight into the client's experience. In terms of projective identification, I refer here to Ogden (1979), where he states that it has to do with ridding the self of unwanted aspects and depositing them into another person. This may be used by the client as a defence against raw annihilation anxiety, which is then experienced by the therapist as pressure exerted in the interaction to think, feel, and behave in a manner congruent with the projection. Via the mechanism of projective

[2] Klein noted in her theory that from the earliest months of infancy the mother's breast takes on a powerful significance; "introjection" is the taking in of "good objects" and "projection" is the rejection of "bad objects" accidentally taken in. This is the "paranoid schizoid position". Later- the "depressive position"- the child comes to realise that both good and bad reside in the one person; the mother is both nurturant and punitive.

identification, eating disorder clinicians often revert to concretised modes of thinking and become containers for clients' psychosomatic issues as well as a range of countertransferencial responses such as exhaustion, psychosomatic complaints and temptation to impose their values on the client (Zerbe, 1992). In this way, a client's primitive experience, such as a complaint of gastrointestinal distress, may be experienced by the therapist within her own body as a headache, intense anxiety or a need to self soothe. Often, in the early stages of treatment, it is the role of parents and clinicians to hold these projections so that the part of the client that threatens to destroy the self from within, or which fears recovery from anorexia (that part of the self identified with the anorexic thoughts and behaviours), can be explored and thus allow the healthy part to gain support for the long process of recovery (Malan, 1997, Farber, 2007). Some clients recognise their need to project feelings onto others so as to use relationships to express parts of the self (Gentile, 2007).

In this way, countertransference with anorexic clients can trigger powerful superficial responses in the therapist due to the client's concrete thinking and primitive psychological defences (Crisp, 1997). Though anorexia is a life threatening illness, clients are noted to be attempting to change themselves and their lives through the control of their bodies (Skarderud, 2007) while at the same time being extremely resistant to treatment for the condition (Kaplan & Garfinkel, 1999). It is this psyche/soma split that Sacksteder (1989) points to, noting that the personalities are not identified with or located within their bodies, but instead their bodies live out a life that is quite separate: "The

psyche drives or operates the soma with conscious care" (p.367). Within this, Sacksteder (1989) notes, that it is as if the soma is threatening to overwhelm the psyche leading to a sadomasochistic relationship where the psyche persecutes the soma and the soma feels persecuted by it. The idea that the soma can be starved to death and the psyche can be left to survive is a belief that clients hold and which clinicians are confronted with as a delusional state and one which can be difficult for a client to come to terms with.

The transference and countertransference experience "represent two components mutually giving life to each other" and are therefore helpful in creating the relationship with the anorexic client in the 'here and now' (Magagna, 2007, p.261). Magagna notes that this is supported by meeting the anxiety in the client at the moment it is experienced. This is especially important to the younger anorexic clients.

Focus of Therapy for the Anorexic Client

Movement towards aliveness is reflected in what Crisp (1997) says is the pivotal intervention in supporting a client to face into treatment: to give her a greater sense of a future life and a sense of being someone other than a person with anorexia. This would be consistent with Bruch (1973) seeing anorexia nervosa as a desperate struggle for a "self respecting identity" (p.321). In this way, Bruch didn't search for underlying conflicts but, instead, helped clients develop a sense of competence and effectiveness in dealing with their daily problems of living through "constructive use of ignorance" and "fact-finding"

(p.325). She helped clients to reconstruct the stresses, real or fantasised, that led to their eating disorder. This active participation in the inquiry leads to clarification of their cognitive distortions and helps patients rely on their own thinking (Chassler, 1994).

Cognitive Behavioural Therapy

Cognitive distortion is often addressed through Cognitive Behavioural Therapy (CBT), which is widely used with clients with Anorexia Nervosa. Clients can come to understand the concreteness of thought and reality towards weight and food (Garner, Vitousek, Pike, 1997). The conceptual framework for the therapist and client relationship is considered a prerequisite for a strong alliance and for effective psychotherapy (Garner, 1988, Orlinsky, Grawe, and Parks, 1994). Part of the developing of trust and a collaborative relationship (Beck et al., 1979). Garner, Vitousek & Pike (1997) acknowledge that cognitive therapists have been reluctant to view the therapy relationship as linked to past and present relationships, in part due to this sounding like transference. In making use of this information, cognitive theory has now evolved to integrate interpersonal processes (Linehan, 1993; Safran & Segal, 1990). The reason for this is that eating disorder symptoms can have a strong interpersonal message, or alternatively are related to problematic interpersonal issues that can be triggers for anorexic symptoms. As social deficits are observed, interpersonal themes are addressed early on in the use of CBT for anorexia nervosa (Garner, Vitousek, Pike, 1997; Lineham, 1993). However, it seems that articles on CBT do not refer to transference per se. It is not actively

used as a tool to inform the therapist. What is highlighted is the role of the therapist in problem solving and the integration of values and beliefs; this is seen to be part of the process for fostering the patient's own identity (Safran & Segal, 1990). The active therapeutic stance in CBT relates to the issue of alexithymia[3], the inability to express and identify emotional and affective states (Sifneos, 1972), which is often experienced as a clinical trait in or by the anorexic client (Skarderud, 2007b). This active and challenging therapy supports behavioural change through the client making use of the therapist, but the literature shows a lack of acknowledgement of the transference in influencing the approach and outcome for the client.

