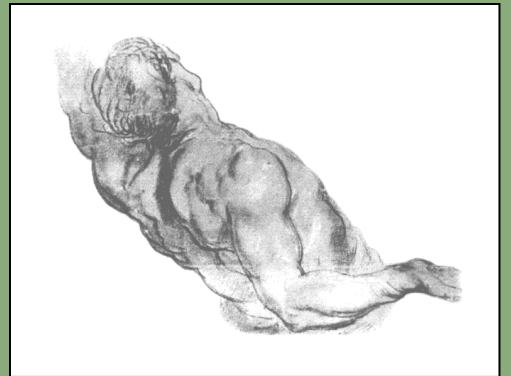


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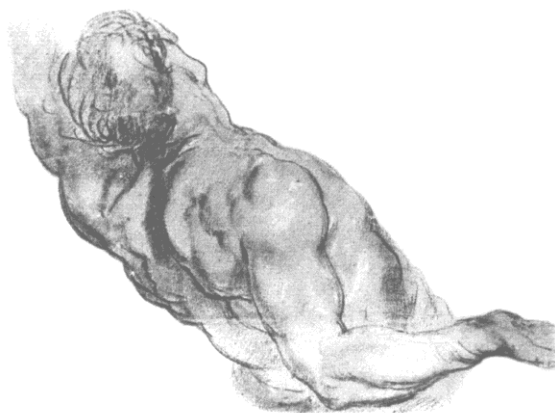


Volume 7 Number 2 2008

The Official Publication of
THE UNITED STATES ASSOCIATION FOR
BODY PSYCHOTHERAPY

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USABP Mission Statement

The USABP believes that integration of the body and the mind is essential to effective psychotherapy, and to that end its mission is to develop and advance the art, science, and practice of body psychotherapy in a professional, ethical, and caring manner in order to promote the health and welfare of humanity.

Body Psychotherapy for Treating Eating Disorders

Morgan Lazzaro-Smith, M.A., LPC

Abstract

Eating disorders are a growing concern among medical and mental health professionals. Because they are disorders of both body and psyche, the orientation and experiential techniques of Body Psychotherapy/Somatic Psychology can be particularly effective in their treatment. Previous studies have identified variables correlated with eating disorders, which include acute and developmental trauma, anxiety, self-esteem, media influences, and awareness and expression of emotion. Few studies have addressed body-centered treatment approaches, which can be especially well suited to address these factors therapeutically. This study uses interviews with nine therapists and seven eating disordered clients to investigate why and how treatments incorporating somatic elements can be useful for eating disorders. Findings suggest that the development and symptomology of such disorders very often involve a disrupted relationship between mind, body, and sense of self, and a closely associated inability to effectively feel or express emotion. Body-oriented treatment methods help clients reconnect to their bodies and emotions, and thus build a stronger, more embodied sense of the true self. As they learn to better manage and respond to affective arousal, the body becomes less estranged and emotions less frightening, and priorities and perspectives shift. Applicable body-centered techniques are those that focus on breathwork, mindfulness, sensory awareness, relaxation, self-regulation, centering, and movement.

Keywords

Eating disorders - Body psychotherapy - Body-centered therapies – Embodiment
Self - Dance/movement therapy

INTRODUCTION

The number of people struggling with eating disorders and disordered eating is growing at a significant rate among both men and women of diverse backgrounds (Kalodner & Delucia-Waack, 2003). Of the more than 70 million people worldwide with eating disorders, at least 24 million of those are in the United States, and as many as 1 in 5 American women engage in disordered eating to some degree (Renfrew Center, 2003). For this reason, and because eating disorders have the highest mortality rate of any mental illness, it has become crucial that mental health professionals, educators, and the general public be given the tools needed to recognize and combat an ever-growing epidemic.

The question guiding this study was this: How to best counteract the social and developmental forces, as well as the traumatic experiences that disrupt individuals' self-acceptance and their healthy, cooperative relationships to their bodies? In other words, what kinds of treatments can effectively repair the severed ties between body and self? And more specifically, how can treatments incorporate the body-oriented, experiential elements of Body Psychotherapy (BP) to serve this purpose?

