

**The Use of Transactional Analysis in the Treatment of
Eating Disorders**

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*This article was published in the Transactional Analysis Journal
July 2005 Volume 35 number 3*

Abstract

Since 1859, when Marce described a “hypochochriacal delirium” characterised by food refusal, eating disorders have been recognised as having a psychological component (Silverman 1997). In this article I examine the psychological factors inherent in Anorexia Nervosa and Bulimia Nervosa using a TA developmental perspective. I discuss the interaction between psychological and physiological factors which maintain an eating disorder and offer a psychotherapeutic approach including the consideration of dietary advice, weight monitoring and medical intervention. With reference to case material I argue that ensuring adequate nutrition is compatible with the role of a TA psychotherapist.

In this article I concentrate on the eating disorders Anorexia Nervosa and Bulimia Nervosa and consider some challenging issues which are specific to the treatment of eating disorders. I use the feminine pronoun throughout, as ninety percent of people with eating disorders are female (Hoek et al 1995). Similar psychological issues appear common in people of both sexes who have eating disorders, although the social pressures on men and women are very different.

Eating disorders are frequently seen as difficult to treat, clients sometimes appear to be reluctant to change and severe anorexia nervosa is a frightening and confusing disorder for anyone who comes in contact with it. Where the therapist works in a multi disciplinary team, roles can be negotiated and shared, along with the sharing of anxiety, and a team approach enables practitioners to cover the many different aspects of

treatment. However an independent therapist in private practice or a counselling agency can feel confused and isolated, particularly so, if as the weeks pass they witness a young person relentlessly losing weight. It is not uncommon to find a cooperative patient attending sessions but becoming dangerously thin, leaving the therapist feeling impotent and frustrated. In this article I touch on each of these areas and offer some guidelines for a TA approach to treatment, drawing on ideas from Transactional Analysis theory and other contemporary sources.

Evidence base

The most thoroughly researched treatment for eating disorders is Cognitive Behaviour Therapy (CBT), (Wilson, Fairburn and Agras 1997) which has demonstrated that an approach involving the provision of information and the challenging of irrational thoughts and maintaining beliefs is effective in reducing bulimic symptoms. Research into Interpersonal Psychotherapy (IPT) (Fairburn 1997)) also shows effectiveness in the treatment of bulimia nervosa although, as yet, there is little evidence about the treatment of anorexia nervosa. There is a scarcity of research about other therapies, although psychodynamic approaches are widely used in the field of eating disorders. My own clinical experience shows that TA has much to offer in the treatment of eating disorders and it incorporates many interventions which are used in CBT or IPT. In TA, these interventions are integrated within a psychodynamic framework which addresses issues arising from childhood unmet need. The therapist's ability to adopt behaviours associated with different ego states adds a flexibility which is suited to the

complex area of eating disorders. I am not aware of any research about the effectiveness of TA as a treatment for eating disorders and I would like to see this article stimulating discussion about the use of TA in this context.

Definitions

Anorexia Nervosa is a condition in which a person intentionally maintains a low body weight, and in women this is to such a degree that the menstrual cycle ceases. The low weight is attained either by eating too little or vomiting, exercising or use of laxatives.

In Bulimia Nervosa the same behaviours apply, but there is a cycle of dieting, bingeing and vomiting where sufficient nourishment is retained to maintain a reasonable body weight. The normal body weight enables some people to keep their disorder secret, sometimes for years. Bingeing on food is a natural consequence of starvation, but purging, through vomiting, laxative abuse or excessive exercise is a conscious choice to rid oneself of “fattening” food. (A binge is the consumption of a large quantity of food in a given time, accompanied by a sense of being out of control (American Psychiatric Association 1994)).

Half of the total number of eating disorders (Fairburn 2002) do not fulfil the diagnostic criteria of DSM 4, because they are lacking particular characteristics or combining symptoms from different disorders. These are defined as atypical eating disorders, and it is also common for the nature of disorders to change over time, for example roughly fifty per cent of people with anorexia at some point “cross over to normal weight bulimia nervosa.” (Sullivan 2002, p 228).

The common thread in all eating disorders, however is an over evaluation of the importance of shape or weight – which is the criterion that the individual uses to determine his or her self worth.