Self Psychology

The other therapy model commonly used in treating anorexic clients is self-psychology. It is seen as a relational model supporting the views of Bruch (1978) that recommend assisting the clients to rely on their own inner experience and to help focus on identification and validation of their subjective experience. This is considered by some such as Steiner-Adair (1991) and Wolf (1978 as appropriate in terms of female psychology where, through self-object transferences, the experience of calmness and strength can be had through the experience of merger. Often with such clients, the only evidence of inevitable disruptions of relatedness is seen in an increase in somatic preoccupation for the client (Wolf, 1991). This is in part due to the tendency to minimise emotional distress and the failure to learn the processing of difficult and

[3] Alexithymia is a disruption to both affective and cognitive processes; the incapacity to identify and express emotions and feelings (Stifneos, 1972).

negative emotions, particularly anger and loss (Corcos et al., 2000). Increased understanding for the client of affective experience translates into an enhanced sense of agency was first highlighted by Bruch (1973) when she shifted her emphasis on therapy with anorexic clients towards "evoking an awareness of impulses and feelings originating within themselves and toward their learning to discriminate between various bodily sensations and emotional states" (p. 263). Ego functions such as signal anxiety (the ability to anticipate danger) are sorely deficient in these clients, and they suffer from intrusions into their states of consciousness that result in psychological and somatoform dissociation; this in turn results in severe deficits in self regulating and self care functions of the ego (Khantzian & Mack, 1983). Implications for therapy should therefore target the dissociation and build signal anxiety and ego functions (Farber et al., 2007). Goodsitt (1997) similarly notes that anorexic symptoms reflect nonsymbolic emergency measures to deal with anxiety that accompanies a disrupted self, or are measures aimed at vitalising an empty depleted self. The opportunity for the client to experience a more enlivened state is reflected in the therapeutic endeavour as "a new opportunity to invest in herself and another person, with the aim of developing a more effective and vitalised self – a self that enthusiastically occupies psychological space" (p. 226).

The Eating Disorder as a Symptomatic Expression of an Internal Conflict or as a Reflection of a Disorder of the Self

The idea that the body self is a unique vehicle of communication (Freedman and Lavender, 2002) is reflected in the statements that the self at its core is a

body self (Goodsitt 1983; Krueger, 1986) and "the ego is first and foremost a bodily ego" (Freud, 1923, p.26). It becomes difficult for the anorexic person to regulate metabolic activities and Goodsitt (1997) sees the attainment of a stable, cohesive self as the pathway to the anorexic person being able to process external stimulus, be it food or information.

Goodsitt summarises application of theory by stating:

> …eating disorders are symptomatic expressions that can occur in a relatively intact or structured psyche and reflect an internal conflict or can occur in an undeveloped or incomplete mental structure and reflect a disorder of the self. (p. 207)

Goodsitt (1997) and Skarderud (2007) both note that the eating disorder pathology often reflects psychic reality poorly integrated, and that the central role of the body is to attempt to restore cohesion or vitalisation; these painful experiences of mind and self are experienced as numbness, emptiness, not feeling alive and not really living. Goodsitt notes that the lack of self-soothing alongside tension and mood regulating, feeling restless and empty, leads the anorexic person to constant activity and strenuous activity to drown out these painful internal conditions. This sees the therapist role responding to these suffered disappointments and psychic injuries as parent, teacher, guide and coach (Levenkron, 1983). The need for empathic attunement requires the therapist "to fill the deficit and manage the transference" Goodsitt (1997, p.219). In this way, psychotherapy provides opportunities through the therapeutic relationship to foster mentalising and for the transference enactments to provide opportunities to learn and understand past failings (Skarderud, 2007). This relates to Symington (2007) and his idea that, through

negative transference, the undeveloped aspects of the psyche are recognized by the client. Symmington says that in focusing on integration and the theme of destructive and constructive forces, it is more painful for the client to recognize thwarted development than it is to see oneself as bad. He suggests focusing on growth and expansion as this is usually more hidden than what is destructive. Zerbe (1992), in integrating feminism and psychodynamic principles, reports using a very expressive therapy that allows for the therapist to be emotionally involved and to show aspects of the "real self" to the client; developing the self and expanding learning and critique. She says it takes time the client time to attain a greater sense of power through "new dimensions of personal, spiritual and intellectual authority" so as to gain tools to sustain and develop the self (p.173). Zerbe also makes a stand for the therapist to go beyond the repertoire of techniques to rely on intuitive capacities and "make the best of even the worst moments" (p.172).

Beresin, Gordon & Herzog (1989) studied thirteen women who had recovered from anorexia to review their process, and to ask what had caused the Anorexia Nervosa and what experiences helped or were harmful in the process of recovery. Individual psychotherapy was the highest rated of all treatments, but it was also viewed as potentially the most destructive. The participants spoke of the ideal qualities of the therapist as being honest, consistent, flexible and reliable, "conveying respect and warmth towards the client", as well as being "active, firm but empathic, and confrontative when necessary" (p.114). The participants responded uniformly negatively to "inexplicit goals,

inactivity, silences and formality", saying they feared reliving family dynamics of being controlled by hidden agendas and unspoken rules and "exploited by an adult's narcissistic needs" (p. 114). The transference to this is that the client becomes sensitive to the therapist's theory, stance and ideology and becomes the "perfect patient", experiencing a repeat of the family "dictating covertly" (p.115). This kind of transference can easily undermine the potential for the therapist to be a secure base, resulting in "pseudotherapy" (Wallin, 2007). Life experiences were seen alongside individual therapy as the most rewarding, but also high risk and potentially destructive (Beresin, Gordon & Herzog, 1989). Goodsitt (1983) suggests there is a need to balance the premium of therapeutic process with the therapeutic value of daily life and the potential for good experiences, so that the therapist becomes a self object or transitional object encouraging growth in 'life-promoting' experiences. Others, such as Krueger & Schofield (1986) have noted the importance of external affirmation for this client group, as they seek "to gain some sense of recognition" due to deficient self regulation with "little or no recognition of an internal centre of initiative or reference" (p.324). Food, in this way, is used as a basic external source that can supplement a deficient internal regulator and a deficiency to integrate a basic concept of mind and body.