Some identify eating disorders as psychosomatic illnesses, an “unconscious dynamic between the psyche and a bodily manifested symptom” in which individuals come to believe that “their bodies are the problem and their behaviors the attempted solution” (Krantz, 1999, p. 84). In reality, their bodies have become “the barrier against feeling and growth” (p. 84). Underlying the symptoms are painful psychic and emotional conflicts that such individuals have made an unconscious decision not to feel or express, usually because they believe it is unsafe or unacceptable to do so. Research is making it increasingly evident that many of these cases involve a history of acute or developmental traumas, which have resulted in “a relationship with the body in which it seems to them unintelligible, uncontrollable, undermining, and at the extreme under the control of alien or enemy forces” (Attias & Goodwin, 1999). Regardless of the origins of their pain, these clients often turn to the body as a concrete focus of attention and a means of relief from what they cannot bear to feel. It is widely acknowledged that the people most susceptible to eating disorders are those who do not have a strong sense of their selves. Without a stable internal sense of identity, they can be steered by external standards towards what they are shown is acceptable, admirable, and loveable. And like the profile for those who struggle with addictions, they will seek something to fill the emptiness or to calm the feelings and sensations that for them are too overwhelming to manage.

Eating disorder diagnoses include (APA, 2000):

- 1) Anorexia Nervosa (AN): Refusal to maintain normal body weight, intense fear of weight gain, significant disturbance in perception of body shape or size, and amenorrhea. Anorexics are classified as either Restricting Type or Binge-Eating/Purging Type.
- 2) Bulimia Nervosa (BN): Recurrent episodes of severe binge eating followed by inappropriate compensatory behaviors to prevent weight gain, such as vomiting, laxatives, diuretics, enemas, fasting, or excessive exercise. Bulimics are classified as either Purging Type or Nonpurging Type.
- 3) Eating Disorder Not Otherwise Specified (EDNOS): Includes all disorders of eating that do not meet full criteria for Anorexia or Bulimia. One of these, Binge-eating Disorder, is estimated to be twice as prevalent as AN or BN, and as symptom severity increases, a progression towards diagnosable BN may occur (Kalodner & Delucia-Waack, 2003).

Separate from the clinically diagnosed eating disorders, there are a high number of people who are dissatisfied with their body shape and engage in unhealthy and disordered eating and/or exercise practices as a result. From 19 to 23% of the general population in 2003 were estimated to have had such eating disturbances (Kalodner & Delucia-Waack, 2003). That statistic has likely increased with the years, as has the number of people with diagnosable other eating disorders.

Central Principles of Body Psychotherapy

What sets Body Psychotherapy (BP) apart in the larger field is simply that it is an integration of body-oriented techniques into the traditional framework of psychotherapy. Its unique assumptions, theories, and practices occur in addition to, not instead of, the cognitive, verbal approaches that are more widely known. One of the most important assumptions of BP is that there is no real separation between body and mind, so it is ineffective in the long run to work from the old Cartesian dualism that is currently being questioned in all reaches of academia, in medicine, and in the personal healing efforts of people world-wide. Since 1998, the National Institutes of Health have included a Congress-mandated National Center for Complementary and Alternative Medicine, which clearly acknowledges the importance of the mind-body connection to understanding health, and actively supports related research and education (Dunn & Greene, 2002; National Center, n.d.). It is more accurate to speak of the body and mind as a unified “feedback loop or continuum rather than two separate though cooperative systems” (Caldwell, 1997, p. 7). The following principles are central to the orientation and clinical practice of BP:

Mind/Body Wholism

Consciousness is a bodily phenomenon that cannot be located in isolation somewhere in the brain. Our thoughts and mental images ripple out into the body via numerous pathways, which scientists are beginning to better comprehend (Pert, 1997). We know that what we experience is processed through complex cerebral systems of perception and memory. What might be often overlooked is that all of this information is first taken in by our bodily sense receptors – eyes, ears, skin, mouth, nose, and proprioceptors. BP acknowledges, therefore, that memory is also encoded in the cells of our bodies (Pert, 1997). Events in our lives affect us somatically as well as cognitively, shaping not only our belief systems about the world, but also the ways our bodies form themselves in relation to the world – muscular rigidity, tension and postural patterns, areas of numbness or of sensitivity, even proneness to certain illnesses (Aposhyan, 2004).

Embodiment

In BP, to be embodied in any given moment means to be deeply aware of what one is experiencing in response to the environment. It means knowing oneself in a sufficiently integrated and variegated way, able to sense and to trust one’s internal emotional responses and impulses rather than relying on external sources for validation. It is not a static trait, once accomplished forever a given, but rather something that anyone – therapist or client – must intend and practice. “Our embodiment is the alchemical process that transforms us in this world” (Conger, 1994, p. 198). It is a comprehensive self-awareness that includes all levels of one’s experience: body, mind, and emotions. Improving one’s level of embodiment is accomplished through building the fundamental skill of somatic awareness and increasing one’s ability to feel comfortable in their own body.