The development of an eating disorder

Over the years various theories have been proposed about the causes of eating disorders, but now it is generally agreed that it is a combination of factors which lead to the development of an eating disorder. These include the influence of the media on women’s body image, individual character traits, developmental issues and some genetic factors. In addition, traumatic events or severe unmet need are present in a proportion of eating disorders, but evidence is unclear as to how an eating disorder becomes the identified symptom rather than another mental health problem. In this section I look at a selection of causative factors and in a later section I concentrate more on the developmental and personality traits which are relevant to psychotherapeutic treatment.

Media influence

There has been much discussion about the influence of the mass media on women’s body image. In 2000 a summit took place in Britain between fashion editors and government representatives to assess the connection between popular images of the female body and eating disorders. The psychotherapist Susie Orbach was a panel member and she spoke eloquently on the role of media and their power to promote body dissatisfaction in women (Orbach 2000). One conclusion of the conference was that fashion icons do not cause eating disorders, but do

appear to provide a context for them to develop (Freeman 2000).

It appears that certain young people adopt the “skinny model” as a role model and internalise a Parental message from the media as if it were a cultural Parent. The image provides a possible means of becoming OK through changing the body shape, where the individual does not have a sense of her innate OK ness.

Personality factors

As well as external influences, most authors agree that people who develop eating disorders have certain traits in common which can be seen as predisposing factors in eating disorders. They have been identified as perfectionism, low self esteem, a sense of ineffectiveness and a lack of sense of self. Hilda Bruch, a psychoanalyst who during the 1960s challenged traditional psychoanalytic approaches to treating eating disorders, was the forerunner and a major influence in the development of cognitive behavioural therapy as a treatment for eating disorders. She examined the thinking patterns of people with eating disorders and recognised their low self esteem and sense of ineffectiveness (1973). She described their “acting only in response to demands coming from other people in situations and not as they want to.” (1973, p254 cited in Garner & Garfinkel p130). She describes her patients as “feeling incomplete in their sense of separateness” (1985 p13) where an “attitude of basic mistrust permeates their self concept and all relationships” suggesting that family life has discouraged independence and expression of feelings. Her therapeutic direction was to “help patients discover their genuine selves and what is valid

about themselves.” (1985 p15) In TA terms we would recognise a number of these issues as script : the Be Perfect and Please drivers, Don’t feel, Don’t be you, Don’t be a child and Don’t be important injunctions and an underlying belief that I’m not OK.

Triggering factors

Eating disorders most frequently occur from puberty (or sometimes at other times of transition in later life) and can be triggered by significant life events, for example a loss or relationship difficulty, or sometimes an episode of abuse. Childhood sexual abuse is sometimes cited as a cause, although abuse appears to contribute to a variety of psychiatric conditions which includes eating disorders (Vanderlinden and Vandereycken 1997). Puberty itself is a transitional crisis which brings physical and psychological upheaval as sexuality develops. Some authors (Crisp, 1980) emphasise the significance of eating disorders in avoiding, or even reversing sexual development. The consequence is the absence of sexuality, relationships, adult physical characteristics and adult responsibilities.

Reinforcement of the eating disorder

Weight loss is achieved through various means and is reinforced by a sense of satisfaction at the success and joy from being in control. One client described her need to control at least one thing in a life where she had little autonomy.

“I had this great feeling each time I weighed myself, and saw the needle go lower. I felt terrible if I put on just a little, although I knew really that

weight can naturally go up or down a couple of pounds.”

Reinforcement also arrives in the form of strokes from friends and family, especially if her body shape has been more substantial than that promoted by the fashion industry. Comments which praise the new slimmer version and congratulate the young person on her restrained eating boost self esteem and a sense of achievement. She moves from a position of I'm not OK, You're OK (I-U+) to I'm OK, You're not OK (I+U-), frequently she experiences a feeling of superiority at her self control, pitying those whose will is weak enough to keep them fat. It is control but not autonomy, a desperate control aimed at creating a conditional OKness in place of a solid position of I+U+. Berne defined autonomy as awareness, spontaneity and intimacy but restrained eating to maintain OKness entails a high level of discounting, defensiveness and games/rackets.