Integrating Writing into Treatment

In the process of recovery, often spoken about by self psychologists as a "psychological rebirth", self understanding is enhanced through self-talk and self-reflection activities such as diary keeping. These present new

opportunities to test out what the client has learned about herself (Beresin, Gordon & Herzog, 1989). Gentile (2007), a feminist psychoanalyst, describes how for an eating disordered client, 'diary keeping' can be an important transitional phenomenon which can create a bridge between multiple spaces of existence and dissociated self-states. She describes the process for the client as a structure of text that can wrap tightly around her as a protective skin when remembering abusive incidents or loosened into prose when remembering less traumatic incidents. In this way, it is not just reality or fantasy but what Ogden (1992) calls the "potential space between the two" (p. 202); a way to breathe life into experience and to have subjectivity (Gentile, 2007, p.174). In concluding the analysis over three years of the diaries of a woman with a long history of an eating disorder, the client reports what had been most important to her, was Gentile's sustained attention. Gentile relates this to Winnicott's (1971), recognition that this impacts the client by having the client be interested in their own subjectivity and, in turn, the subjectivity itself is thereby altered. Farber (2005) also notes that writing can act as an action symptom, alleviating tension, communicating material that remains part of one's personality, and therefore something guarded. In this way, writing can work off the problematic affect of shame and embarrassment so that the material is easier to tell to another. This could be seen to ease transferential resistances and need of the therapist, while also offering a sense of organic continuity and an end to suspense and uncertainty. In effect, it is moving the client through a transitional phase towards a greater sense of self. Farber

reports that some clients need the therapist's presence in order to write, and that later the writing alone becomes an extension of the holding environment as they imagine or remember the therapist.

Bodily Communication

A tendency to intellectualise or request that the body be foremost in the therapy to the exclusion of verbal communication is common with anorexic clients (Sella, 2003). Sella considers anorexic clients to have a clear sense of their bodily sensations and movements as the only fields of psychic independence, authenticity and self agency, and suggests that therapy that does not relate directly to this experience is regarded as irrelevant, ineffective or as retraumatising, reflecting severe misattunement to these bodily aspects of self. The psychic self is made up of structural aspects of the self that are healthy or symptomatic and which therefore might "respond differentially to a particular psychotherapeutic intervention" (p.39).

Stern's (1985) model of "cross modal attunement" incorporates the psychic self in a way that encompasses the therapist adjusting to and attuning to intensities and vitality affects so as to address regressive and foreclosed aspects of the self. The 'somatic countertransference' and 'body-orientated' psychotherapies (Staunton, 2002) suggest the therapist stay inwardly focused and make use of the countertransference to enable the client to learn about "her subjectively experienced sensorial-emotional experience" through her patterns of projective identification and the "intersubjective generated experience of the

analytic pair" (Ogden, 1994, p.94). This transference experience can be had either through 'silent interpretations' which are held and processed by the therapist or as a shared experience which helps to relieve the client's sense of aloneness and allows her to reality test, integrating fragmented aspects of the self (Sella, 2003).

In this approach, a large part of the work together is done implicitly "through good enough attunements in regard to the bodily, sensorial and energetic aspects of the self" (Sella, 2003, p. 49). This is seen to be part of the building blocks of the psyche and the basic strata of what Stern (1985) called the 'emergent' and 'core' sensory preverbal self, and could relate to areas of the self which, rather than being foreclosed are set in a different structural pattern that persists throughout life. This is seen to be consistent with Anzieu's (1990) idea that the psyche is not **a** system but a system that integrates several subsystems.

Body awareness and desomatisation is an important part of psychotherapy with anorexic clients (Krystal 1997). Wallin (2007) suggests therapy involves not only "recognising and containing bodily sensations and affects, but also interpreting or making sense of them" (p. 305). It is this "resomatisation" that Wallin says is crucial for an avoidant client; supporting the client to reclaim a body that feels. This is something that was lacking in their early attachment experiences and now has them adopt a "deactivating" attachment strategy to tune out all internal signals and need of other (p.306). This living in the head

has the client appear “low on life and affectively muted”; resulting in their lack of a nurturing or receptive relationship to their own bodies (p. 306).

Wallin suggests that, when there are no words to convey what the client feels, we must let the client know what we hear the body speaking. This enables the client to become more grounded in their body and to integrate bodily and emotional experiences that they have not previously claimed as their own. “For the body to become a therapeutic resource, mindfulness is required of the therapist” (p. 294). The therapeutic encounter reveals the rhythmic actions of body movement (Freedman & Lavender, 2002). The stance of immobilisation, as seen in the shielding of bodily rhythms, means the body’s actions seem to interrupt and negate symbolic links and the psychic life appears to evacuate. Freedman & Lavender, (2002) say the anorexic person has a concretised sense of stuckness which is all absorbing, resulting in little access to an inner world. Aggressive experiences are avoided in favour of action patterns or somatisation, and dreaded thoughts are repudiated so that affect is foreclosed. This speaks to early deficits. In this way too, Kristeva (1999) refers to “anorexia as a paranoia turned against the self” and a process of “mummification” that is part of the deadening of the body and of sexuality (p.16). Kristeva suggests the anorexia can be modified into psychic pain through the acknowledging of anxiety. In this way, the working through of mental suffering replaces the “somatic acting out with the drama of the struggle between ego and superego” and Kristeva suggests this is a “victory over psychic death, a coming to terms with the otherness within the self, which

can arise as a conflict with the analyst….The telling of cruelty brings us back to life, body and soul reunited" (p. 17).