The body can serve as a resource when dealing with the extremes of either high arousal states or a dissociative flattening of affect and energy, especially in the context of trauma. Simple somatic practices can help the client learn to self-regulate when at risk of being overtaken by intrusive memories or images. Exercises that engage clients with their immediate sensory experience land them more solidly in the body, and they are empowered with the new option of remaining present and allowing resolution to occur within the safe container of therapy (Ogden, 2003). Additionally, the resourcing skills they learn in treatment can become part of their repertoire, and they are likely to use these skills when faced with anxiety-arousing situations in their lives, rather than “checking out” or resorting to dysfunctional coping behaviors.

Conger (1994) speaks of the development of an “enduring self” (p. 203) as the goal of BP with fragmented, disembodied clients. This lasting, durable sense of self can observe the environment and events that occur with neutrality; it knows itself as related to others, to nature, and to life itself; and it can trust its own ability to get through the pain and suffering of the present moment without seeking to dull it or escape it. With a solid embodiment of this enduring self, clients are better able to discern what it is they long for, what their hearts are hungry for, and what they need in order to feel safe enough and strong enough to take desired steps in their lives. This concept seems closely related to that of the “true self” versus “false self” (Miller, 1981; Winnicott, 1965), which is often crucial to the understanding of body image issues and eating disorders.

Organicity: the Body’s Wisdom

Organicity is a term used in Hakomi Therapy as developed by Ron Kurtz (1997). While not all body psychotherapists use this term, the essence of the concept is a widely accepted starting point for the work. It refers to the inherent drive of the psyche toward health and healing, given the right environment. Just as damaged cells will naturally

rebuild themselves in a clean and dry environment, the human psyche will find its way to health if supported within a therapeutic container that is safe, compassionate, and attentive. "...By exploring one's experience in a safe and sensitive environment, a deepening will take place that will lead to an inherent wisdom and a reorganization of characterological structures, permitting more of the essential self to emerge" (Fisher, 2002, p. 6).

Developmental Psychology and Neural Plasticity

Our early environments shape the formation of the self, which occurs through the body's developing neurophysiological functions and is visible in the physical structures of the body, as well as in behavior and thought patterns. A certain amount of safety, affection, and responsiveness to our basic needs is crucial throughout childhood, and especially in early infancy, for us to progress through the stages of development and integration of the self. "The degree to which this Self finds its authentic expression through the person's emotional, cognitive, and relational life is profoundly influenced by early childhood experience when the Self is at its most fragile and vulnerable" (Rand, 1997, p. 75). Our increasing knowledge of the human nervous system is showing that old habits can be replaced by new behaviors and new beliefs, which become, through repetition of embodied experience, new neural networks in the brain and body. Through corrective therapeutic experiences, dysfunctional patterns can be replaced with more appropriate, adaptable modes of being that allow for a fuller expression of one's true self. Focusing on bodily, present-moment experience rather than abstract concepts leads to more grounded, concrete insight and understanding (Kurtz & Minton, 1997). Old character structures and holding patterns, because they are largely physical phenomena, can be dissolved more effectively through "direct experiences of our authentic energy and movement" (Caldwell, 1997, p. 12) than through verbal insight-seeking means alone.

Common Basic Techniques Across BP Modalities

These include mindfulness (or mindful awareness), breath work, and sensory awareness; centering, grounding, and assessment of paraverbal and non-verbal patterns; and incorporation of movement, play, and creative arts. The techniques of BP are becoming more widely used in the mainstream therapeutic culture, as models of health and healing are expanding. The over-arching paradigm of mind/body wholism is gradually moving out of the fringes and into the mainstream of health care. A large part of BP's value lies in its appreciation for the importance of an embodied lifestyle and a multi-faceted model of health. As clients' sense of self expands and takes root more firmly in the physical being, a larger repertoire of response to life becomes possible, and clients can greatly increase their personal effectiveness.

METHODS

Sample and Procedure

Participants in this study included nine psychotherapists and seven clients (n = 16). All participants were female. Eligibility for therapists was based on a self-reported degree of specialization in eating disorders and body image, and at least one year of working with this population. Years of experience range from one to ten years. While one of the therapists reported initially that she did not incorporate body-oriented techniques, it was determined upon further questioning that this was not in fact the case, and her interview was used for data along with the others. Of the nine participating therapists, four were currently working at established eating disorder treatment centers, and the others were found through the local advertising of their private practice specializing in eating disorders.