Particular difficulties in the treatment of eating disorders

So what is it about eating disorders which makes it a complex area in which to work ?

I think the following issues deserve special consideration :

The degree of physical risk.

The interrelationship of psychological and physiological symptoms

The obsessive compulsive nature of eating disorders

The need to introduce behavioural change as soon as possible.

Physical risk

According to the Eating Disorders Association (1994) Anorexia Nervosa has one of the highest mortality rates of any mental health problem, and causes of death include starvation, heart failure or suicide. (Crisp, A.H., Callender, J.S., Halek, C., & Hsu, L.K.G. (1992)) Although Bulimia Nervosa is not associated with low body weight there are also physical risks associated with vomiting such as physical trauma or electrolyte imbalance which can lead to heart irregularities (Goode 1985). It is essential therefore that the therapist has a working relationship with the patient's GP and that this is part of a three way contract. A medical doctor can undertake a series of tests according to the severity of the condition, which will indicate the degree of risk and this can act as another factor to enhance motivation for change. In cases where the client has a very low body weight coupled with an anorexic mindset the therapist needs the back up of a specialist mental health service, as this is a serious mental illness and not appropriate for a lone practitioner.

There are occasions when the most skilled psychotherapist will have no effect on the powerful “anorexic mind”, which appears to take on a life of its own, pursuing a course towards self destruction. Protection is the issue here, and a balance needs to be sought between assessing the degree of psychological input and physical care. This discussion can only take place with medical involvement. There will be times when the therapist needs to hold back, bide her time, ensuring that safety is maintained while giving the

message : “I am still here when you are ready to do this work.”

Psychological /physiological interaction

So what are the elements which drive this “Anorexic Mind”, which is capable of defeating skilled and experienced psychotherapists? Above I referred to the interrelationship of psychological and physiological factors. This is a most powerful combination, and while most clinicians agree that there are psychological issues which predate the onset of an eating disorder there are additional psychological features which are **caused** by lack of nourishment. Palmer (2000 p 69) uses the term “entanglement” to illustrate how physiological needs become entangled with psychological needs and explains that treatment needs to address both these areas.

Current approaches to treating eating disorders have been influenced by a piece of research into starvation which took place in Minnesota in 1950 (Keys et al). Although today we would question the ethics of such an experiment, it has yielded valuable clinical information regarding the physical and psychological effects of starvation. In summary, the symptoms experienced by the group of physically and psychologically fit young men who took part in the experiment, were a result of starvation, not underlying psychological problems. The symptoms included obsessiveness, depression, preoccupation with food, bingeing, withdrawal. The implications of this finding are that people who are starving are likely to remain obsessive, depressed etc until they are adequately nourished and that psychological approaches aimed at the

symptoms are unlikely to be effective. This leads to the conclusion that regular and adequate nutrition is an essential part of treatment if cure is to be achieved. In cases of severe under nourishment resulting cognitive impairment makes psychotherapeutic interventions ineffective.

So how can a psychotherapist make use of this material? TA therapists are familiar with delivering information to their clients when they teach the ego state model or drama triangle, for example. It is equally appropriate to give information about nutrition and the effects of starvation within the therapy, with sensitivity to the client’s need to remain in charge of her own treatment as much as is safe.

The obsessive compulsive nature of an eating disorder

Some authors liken eating disorders to an addiction in which the individual is addicted to losing weight, or to bingeing and vomiting. People sometimes describe the trance like experience of bingeing in which feelings are numbed and there is blessed escape from the conflicts of life as experienced in substance abuse. For example :

“I enjoy going round the supermarket choosing the foods I am going to binge on. I plan the whole event for when my flat mates are out and I can put on loud music and not have to think about work or my friends.”

Fairburn (1995) challenges the view that an eating disorder is an addiction, describing a self-perpetuating cycle, rather than a process ending in oblivion or unconsciousness as with substance abuse. Indeed food is not an addictive substance, rather a substance essential for life.

In my opinion eating disorders appear to have more in common with obsessive compulsive disorders, and often incorporate other behaviours such as obsessively calculating the calorie content of food or compulsive exercising. The accompanying drivers and injunctions would, using Joines' and Stewart's model of personality adaptations, support this (2002).