Encapsulated Pre-Verbal Substrata

Sella (2003) notes, that more recently (i.e. the last four decades), psychoanalytic writers have "recognised the existence of an encapsulated pre-verbal substrata that precedes symbolisation" and this "foreclosed" aspect has rarely been addressed in eating disorders (p. 38). These observations have been supported by developmental studies by Stern (1985), trauma and ethological research (Rothschild, 2000) and neuro-psychological research (Damasio, 1996), who note the bodily manifestations as "foreclosed or encapsulated", rather than seeing it as symbolic material being repressed. This relates to what Williams (1997a) calls "no entry defences", anorexia being one of them. These are developed as a result of a lack of containment, which has left these clients open to "perceiving themselves as receptacles of unmetabolised phantasies and experiences projected into them by their parents" (p. 927). Sella relates this to the reason these clients experience intellectual interpretations as false aspects of self.

It is within this context of client-therapist communication that the "intersensorial connections" must precede the interpretative function (Anzieu, 1990, p.60). Anzieu (1990) proposes that, with some clients, therapy would need to begin with rhythmic rocking and body to body contact and play. This follows Stern's (1985) theory and Little's (1981) clinical position that the self

can transition from a non-verbal to a verbal 'self'. Williams (1997a) notes the countertransference experienced by clinicians working with the 'disorganised porous client' is one of a softly spoken approach, a feeling of being careful around their experience of being invaded and intruded upon, such as the consequence we understand as persecutory anxiety[4] which has left these clients 'psychically porous'.

The countertransference of the 'no entry' client, who has developed defences against the projections, is different from that of the psychically porous client, and as a result, a breaking and entering of powerful projections by the client into the therapist, parallels their dread of being invaded. This, Williams states is what Grinberg (1962) called 'counterprojective identification' and it is this that alerts therapists to the possibility that these clients have been on the receiving end of massive projections. As Ogden (1979) notes, it is the therapist who must be open to this communication, in order to objectively make use of this information in the transference. The danger is that the therapist identifies with being what the client projects and as a result a disruption, retraumatisation or rewounding occurs for the client.

In their research Vanderlinden and Vadereycken (1997) found that animal subjects in excitation or danger will ignore food for abnormal lengths of time, and suggest that, in relation to anorexia, if feeding in "the infant's first year of life is stress inducing, it may contribute to the formation of sympathetic,

[4] A psychoanalytic term for anxiety produced by fear of attack from hostile others. Alternatively it can be understood as irrational fears of harm to loved ones; the outcome of denial and projection of one's own hostile feelings (PDM, 2006).

dopiaminergic, sub-cortical ascending circuits that constitute the physiological correlates of emotional memories embedded in the amygdala" (p.41). They propose this may be at the root of the syndromes resistance to therapy. This relates to the connection between being loved and being fed (Alexander, 1950) and later to Williams (1997a) and Brigg's (1995) connections between emotional and verbal input and food, a parallel process of physical and emotional introjection-digestion.

Interpersonal Therapy

The interpersonal dilemma for the anorexic client can be seen when two contradictory motivational currents are present in the client's communication to the therapist (Stern, 1992; Havens, 1976). Stern, an interpersonal analyst, describes the nature of the conflicting currents as opposition "between legitimate needs of the self (such as needs for emotional nourishment, affect containment, empathic mirroring, or support for separation- individuation" and self denial or "pseudoself-sufficiency that has its roots in early requirements imposed by the family system" (Stern, 1992, p.597). Stern notes this manifests in the form of denial of transference feelings and/or disavowal of the therapist's importance.

By encouraging the client's true feelings, as opposed to compliance to secure relations with needed others, Stern (1992), acknowledges the techniques of Sullivan (1957), Havens (1976) and Gustafson (1986) in managing motivational contradictions. This, he notes, helps to integrate dissociated affects and to resolve basic developmental conflict. By containing and

supporting through this conflict of "dissociated primary needs and characterlogical opposition", and by mirroring and interpreting the dilemma that this opposition creates for the patient and their relationships, there is for the client a verbal and nonverbal container for the opposing currents as they are acted out in the transference (Stern, 1992, p. 598). Stern summarises this with the idea that, in the strengthening of the self-experience (ego) for the client, there is allowance for movement towards resolution of the paralysing conflict of self needs and dissociated needs.

In this chapter, I have presented literature surrounding countertransference as experienced and used in the therapeutic setting with clients with Anorexia Nervosa. As a psychoanalytic, psychodynamic tool used by the therapist, it is subjective by nature and difficult to critique. The literature around this topic is qualitative and therefore open to interpretation. Plenty is written about these clients eliciting negative countertransference due to the power of what their bodies and psyches are communicating, with the research around treatment approaches appearing to place less emphasis on interventions and greater importance on the therapist's own responses, along with the therapist's ability to contain and hold, to reality check, to be congruent and authentic, to be a life embodying role model and faith holder. I will go on to develop this discussion in the next chapter and continue to link and synthesise their relationship to the theme of aliveness and deadness within the anorexic client.

Chapter Five: CONCLUSION

In this final chapter I integrate and review the themes of chapters three and chapter four; aliveness and deadness in the therapeutic encounter, and how this lives in the transferential relationship with the anorexic client. The therapeutic approaches used, are aimed to enhance and engage the potential for motivation, transformation, support for and interest in, sense of self and their own lives.

Summary of Findings

The themes of this dissertation link with the lived experience in the 'moment to moment' movement within the therapeutic encounter and all that this embodies as psychic space meets relationship and intersubjectivity. Psychoanalyst Julia Kristeva (1995) argues for a reinstatement of a notion of psyche and soul that incorporates the body and embodied moments, and notes that much about contemporary psychoanalysis is being currently challenged around issues of embodied, psychic and social life. On one hand, she says, there is a blend of neuroscience and psychopharmacology which now characterises psychiatry, and on the other hand post structuralists and cultural theorists emphasise social subjectivities, which pathologise women's experience within Western patriarchy. Cited in Barnard (1999), she regards the body's semiosis[5] as emerging in and out of relation to the maternal body, "especially as that relation represents the first space within which the

[5] Semiosis is defined as signs and symbols of patterned communication from non-verbal to verbal (Reber, 1995).

differentiation into social subjectivity and hence into embodied psychic life occurs" (Barnard, 1999, p. 369). Clearly, feminist psychoanalysts like Kristeva, are challenging the separate discourses and looking to the bridge of psyche, soul, body and embodied moments.