All clients reported being diagnosed with an eating disorder, and each had been in ongoing treatment targeted specifically at the eating disorder. In addition to outpatient treatments, five of the seven had also experienced inpatient residential programs. They were at varying stages in the recovery process, with ages ranging from twenty-one to fifty-two, and a mean age of thirty-five. Their treatments had included a great diversity of therapeutic modalities, some of which were not explicitly somatic. Interviews allowed, however, for the uncovering of any aspects of their treatments that had been body-oriented and experiential. Two of the seven clients were referred to the researcher by their therapist, who had been previously interviewed. She informed them of the purpose of the study and told them to send an email if interested in participating. Her assessment of their ability to participate was based on the knowledge that they were well along in the recovery process, and had already expressed in various ways their appreciation of the somatic treatments they had received. One client volunteered herself after seeing the flyer that was posted at her treatment center. The remaining three learned of the study through a notice that was posted in an online newsletter for eating disorders. For all clients, an initial discussion via email determined their understanding of the study and their willingness to participate. In several cases, the researcher emailed a copy of the thesis abstract for them to read. All clients were then mailed the consent forms to sign prior to the phone interview.

Data Collection and Analysis

Data were collected via in-depth, open-ended, semi-structured interviews that lasted between forty-five and ninety minutes. In most cases, the interview lasted about one hour. A prepared list of questions served as the starting point, but interviews were highly personalized according to the participant. In all cases, additional questions and requests for clarification were meant to take the interview in the most meaningful and elucidating directions possible. While participants were informed of the purpose of the study, the researcher tried not to steer their responses towards any particular viewpoint. Rather, bias and leading questions were avoided as much as possible. In just two cases, interviews were preceded by written questionnaires, which were merely shortened versions of the interview questions. This was because these participants were not sure initially if they would do an interview. These individuals chose to be interviewed later, so both their questionnaires and the interviews were included in the data.

Data collection and transcription happened simultaneously, with some interviews being transcribed by the researcher while still in the process of conducting interviews with other participants. This helped familiarize the researcher with the material, and better focus questions for subsequent interviews. To begin the analysis process, all interviews were read in their entirety. Passages of text that were in any way related to the research question were segregated for further use in the analysis. These portions were then searched for “meaning units,” relevant phrases that could be organized according to their relationship to the research question. With multiple searches of the complete data, repeating themes were extracted and then systematically organized using the methods of constant comparison and analytic induction. As patterns emerged within concepts, additional sub-themes were delineated and the data were regrouped. Interviews were read thoroughly multiple times throughout the analysis, in order to hermeneutically confirm the themes within the original context. Throughout the process of analysis, theoretical memos were created to document the emerging relationships between concepts, themes, and sub-themes. These relationships were thus inductively derived directly from the participants’ statements. Negative examples, which may not necessarily support the research question, were not excluded, but rather were given equal consideration.

RESULTS

In analyzing the complete set of data, three major themes emerged in relation to the thesis question of how Body Psychotherapy (BP) can be a useful element in the treatment of eating disorders. The first theme pertains to why BP can be useful. Both therapists and clients spoke to some degree about what they perceived to be the origins of the eating disorder, as well as some common characteristics among people with such disorders. Certain issues emerged here that indicate body-centered problems calling for body-centered interventions. The second theme pertains to the specific usefulness of BP, and seems to stem directly from the issues addressed in Theme 1. Within Theme 2, it becomes clear what the techniques look like and how they are experienced as helpful. The third theme that emerged highlights the larger outcomes of treatments involving BP on several levels – cognitive, somatic, and emotional. Theme 3’s section highlights the ways in which clients take what they learn in treatment out into their lives, and the positive changes that result. Besides naming some of the characteristics of this population, they highlighted why these characteristics seem to call in many cases for therapeutic modalities that address both mind and body, in order to work towards a more cooperative and functional mind/body unity.

Clients usually enter treatment in a state of relative disembodiment, unable to effectively identify or express what they are feeling. Estranged as they are from body, emotions, and self, therapy must therefore focus on building the skills needed as clients begin to uncover and reconnect with these suppressed parts of themselves. With the experiencing of emotion so unfamiliar and scary for them, therapists must facilitate the learning of self-regulation skills for managing the emotions, help clients find a more gentle and accepting manner of self-relating, and encourage them as they begin to express themselves with more clarity and confidence.

Since BP often emphasizes the nonverbal, clients can access unconscious material for which they may know no words. Inherently present-centered and “hands-on,” it also provides opportunities for new experiences and real practice that can contribute to changes in deeply-embedded behavioral patterns. This can lead not only to the cessation of symptoms, but also to a profound reconciliation with the body and self. Clients can come to know their bodies as a source of wisdom, strength, and pleasure. More aware of who they are and what they feel, they are empowered to make different choices in their lives and to seek what is truly fulfilling and satisfying.