Introducing Behavioural Change

If eating disorders are considered to be an obsessive compulsive disorder, the implications for therapeutic contact would suggest that initial contact is through the channel of thinking, followed by increased focus on feeling (Ware 1983). Behavioural change is considered the trap door and yet in eating disorders it is necessary to initiate change in eating behaviour as soon as possible. Although this appears to be a contradiction, the need for food is so fundamental that a state of starvation compromises any psychological intervention. This necessitates the integration of regular and adequate eating into the therapy.

Bruch expressed it concisely thus : "Nutritional improvement and resolution of psychological problems should occur in close interaction, and lasting recovery requires a change of the inner image a patient has of herself." Bruch, H. (1985 p.14)

Studies of starvation have shown that where there is very low body weight, brain mass is reduced and cognitive

functioning is impaired (Lenon 1985). In contrast, patients who are re-nourished in an in-patient setting become increasingly able to think flexibly as their weight increases, allowing them to become accessible to psychotherapy. However, treatment programmes which in the past concentrated solely on weight gain without addressing psychological issues were found to be ineffective in the long term. It might be argued that material from the starvation study would not apply to someone of normal weight who is bingeing and purging. However bulimics generally try to resist eating for long periods to reduce weight and the body reacts as if it is starving, hastening the next binge. In treating bulimia, regular healthy eating works in cooperation with the body's mechanisms for survival, as opposed to against them, enabling the person to break free from the cycle of starving, bingeing and purging (Fairburn 1995). In summary, with both anorexia and bulimia, behavioural change in the form of regular eating will enhance the potency of the psychotherapeutic work by allowing important psychological issues to be addressed.

Diagnosis in TA terms

In this section I look at eating disorders in terms of psychodynamic and TA theories, exploring the relevance of child development.

Self Esteem and Basic Trust

Common to all authors on eating disorders is the importance of self esteem, and in TA terms self esteem is expressed as the belief "I'm OK with me, and You're OK with Me". The child whose needs are sufficiently met recognises that although not all needs can be met immediately or completely,

the levels of satisfaction and frustration are in sufficient balance for her to conclude that she is valued and that others can be depended upon. This is expressed as the life position “I’m OK, You’re OK”. This process commences from the early holding and feeding experiences of the oral stage and lays the foundations for consequent developmental stages. The process continues as the infant learns to recognise the differences between self and other, and as a toddler, acquires physical skills which enable her to take a few tentative steps away from mother and return to the safety of her lap. During this time she develops a sense of her own separateness and sense of identity.

In Erikson’s (1959) model of childhood development he identified certain tasks associated with each stage, and in the oral stage he identified the task of establishing a sense of basic trust, that the environment will respond adequately and reliably. During the anal stage (age 2-4 years) while the child learns to control her bodily functions and mobility, the task is to establish a sense of Autonomy, which if not completed resulted in shame and doubt. A major feature in eating disorders is the need for control and we frequently hear people describe how “most things in my life seemed out of control, but my weight was one thing where I could have some control.” If childhood autonomy is not attained, the lack of this early experience is felt when issues of separateness and independence reappear in adolescence. The young adult has little to build upon in attaining adult autonomy. Similarly where there is an early deficit in basic trust, the adolescent lacks trust in anyone but herself, and we see the young person become increasingly

isolated from her friends as she seeks respite in the restrictive demands of anorexia. Levenkron (2000) contrasts this anorexic withdrawal with the healthy adolescent behaviour of moving away from parents towards the support of a peer group. Where people are not perceived as trustworthy Anorexia can become a best friend.

Script and Eating Disorders

Drivers

People who have eating disorders frequently have Please and Be Perfect or Be Strong as their Drivers and the underlying belief is : “As long as I can keep other people happy I am a worthwhile person” ; or : “As long as I can do things perfectly I am an OK person.” The Be Strong driver indicates a need to hide vulnerability, by not expressing needs. Maintaining such standards indefinitely is an impossible task for any human being and failure results in low self esteem and guilt. In addition, people who develop eating disorders seem to develop a parallel belief that “I can stay OK if I am slim.” More dangerously, in combination with Be Perfect is the “anorexic driver” : “I can stay OK if I **continue** to lose weight.”