In considering Kristeva's (1995) observations, I am well aware of my own needs for life sustaining and supporting activities that offer hope, faith and creativity as I work with eating disordered clients. Part of the stress of working with the anorexic client is the need and ability to tolerate potential loss of life (through starvation or suicide), and therefore the intense responsibility necessary for management of medical and behavioural issues. However, this risk of death can strike at our constructs around embodied life and faith, and our ability to metabolise unspoken communications, along with much needed compassion for self and other.

In considering this concept of deadness within the therapeutic encounter, psychoanalysts such as Jed Sekoff (1999), reflecting on Green's concept of "The Dead Mother", note it is not so much death per se that we struggle with "but statis - the freezing of movement across psychic pathways" (p. 122); in this he says, we can put aside "potions and incantations and instead discover the art of living in the liminal" [6] (p. 122).

[6] Liminal is an anthropological term for what Sekoff (1999) calls a "blurred state at the moment of death… that dizzies us with it's dissolution of fundamental boundary lines…where the usual rules of order…are thrown into question" (p. 119).

The views expressed by Kristeva and Sekoff relate to the continued commentary and exploration of the unfolding information contained within the axis of deadened to enlivened states.

The Continuing Complexity of Anorexia Nervosa

In defining Anorexia Nervosa, the unknown aetiology and lack of understanding of the pathogenesis still hinders the development of effective interventions (Wagner et al., 2007). Within this continued search for understanding, neuroscience, biology, psychiatry, psychology and psychotherapy continue to explore pre-morbid issues that relate to phobia, anxiety and depression as well as avoidance of novelty, perfectionism and regimentation that see this client group exposed to greater vulnerability and psychological risk (Kaye, 2008). On other key issues is the role of starvation and the impaired ability to experience pleasure (Kaye, 2008). A multidisciplinary approach is evident in the current treatment strategies for this complex disorder (Salbech et al., 2008).

The Therapeutic Encounter and Themes of Deadness and Aliveness

The therapy space is a recreation of the psychic structure (Parsons, 1999) and a place where the expression of the psyche and embodied life of the client can be inquired into. The experience of this negation (Green, 1986) is full of information. Ogden (1995), noted that lifelessness in the client is enacted in the sense of lifelessness in the therapy, and Winnicott (1971) and Ogden

(1995a) thought that the experience of aliveness as a quality in it's own right should be the goal of all therapy.

Eigen (1995a) who has written extensively on psychic deadness sees the anorexic person as an embodiment of death, stating that the destruction and negation of life is related to an "active breaking down" rather than a falling apart (p. 281). This, he says, is due to an overwhelming stimulation, the ego's attempt to do too much, resulting in a blankness of nothingness. In contrast, Klein (1953) does not focus on psychic deadness as Eigen does, but points to emotional deadness as a measure of unconscious anxiety and the conflict model of life and death (Freud's death instinct) as central to psychic life. This links to the "black hole" first referred to by Bion (1970) as the infantile catastrophe and the idea of annihilation as the fear of losing one's self, being engulfed, abandoned, devoured, penetrated or mutilated (Farber, 1997; Grotstein, 1993; Tustin, 1990). Likewise, Modell (1994) says the feeling of deadness can be modified when people come into better contact with themselves. Similarly, Geist (1998) noted that, in self psychology terms, eating disordered clients lack the psychological connectedness because of a lack of empathic resonance and have often experienced trauma not as a rememberable event but as what Winnicott (1974) termed, "nothing happening when something profitable might have happened" (p. 106). This relates to the false self which Winnicott (1971) linked to the part of the self that feels dead as a result of experiences (for the developing infant and child) of impingement and deprivation. The importance of the intersubjective field within the therapeutic

relationship was, for Winnicott, linked to the source of vitality in the psyche-soma, an opportunity for the client to experience a quality of aliveness. In this way, Eigen (1995a) and Goss (2006) think it is important for the therapist to be aware of their own antigrowth tendency so as not to become fused or polarised by the client's "force field" and to make more conscious the deadening aspects of the client. This relates to Symington (2007) and his idea that, the therapy focus should be on growth and expansion towards integration; the growth usually being more hidden in the client than that which is destructive. Zerbe (2007) also noted that the negative transference could be developmentally reparative, if the therapist could contain and work with the negative transference, to be the "bad object". For many anorexic clients feeling safe enough with someone to have the capacity to hate as well as love is an opportunity for developmental repair (Winnicott, 1953).

Death as a Living Theme in Anorexia

The theme of death, according to Bachar et al. (2002) and Farber et al. (2007) has been significantly overlooked in the literature on eating disorders. Farber et al. (2007) focus on the psychopathology of Anorexia Nervosa as an unconscious destruction and preoccupation with death and anxiety about annihilation. Part of this life threatening disorder is due to the dissociative processes that separate and compartmentalise psyche and soma. They note that these defences compromise ego function and leave the anorectic with poor affect tolerance. Others, such as Malan (1997) and Warren (1997), would indicate that it is not so much about the preoccupation with death as about the

inability to deal with life constructs and issues. Malan (1997) focuses on the use of the therapist as a crucial link to the 'cord of life' for the client. While Warren (1997) asks the meaning, behind the behaviour. Likewise, others such as Crisp (1997), see the anorexic symptomatology as a way to deal with life's transitions (often impending puberty) as an unconscious response to a brush with the real world and personal mortality. The minimising or avoiding feelings and emotionality may be a way of dealing with experiences for a temperament that finds life's challenges all too much (Strober, 2004). Ogden (1995a), notes that this is more about warding off of intense anxiety by trying to be untouchable in her isolation (and a need for control) rather than a preoccupation with death as discussed by Farber et al. (2007).