The following tables offer a summary of the central themes and sub-themes that emerged in the interviews:

Table 1. Eating Disorder as a Mechanism of Managing the Relationships with Body and Emotions

I. Relationship to Body	A. Estranged from one's body	1. Mind/body disconnect 2. Tendency to intellectualize
	B. Fear of one's body	1. Body hatred 2. Shame and dissociation
II. Relationship to Emotions	A. Disconnected from one's emotions	1. Eating disorder to avoid or manage emotions 2. Self-judgment for feeling emotion
	B. Excessive Anxiety	1. Eating disorder to avoid or manage anxiety 2. Fear of being oneself 3. Fear of relationships with others 4. Pressure to perform/succeed

Table 2. Applications of BP in the Treatment of Eating Disorders

I. Self-Regulation Skills	A. Relaxation B. Breath C. Grounding/containment D. Identify and distinguish emotions and anxiety E. Recognize dissociation cues and strategize for avoiding dissociation F. Identify needs and take responsibility for getting those needs met
II. Other BP Techniques	A. Mindfulness B. Recognition of satiety cues C. Embodiment of the therapist
III. Additional Useful Elements of BP	A. Practice/experience vs. solely talking B. Movement or art can be revealing C. Express through movement or art what one cannot say or think clearly with words

Table 3. Outcomes of BP Techniques and Approaches

I. New Perspectives (Knowledge) Gained from BP	A. Understanding of one's body as a resource B. Understanding of moderate exercise as being healthy and helpful C. Understanding that answers/wisdom can come from oneself D. Understanding the body's need for fuel/nourishment
II. New Relationship with One's Body/Self	A. Trust and appreciation for one's body and self B. Self-acceptance and non-judgment C. New relationship to exercise D. Enjoyment of food E. More vitality F. Sense of self or identity beyond the eating disorder or the body/appearance
III. New Relationship with the Environment	A. Less avoidance of engagement with others and/or with one's life B. More sense of choice and empowerment C. Shifting priorities regarding one's life

	D. Permission to have feelings and desires
IV. New Relationship with Emotions	A. Decreased fear of emotions B. Relaxation is acceptable and enjoyable

DISCUSSION

The extensive responses of interview participants provide a great deal of information as to how experiential, somatic treatment modalities can be effective for clients with eating disorders. Recognizing the extensive range of eating disorder etiology and symptomology, the question arises: How much generalizing can be done accurately and responsibly? It seems that, above all, therapists must assess the *individual's* needs in developing the appropriate treatment and tailor techniques accordingly. This study sheds light on some important therapeutic issues, which must be considered within the context of the unique history and current circumstances for each client.

Rigor of Study

Credibility, Auditability, and Fittingness

Throughout the data analysis process a high degree of attention was given to assuring that the information was conveyed accurately and responsibly by the researcher. Triangulating across data sources, the researcher continuously compared and contrasted what was reported by the different participants. The congruence of findings was continuously assessed, with both typical and atypical elements of data being taken into consideration and thoroughly mapped out during analysis. Through ongoing readings of the interviews in their entirety, emerging themes and sub-themes were hermeneutically confirmed within the original contexts.

A high degree of auditability was achieved by taking extensive notes before, during, and after interviews, as well as throughout data analysis. These notes served to record the ongoing subjective impressions of the researcher. The documentation trail clearly lays out such importation factors as: researcher's perspectives, purpose of the study, questions arising during the literature review and data collection, means and duration of data collection, the stages of theme development, and the process of data coding according to themes.

The degree of fittingness of this study, though always limited by the chosen population studied, has the potential to be quite high. For qualitative research, sixteen participants (n=16) is a large number, so data becomes relevant to a greater range of individuals. Among participants there was considerable diversity in terms of their perspectives, eating disorder diagnoses and levels of recovery, histories, and treatment approaches. It is hoped that this study will lead therapists of any orientation to acknowledge, and even incorporate, the beneficial somatic elements into their practices when working with eating disordered clients.

Additional Strengths of this Study

Qualitative research provides us with in-depth personal accounts of phenomenological experience. In this case, subjectivity is valued as we listen to what people can tell us about the process of recovering from mental illness. While the objective, empirical nature of quantitative studies can measure outcomes, qualitative research attempts to achieve an understanding of how and why such outcomes may occur. This study provides new information in several relevant areas. It fills in a piece of the large gap in scientific literature pertaining to somatic treatments for eating disorders. It is also one of just a few studies that focus on describing the personal experience of clients with eating disorders, whether in recovery or already well-recovered. In addition, as far as can be discerned it is the only study that looks at therapists' experience treating this population. Most clinicians do not regularly take such time to reflect upon and define the way they work with such focus and precision, especially when their methods might start to feel instinctual and automatic after a long time in practice.