Personality adaptations

According to Joines and Stewart (2002) the combination of Be Strong and Be Perfect alongside injunctions against being a child, being close or enjoyment would suggest either a paranoid adaptation or an obsessive compulsive adaptation. The paranoid adaptation also involves Don’t Trust and Don’t Feel and in my experience both of these adaptations can be seen in anorexia in varying degrees. For example the excessive need for control

and mistrust of others particularly around the subject of food or weight appears to be paranoid thinking. Joines and Stewart also associate the passive aggressive adaptation with bulimia.

The Paranoid is a survival adaptation, originating in the oral stage, and the obsessive compulsive and passive aggressive adaptations are performing adaptations, so it is possible that they occur in different combinations. Above I have argued that eating disorders appear to be obsessive compulsive in nature so I would identify this adaptation in combination with paranoid as one of the most common.

Impasses

The Gouldings (1979) drew attention to the fact that psychological problems frequently arise where the ego states are in conflict, creating impasses. A child has the creative ability to survive in an imperfect world where all needs cannot be met adequately. When inevitable conflicts between Parental injunctions and Child needs arise, the Little Professor finds temporary solutions which are based on limited information and which suffice until circumstances render them no longer viable. When an eating disorder occurs in adolescence it seems that an early adaptation is challenged by the onset of puberty.

A major task for the adolescent is to establish a sense of identity which will be different to that of her parents. For a child who has injunctions around being herself, growing up, being sexual or expressing feelings (in particular unpleasant feelings) the onset of adolescence presents an impossible dilemma. According to Mellor (1980) injunctions are generally given between the ages of 4 months and 4 years, although some authors would

identify injunctions as occurring at other stages in response to particular circumstances. Survival decisions which are made by a young child are later challenged by the onset of puberty. Her bodily changes imply sexuality, adult responsibility, relationships and a terrifying sense of losing control to biological forces. For some young people an eating disorder is a perfect solution to an impasse - it occupies her thinking, disguises her feelings and reverses her biological development. This enables her to obey Injunctions and at the same time neutralise the pressures of adolescence. The impasse is within the Child ego state, the conflict being between P1 and C1. The Little professor sometimes discovers the solution by chance – as a result of a planned “diet” to lose a little weight. She finds a way to retain the ordered life she knew pre puberty, and maintain her injunctions, which represents what has been an effective survival strategy.

This conflict and its scripty resolution are illustrated in figure 1.

Eating disorders as a racket

An eating disorder is a Racket, that is, a substitute for feeling which the child perceives as unacceptable (English 1971). In my experience the substitute feeling is usually expressed as a somatic sensation, described as: “I feel fat.” The sensation is accompanied by scripty thoughts, feelings and behaviours which make up the racket system or script system. “Feeling fat”,

becomes a shorthand expression for other emotional experiences - from loneliness to fear, jealousy to hurt - and consequently prevents effective problem solving. Erskine and Zalcman, (1979) describe the self-perpetuating racket system which, if interrupted by therapeutic intervention at any level can lead to script change rather than script reinforcement. As described above, intervention on the behavioural level is necessary to counter the effects of starvation.

A note on diagnosis

So far I have discussed the development of different eating disorders as if they are a generic group rather than referring to separate categories of anorexia, bulimia and atypical disorders, although there are clear observable differences in a patient's presentation. The case study below is of someone with Bulimia Nervosa, but, the majority of eating disorders carry features of both anorexia and bulimia and are "atypical" (Fairburn & Harrison 2003) and for many patients the form of the disorder changes through time. All eating disorders have some common themes, the principal of which is the measuring of self worth by body shape or weight (Fairburn & Harrison 2003). In assessing the initial focus for treatment, the principal consideration is the individual's physical state. For example, someone who is dangerously underweight will need more emphasis on physical safety than someone who is normal weight through bingeing and vomiting. Similarly someone who is bingeing and vomiting several times a day will be more at risk of cardiac arrhythmias due to electrolyte disturbances than someone who is vomiting two or three times a week.