While researchers, such as Malan (1997), see the 'pull to death' with the anorexic person as a dangerous and difficult clinical encounter, he also notes the opportunity to utilise the therapist as part of the 'cord of life'. This speaks to the dialectical structure that Israelstam (2007) notes can offer a new dynamic tension out of the life-death dialectic. Within this dialectic edge, Israestam suggests the 'inherent' capacity exists for Winnicott's (1971) potential space. Though Winnicott (1953) did not refer directly to the life-death construct, his theory of mind did account for how we are able to cope productively with the realities of loss, separation and death. In the potential space is the opportunity for transformational thought to come alive (Winnicott, 1971).

The Body's Central Role for Defense and Refuge

The central role of the body for the anorexic person is often related to the fact that psychic reality is poorly integrated. This results in the body taking on an excessively central role for the continuity of the sense of self and a contradiction results, where what the anorexic seeks as rescue destroys her life (Skarderud, 2007). As noted by Freedman and Lavender (2002), for the anorexic person "undigested, destructive, even violent urges, frightening moments of erotic promptings, or psychotic like disorganization diminish the possibility for coherent representation, and may lead to mindless repetition or even physical immobility" (p.196). This speaks to the somatic preoccupation that Wolf (1991) noted could alert the therapist to evidence of disruption within the relationship. Similarly, Magagna (2007) points to the benefit and mutuality of the transference and countertransference, placing the relationship in the 'here and now', and to the importance of meeting the anxiety of the client in the moment of enactment, giving the client an experience of empathic support and reassurance.

What Is Being Expressed Through The Body?

Though therapists are able to speak to the effective treatment of somatic concerns in clients, they are less effective at being able to "explain why and how the body was being used to defend against and to express conflict" (McDougall & Coen, 2000, p. 159). McDougall & Coen say that this is not surprising, since it is difficult to explain causes and mechanisms "especially the leap from a mental process to a somatic innervation" (p. 159). McDougall

(1989) is optimistic that the unfolding transference helps to dissolve psychosomatic symptoms, replacing them with transference affects once the client is able to bear her feelings and that early trauma that can not be expressed verbally must be expressed by the body, therefore it is impossible to separate psychic life from soma experience (McDougall, 1989). Coen (1992) suggests that, rather than seeing somatic symptoms as expressing conflicted wishes, it may be useful to consider that some clients have affect intolerance. This relates to Kaye's (2007) idea of the anorexic person having a biological limitation in terms of processing interoceptive information; such as temperature, touch, muscular and visceral sensations. Kaye notes that interoception is critical for "self awareness as it provides the link between cognitive and affective processes and the current body state" (p.134). According to Kaye, this could explain diminished insight and motivation to change, alongside a dysphoric temperament inherent in a dysregulation of emotional and reward pathways. This leads to starvation as a respite from the dysphoric and anxious mood so that starvation is pursued in an attempt to "avoid the dysphoric consequences of eating" (p. 134). Such neuroscience proposes links with, what Fonagy and Target (2007) say are changes in cognitive science which mean the brain is now viewed as more continuous with and as an organ of, the mind, emphasising the bodily origin. Thus, "disorders of the mind are also disorders of the brain"(p. 445).

Use of Countertransference as an Informing Tool to Integrate Mind/Body

Bodily communication seems especially important when the therapist can use her own attunement for involvement in the client's experience, as a shared experience. "Much of what we pick up from our patients, we may first feel in our bodies and perhaps most immediately in our breathing" (Aron, 1998, p. 28). By observing our own bodily experience we can observe the client's. The brain's mirror neuron system ensures that we actually resonate automatically with our clients and that our somatic states may well represent unconscious responses to the patient's nonverbal communication (Wallin, 2007). So whether or not the approach is through a top down process with mentalisation and neuropsychotherapy, the process is still embedded in the body (Wallin, 2007). Our first five senses respond with firing as we smell, touch, taste, hear and see. Sensation then serves as the primary data, the bottom-up input of firing which will then be processed further in the brain (Siegel 2006). Represented as a schema diagram the author has outlined a therapeutic model to explain the approaches reviewed in this dissertation and their application to the anorexic client, see Appendix A.

For the anorexic client with traumatic attachment, for whom there was no interactive repair provided and extreme levels of stimulation, and therefore intense negative emotional states over extended periods (Schore, 2001b) the use of the therapist as a soothing object could be vitally reparative. Krystal (1997) refers to this "psychic trauma" as common but relatively unacknowledged. This relates to what McDougall (1989) calls core affective

states and internal conflicts, generated in early infancy, when the child has no verbal language for intense emotion and which later translate into physical illness crystallising a complex set of interacting processes, connected with language and relationship. This could well relate to Goodsitt's (1997) self psychology summary of 'the application into theory' as either the "anorexic client who is seen as a symptomatic expression of an internal conflict occurring within a relatively intact or structured psyche or the anorexic client who reflects an undeveloped mental structure and for whom the anorexia reflects a disorder of the self" (p. 207). This could be seen to relate to the issues for the treatable and perhaps untreatable client whom Modell[7] (1994) in the previous chapter made reference to; the client who needs the presence of another in order to process affect and the environmental and biological issues that possibly make some of the complex factors "not reversible in psychotherapy" (p. 376). Goodsitt (1997) notes this need for the client to make use of others; that the therapist is experienced as a vital aspect of the client and therefore not separate as the other. Indeed, Goodsitt disagrees with object relationists who maintain that sexual and aggressive aims are central to the development of anorexia and says that instead of guilt over drive impulses, the experience of annihilation, anxiety and devitalisation are more central to the illness.