Previous research has attempted to measure outcomes for the most common mainstream modalities, especially Cognitive-Behavioral Therapy and Family Therapy, which have been shown relatively successful depending on factors such as eating disorder type, severity, duration, and the individual's age. Where the phenomenological relationship to one's body itself fits into this picture is a topic largely neglected. Considering the high relapse rate for this population, the psychosomatic nature of eating disorders, and the extreme level of disconnection to the body and its feeling states that is usually such a significant part of the problem, it makes little sense to attempt recovery without some sort of body-oriented work. Based on this study, BP offers a unique orientation and set of techniques, which can be particularly suited to treating eating disorders.

The comprehensive effects of experiencing some of these somatic methods, according to those interviewed, include an overall shift in perspective in which the body becomes re-integrated into one's sense of self.

The original question of this study was how using the body itself in therapy can make treatment for these issues more effective. During the process of the research, the question seems to have become more specific: Why must we and how can we incorporate the body to help bring back to light the true self of someone lost in an eating disorder? Although the etiological origins of these disorders cannot be universalized, characteristics that are commonly shared were clearly identified. It may be safe to say that in most cases, regardless of the reasons, the body comes to be perceived and treated as *other* rather than *self*. The reality of its biological needs and responses, and of its genetic predisposition towards a certain natural shape, becomes a hindrance and a force with which to battle. Sometimes the body becomes a bitter enemy.

Research is elucidating the effects of trauma, both acute/situational (as in the case of abuse, assault, and other significantly impactful events) and developmental or relational, on the body/mind/self. Whether it is the result of a single event, chronic abuse, or a whole childhood of insufficient nurturing, one's natural state of integrity and wholeness can be severely disrupted. Where there should ideally be a continuous dialog and interplay between perceptions, thoughts, feelings, and actions, there is instead a vast disconnectedness. The system cannot regulate itself effectively, and the individual instinctively seeks out ways to cope with the overwhelming chaos of his or her internal and external world, which he or she is without the skills to navigate.

Compounding one's personal distress, the messages communicated by the media contribute to the creation of a culture in which happiness, success, and love are clearly equated with physical attractiveness. And the single standard for attractiveness is limited to a body type that very few adults naturally possess. It seems clear why many individuals reach the conclusion that the reason they don't have the life they want and feel the way they want to feel is because they don't have the body that society tells them they should. Research confirms the deleterious effects of the thousands of media images most people are bombarded with yearly. Those who do not have the foundation of a solid sense of their identity and adequate self-esteem are at high risk of internalizing the media messages, especially when required to find something to help them cope with their pain or emptiness.

Limitations of this Study

A major limitation is that only one person conducted the research. Ideally for this type of study, having at least one additional researcher involved in the steps of data coding and analysis would lessen the chances of unconscious biases influencing the results. While it is recognized that bias is impossible to avoid, the author is aware of a personal assumption that somatic interventions can be highly useful and often necessary. Having additional researchers might also lend a diversity of perspectives that could contribute to additional themes and sub-themes being revealed.

There are a few areas where the sample was limited. First, all clients and therapists interviewed were female. It is possible that male clients would have expressed different opinions of how or if somatic treatments have been useful for them. Likewise, some male therapists may come from a different frame of reference and therefore offer more variety of clinical experience.

Dual diagnoses, while indirectly reported to be the reality for many clients, were not taken into account when analyzing the data. This is something that clearly has a significant impact on both the experience of pathology and the recovery process. In particular, the ways in which PTSD and mood disorders such as depression, anxiety, and bipolar disorder interact with clients' eating disorders could not be investigated within the scope of this study.

Because all clients interviewed have experienced different therapeutic modalities throughout the course of their treatments, it is difficult to isolate specific effects of each. Causality cannot be determined, therefore, and we are left only with their accounts of what they remember to have been helpful or currently perceive as such. It is possible that, knowing the nature of this study, clients could have favored the somatic elements in order to comply with the researcher's goals. The only attempt made to avoid such acquiescence was to avoid leading questions and to actively seek out information related to all types of treatment perceived as personally beneficial.

Implications for the Field of Psychotherapy

Embodiment: BP's Unique Contribution

The concept of embodiment was addressed in some way in almost every interview, whether the term was used or not. It is a meta-theme encompassing several other concepts that were addressed – self-regulation, somatic awareness,

mindfulness, relationship with body and self, and vitality. Its counterpart, which can be termed *disembodiment*, is implicated by therapists and clients as a disconnection between mind and body that manifests in estrangement from the body and self, varying degrees of dissociation, and a potentially harmful incapacity to recognize what they feel.