[7] Modell mentions that the feeling of deadness can be modified when people come in better contact with themselves. He believes that for some who lose out in terms of psychic attunement with their mothers at crucial stages of development, may need to "maintain contact with somebody who can process their affects" and says given environmental influence and biological issues some of these factors contributing to temperament and the ability to process affects, may not be reversible in psychotherapy (Modell, 1994, p. 376).

It seems many psychoanalysts would agree with Goodsitt, as seen in the writings of Farber et al. (2007), deMothe (2001), Eigen (1995b), and Korner (2000). Goodsitt (1997) feels object relations doesn't adequately address the sense of incomplete psychic structure and functioning of the client and the client's need to use "emergency symptomatic attempts at restitution" (p. 225). Perhaps here there is a place for the more active notion of "emotional thinking" suggested by Symmington (2007) which helps to create space in the therapist to process and create a mind for the client. Sekoff (1999) also notes the complex act linking emotion with cognition as being the work of the therapy relationship; "thought feelings constructed ….or incubated between the analytic couple" (p. 122). This relates to Winnicott's (1971) use of potential space where psychic life can live. For the anorexic person, desymbolisation through disavowal, evacuation and foreclosure are critical roadblocks, as explored by Freedman and Lavender (2002). Like Winnicott (1971) and Green (1986), they consider that, through the vital force of transference, the clients inner world can come to life, even in the "most stubbornly held, frozen constellations" (p. 190). They note that their account of desymbolisation receives an implicit and serious challenge from the idea of "Thinking about Thinking" (Bach, 2000) whereby the notion of thought disorder is seen as an unmovable substrate in psychopathology. Again, this relates to the notion of the untreatable client and within this, according to Freedman and Lavender, the therapeutic possibilities could look grave for the anorexic client. Bach points to the encrustations of thought as a form of

ontological insecurity and therefore ontological despair. Freedman and Lavender have the stance of 'no entry' (Williams, 1997) defences as fantasy structures in the mind of the client, which they note also take up residence in the therapists mind. This is linked to Bach's idea that "thought disorders partake of many worlds: of neurochemistry, psychophysiology, cognitive registration, intrapsychic and intersubjective….that is the subtle to and fro of the clinical encounter" (Freedman and Lavender, 2002, p.191). Therefore, Freedman and Lavender, (2002) see the countertransference as useful in countering the unconscious experience in the client's mind. However Freedman and Lavender ask how space can be created when the anorexic client holds a stance of psychic equivalence[8] that has the client be unavailable for relationship and the impact being that the other does not exist at all. Therefore in desymbolisation, the mind of the other is barred. Freedman and Lavender make the following recommendation to therapists:

1. To emphasise reverie so that the client experiences a non-impinging mind able to tolerate confusion and an unbearable sense of tension.
2. To offer "one's own inner working as a source of identification" (p. 192).
3. That the therapist recognise the role of trauma and in this recognition adopt an empathic mode of listening, even when the behaviour of the

[8] Psychic equivalence is defined by Fonagy (2007) as the development of the child relating internal states to external reality. Thoughts and feelings distorted by phantasy will be projected on to external reality in a manner, unmodulated by awareness, that the experience of the external world may have been distorted this way.

client is provocative and harsh, this allows for the opportunity of a reparative experience and not retraumatisation.

4. Finally to remember that the life-preserving aspects live with the destructive aspects. The therapists technique should work to reclaim the split-off, dissociated aspects of the self; bringing the reality of "staying away from food as a way to take control of yourself once more" (p.193).

This they note is all questionable in the treatment of primitive mental states such as the "hard core of no entry". The desymbolisation points to the pathology of taking in and the signifiers mean an eating disorder is also a meaning disorder. This points to the recognition of a psychotic core in these 'no entry' clients and even those in the adaptive normal functioning range conceal what they call a "hallucinatory inner constellation" noting that if a receptive therapist can sense into these moments of impasse then "previously inaccessible experiences can shape a more coherent inner world" (p. 196). In identifying difficulties in cognition for the anorexic client linked to distortion of the body and satiety, Bruch (1973) laid the foundation blocks for the exploration of the body/mind relationship. Symington's (2007) notion of the 'creation of mind' where the therapist's job is to join with the mind-building taking raw feelings and using them in a creative way that will form a thought which he refers to as 'emotional thinking'. Symington says this mind building takes time and suggests focusing on the signs of integration which are usually more hidden than what is destructive, and so the activity to which the therapist

gives attention should encourage this growth and expansion. This is not a denial of the negative but a way for negative transference to come up, highlighting the areas of undeveloped mind such as envy and infantile omnipotence. Within the dialectic of destruction and construction the therapist holds the awareness of both and looks for evidence of inner growth so that what was fragile becomes more solid. This enables the client to have the strength to stand and battle with the sabotaging force inside herself. Perhaps this could link or have a parallel theme to Grawe (2006) supporting the client towards activating approach goals, activating new synaptic activation rather than analyzing or identification of problems which result, in activating episodic memory. Grawe (2006) notes that the approach system "towards oneself….is coupled, for example with the act of ingesting foods" (p. 246). Neuropsychotherapy proposes making use of the therapist as external input so as to be influenced by other neural structures. Therefore, the therapist holds a different view of the client and as the client comes to understand their problem, is able to take explicit goals into implicit motivational goals, in order to support the client to move towards new behaviours that build new neural pathways rather than entrenching old ways of being.

Areas of Further Research

As research continues into the aetiology of Anorexia Nervosa, treatment approaches for this client group, will, no doubt, continue to unfold. Likewise neurobiology and neuropsychotherapy continue to research brain plasticity and remediation and to come alongside psychodynamic and mind/body approaches

to measure the effect of treatment on the client's wellbeing. This dissertation is only a broad overview of the approaches and factors influencing the movement along the deadened to enlivened axis.