The discovery and practice of an embodied way of being might offer the key to recovery for many clients. It is not enough in and of itself; on the contrary, without an impeccably safe container and consistent guidance, support, and modeling by the therapist, increasing body awareness can be overwhelmingly scary and counterproductive. Some therapists said that clients simply may not be ready at first to approach the body this way, and insist on progressing with caution. Choosing words and activities wisely becomes important in these cases. Still, it seems that developing a new way of relating to body and self, which incorporates and necessitates the consistent practice of embodiment, remains body psychotherapists' over-arching goal.

Integrative approaches including embodiment. It must be noted that some clients report it extremely helpful to examine stressors, needs, goals, and core beliefs – all typical elements of Cognitive-Behavioral Therapy (CBT). Clients also report that incorporating journaling and verbal processing with their therapist have been beneficial additions to BP methods, especially when used in conjunction with the body-centered exercises such as movement or sensory awareness. It appears, therefore, that strengthening the body/mind/self connection can greatly enhance the effectiveness of other common therapeutic methods, such as CBT, as the practice increases present-moment awareness and receptivity to insight. The researcher means not to discredit any of the traditional treatment methods used for eating disorders, but rather to demonstrate the usefulness of expanding upon them with the addition of complementary somatic techniques.

Mindfulness. There are actually many varieties of mindfulness, coming from different traditions and holding different intentions. A fundamental element to the somatic treatments, mindfulness is becoming a popular concept throughout the field of psychotherapy, even beyond the clearly body-oriented models. Though the term has come to be used rather loosely to describe any intentional state of self-awareness, it may be necessary to specify with more precision which types of mindfulness are actually suited to these clients.

Other Treatment Considerations

Medication. Therapists note that many clients benefit from medications such as anxiolytics and anti-depressants, and sometimes cannot proceed with the work of facing their emotional experience without this basic level of stabilization and support. In other words, some cannot do the work of facing their difficulties without medical assistance in achieving some needed sense of balance and regulation. Several clients concur, saying that the successful medical treatment of some of their symptoms has been a large factor in their recovery. They, too, refer to medications targeting anxiety and/or depression, and in one case, dissociation.

Group therapy. Some therapists cite the benefits of group treatment for this population, particularly because it is an arena for working with the relational difficulties with which they commonly struggle. Several clients report that groups of various types were very helpful. Groups offer clients the chance to give and receive emotional support, sometimes for the first time. They can cheer each other on through the recovery process, challenge each other when necessary, receive regular reality checks, and emerge from the isolation and aloneness that are so often part of the eating disorder. Some clients also say that they were greatly inspired by witnessing the successes of other group members.

Family therapy. Whether family therapy is conducted from a somatic orientation or not, it seems from participants' reports that, when a viable option, it is often a crucial element to treatment. Some clients say they could not have recovered without their families' willingness to be part of the process with them, insisting that eating disorders are rarely the problem of the identified patient alone. Perhaps even more important with the younger clients who still live at home, it is often the case that the context within which the disorder developed must be addressed and tended to before real change can be possible.

Need for Eating Disorder specialization. The area of eating disorders appears to be one of those for which therapeutic expertise is particularly important. Therapists must have the sensitivity and the skills to support clients appropriately during weight gain when relevant, during the often-painful process of emotional awareness-raising, and during the letting go of familiar coping tools and the gradual learning of new ones to replace them. Therapists must also be aware of the counter-transference issues that can commonly arise in relation to this population. A degree of wariness can be helpful in regards to the sense of urgency and the need to perform successfully, which is cited as common with these clients, and can often lead the therapist to be overly concerned when progress is slower than hoped (Reindl, 2001). Some therapist participants also stressed the necessity of being well acquainted with their own relationships to food and body, so that transference and counter-transference issues can be effectively approached throughout the process of treatment.

Readiness for change. It seems that therapists must assess clients' readiness to change their perceptions and let go of familiar coping strategies. Acknowledging that some do not begin treatment in a state where experiencing embodiment could be useful, work must sometimes proceed very slowly. Without both a solid therapeutic container and a basic level of self-regulation skill, it can be entirely overwhelming and possibly counterproductive to the recovery process if clients are led to

heightened awareness of their internal world without the skills necessary to face the pain and fear likely to arise. Especially if there is unresolved trauma dysregulating their systems, the foundational skills must be built in before work can proceed.

Suggestions for Future Research

The relationship between eating disorders and addictions could not be well explored in this study. It was referred to throughout the literature and the interviews, but in most cases indirectly. Thus far, no thorough exploration has been made as to the similarities and differences between eating disorders and the well-known addictions – substances, sex, gambling, etc. Because there are quite a few apparent similarities in terms of origins and unconscious impulses or drives, it could be informative to look at the ways in which eating disorders may meet the criteria for addictions. Furthermore, with so much recent progress being made in the understanding of the neurophysiological aspects of addictions, drawing parallels here could contribute a great deal to eating disorder treatments.

It could be exceedingly useful for outcome studies such as those conducted for Cognitive-Behavioral Therapy to be done for the somatic therapies. In addition to the anecdotal literature and the occasional case studies, the field is lacking in empirical research to support claims of BP's efficacy. Not only would such studies add to our comprehension of how and why the somatic therapies are effective, but they would also lend much merit and allow BP to step more firmly into place beside the more well-known and recognized modalities.

Additionally, it would be well worth examining how best to incorporate BP into the short-term therapeutic programs now mandated for insurance coverage. Insurance companies are now requiring more formal and systematic documentation of treatment goals and successes. Especially, though not exclusively, for therapists working in inpatient eating disorder hospitals and clinics, it may be necessary to clarify how their modalities can fit into the type of protocol approved by these companies. Several participants lamented that people needing treatment are often denied because of such restrictions, especially in the cases of anorexia, which typically take longer to treat than bulimia.

Finally, how can somatic modalities serve the purpose of eating disorder prevention? There are increasing numbers of programs in communities and schools that target prevention in children and adolescents, certainly a crucial task. It could be extremely productive to explore how BP techniques can help build a strong sense of self and reinforce healthy relationships with the body, which will help carry the children through their difficult transitional periods into adulthood. With this in place, it is hoped that they would not develop such debilitating levels of body dissatisfaction, and would not turn to eating disorders to cope with or shield themselves from life's stressors.

A few words from the clients interviewed in this study:

You were created a certain way for a certain reason, and there's power and strength behind that. And just to embrace that and know that it'll be OK. And to know that if you just kind of sit comfortably in your body and not fight it, that it'll make life so much easier. Because if you always live in this internal war with your body and with your emotions and with an eating disorder, then you have no other energy to put towards anything else that'll make your life or other people's lives better... And when you're in war with your body you think the only thing that's within reach is working on your body, or working on your external appearances more than your internal peace... I'm just so thankful that there is something else behind just the physical body. And there's like a whole story behind that. And everybody's is different. And that's what makes it so beautiful.

You are who you are because God made you that way. And being unique is absolutely the greatest thing... Our bodies are extremely important because they're the vessel that we live in, but at the same time just because that's the visual part that people see does not mean that that is simply who you are, just your body. That's not who you are at all, it's the stuff inside that makes you who you are as a person. And we should value that. And not have to just be brainwashed that our bodies are the only thing that matters.

I feel like so many years were wasted. And I know that was my process, and like I said that's what I needed to get here. But I sometimes see women and I just want to shake them up and go 'It doesn't matter! It doesn't matter what your hair looks like or what clothes you're wearing or how sexy you or someone else thinks you are or whatever. There's just so much value in just being yourself.' I don't feel comfortable in my body because my body looks exactly the way I want it to... In the end you're either going to die or you're going to have to go down to the core of yourself anyhow. And so like, cut to the chase, right? The sooner you do it the better.

I wish I'd known I guess that my body was OK, that there wasn't always something wrong. I wish I'd been comfortable with my body from childhood on. And I guess partly what I want to say to someone is 'look what it's doing to your brain'. Um, and that there is help, and hope... To keep going and keep trying.

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Biography

Morgan Lazzaro-Smith graduated from Naropa University in 2006 with a M.A. in Somatic Counseling Psychology and a concentration in Body Psychotherapy. Previously, she received a B.A. in Cultural Anthropology from the University of North Carolina at Chapel Hill in 1999. She currently works in Fort Collins, Colorado as a family therapist and has a private practice, Sage Living Psychotherapy, specializing in the treatment of trauma, adolescent and family issues, eating disorders, and stress management. She is trained in Level 2 EMDR.

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The Official Publication of
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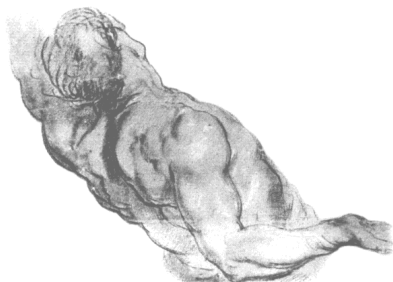
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