As a result of the dissertation focus, one of the areas of possible research, is, the experience and impact of these deadened states on families and health professionals and clinicians. In the process of writing this dissertation, discussions had with health professionals revealed their experience of this and their relationship to the difficulty and confusion in being with the anorexic client. Research into the impact of this experience may help to generate potential space and awareness in the face of a frightening and deathly illness.

In this chapter I have bought together the themes of chapter three and four so as to concentrate on the theme of aliveness and deadness as an informing part of the 'moment to moment' transferencial experience. In extending the review of aliveness and deadness to the therapeutic encounter, the literature emphasises a conscious awareness by the therapist, through various approaches to encourage and highlight insight, awareness and self directed motivation; a greater sense of self. This is evident from the 'bottom up' information of body awareness encouraging feeling states and eventually changes in thinking and behaviour. Other approaches look to work top down through the mentalisation and mindfulness, supporting the client to come into a self beyond the identity of anorexia and its psychological functioning that

slots into core deficits. Transitional phenomena and issues of desymbolisation are discussed.

Concluding Thoughts

This dissertation has reviewed literature on the topic of movement from deadness to aliveness in the anorexic client and the countertransferential experience of this. Psychodynamic approaches recommended for this client group were reviewed through this directional lens and a literature review was conducted looking at the approaches utilising countertransference, integrating psychoanalysis, psychodynamic and mind/body psychotherapy.

I warm to many of the feminist approaches such as those of Zerbe, Kristeva and Gentile who acknowledge the potency of the intersubjective relational stance. Central to this is the embodied mind and authentic expression by the therapist with the client. For the anorexic client, trust, genuine compassion, clarity and robustness on the part of the therapist is life supporting. The ability of the therapist to face the influence of anxiety, to travel in the neighbourhood of deadness, and to maintain 'the cord of life' in the face of 'the cord of death', means the therapist often experiences the fear and anxiety that the client has dissociated or disconnected from. Part of the coming into life from a state of frozenness and isolation is to bear the psychic pain and embodied grief for what has not happened in the event of, the potential, of something positively happening. This may need to be grieved as what will never be retrieved or had, and thereby open the possibility to begin the work of creating anew. The

concept of ‘sense of self’ is a continued debatable question; some therapists believing it can be recreated from the current state or by returning to a prepersonal state and then grown into, while others noting that due to genetic and biological predisposition along with environmental contexts, this is, impossible for some clients. Neuroscience and psychoanalysis continue to explore this issue.

What seems evident is the need for continued supervision, collegial support and ongoing therapy/self awareness on the part of the therapist in order to be consciously available for the work. Just as the client parallels their treatment with life enhancing, daily tasks and creativity, so too, the psychotherapist must balance the demanding work, of containing, processing and metabolising, with life generative experiences, loving relationships and ongoing creativity.

Holding in awareness the ‘moment to moment’ movement of the client allows for the therapist to assess subjectively and intuitively the communicated hopes and needs of the client. This informs the therapist as to whether a ‘bottom up’ or ‘top down’ approach is appropriate. Holding the schema in mind, shown in Appendix A (outlined on page103) has supported my clinical work. I have been greatly heartened by the moments of potential and the creative spaces that have unfolded, revealing new ways of being and allowing for a greater and authentic experience of self.

It is a privilege to have the opportunity to review, metabolise and share this research material, and I have been greatly strengthened in facing into the life-death constructs that this dissertation has explored.

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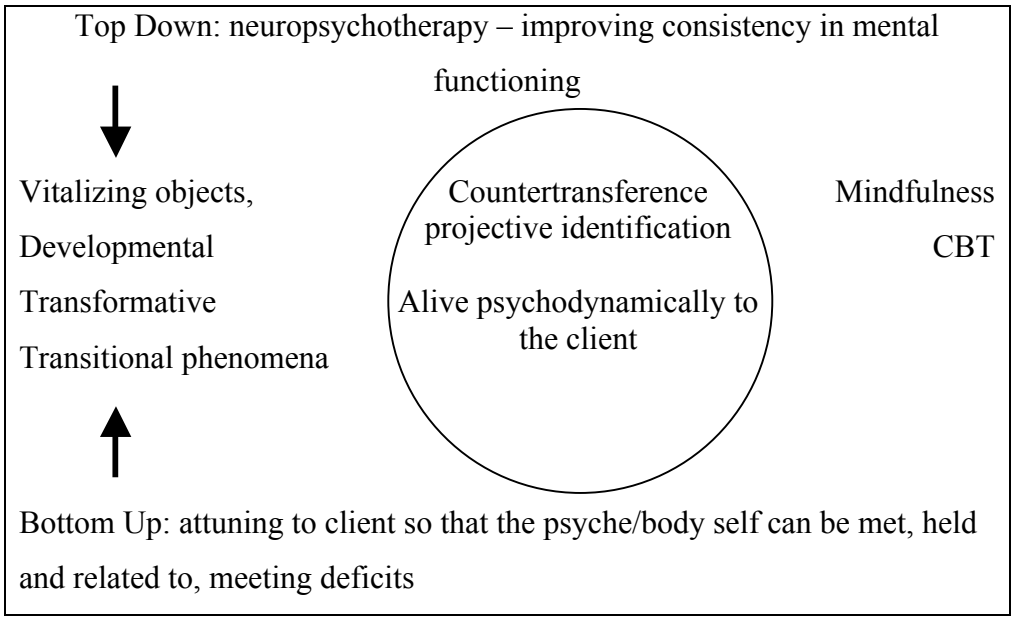
Appendix A

SCHEMA : To Synthesise And Build Inner Life And Cohesiveness: Moving The Anorexic Client Towards A More Enlivened State



Represented as a schema diagram the author has outlined a therapeutic model to explain the approaches reviewed in this dissertation and their application to the anorexic client as above.