During treatment, priorities change according to the level of risk and the quality of cognitive functioning and these need to guide the therapeutic focus rather than the diagnostic term. The section on psychological factors appears to be applicable across the spectrum of eating disorders.

Example of Sally

Sally was a twenty five year old woman of average weight who wished to stop bingeing and vomiting. She attempted to exist only on fruit and vegetables but her starving organism drove her to bingeing usually three times a day, which she vomited to prevent weight gain. Sally felt distressed at her lack of control but was terrified that she would put on weight if she ate regularly.

Sally used bingeing in times of stress, for example, when feeling hurt by a friend's critical comments. Her Parent believed that it was wrong to answer back, and her Child dreaded the possibility of rejection if she upset her friend, so she coped with her unacceptable feelings by bingeing, which allowed her to dissociate and avoid feeling. Because of her fear of weight gain she induced vomiting which led to feelings of self disgust and ineffectiveness. Sally had translated her feelings of anger and sadness into Racket feelings of self disgust and ineffectiveness. One of Sally's tasks in therapy was to learn to identify her feelings which gave her choices in how she could deal with them.

The script system (figure 2) illustrates how Sally's script beliefs interacted with her thinking, feeling and behaviour to perpetuate the bulimic behaviour. In relation to a highly critical father and passive mother Sally had concluded that she was useless and

unlovable, and that others managed their lives competently. She had learned that it was necessary to put a brave face on things rather than risk father's wrath, heeding mother's exhortations to "not upset dad." These conclusions formed her script beliefs, which were consistently reinforced by experiences throughout life, reminding her that she was not OK and that others were. In the diagram the arrow at the bottom shows that the reinforcing memories are confirming her script beliefs. The rage that her Natural Child felt in relation to her unmet emotional needs was suppressed and only experienced in dreams. In place of this "forbidden feeling" she developed an elaborate Racket of bingeing and vomiting, with accompanying feelings of shame and disgust which further reinforced her script beliefs.

People with eating disorders frequently use the term "I feel fat" as if it is an emotional feeling, and I suggest that this is an expression of other, less acceptable feelings. Levenkron (2000) describes the process of abbreviation in which complex combinations of feelings are reduced to one simple concept : feeling fat. A racket system for anorexia might appear as in figure 3.

The Transactional Analytic treatment of eating disorders

In this section I examine my work with Sally in terms of stages of treatment, which I have adapted from Woollams and Brown (1978) and Clarkson (1992). As with any plan, the sequences do not follow strict order as illustrated, as there is some overlapping, and repetition.

Establishing a working relationship

Ambivalence is always present in working with eating disorders and an exploration of the pros and cons of change is useful in forming a therapeutic relationship. As a major fear will be that others may take control of her and force her to become fat (and unlovable) , the Child needs to hear that we will be working together to help her live the life she wants, rather than attempting to enforce a regime upon her. This needs to be a theme throughout the work except where issues of safety become paramount. She needs to feel that her misery and fear are understood, and to experience some hope that things can be different.

When Sally first came for therapy she was ashamed and disgusted by her bingeing and vomiting and needed a therapist to respond with empathy and optimism. It was important for her to hear that her problem is not intractable and that support would be available to help her overcome it, but she was not pleased to hear that eating three meals a day and snacks would be an important part of the cure.

Contracting

Our initial contracting was based on safety and exploration and I was clear that I would need to communicate with her GP to ensure that her physical health would be monitored during therapy. She might incur physical damage as a result of her bingeing and vomiting and blood tests would indicate the presence of heart irregularities due to any disturbance in electrolyte levels. In the case of people with low body weight other health professionals may need to be involved and boundaries will be needed around

maintaining a safe weight and the possibility of hospital admission in the case of dangerous weight loss.

The therapeutic contract

Initial exploratory work prepares the way for therapeutic contracts which explicitly state the desired outcome and the part played by both parties in the planned work.

Later in our work Sally's contract was "I will eat three meals a day and find healthy ways of expressing my feelings", which illustrates how contracting can be a continuing process, as the focus of treatment changes. However although at the beginning of treatment she was clear that her goal was to stop bingeing and vomiting, she had not contemplated giving up dietary restriction. Information giving and discussion about eating disorders utilises the contact door of thinking (Ware 1983), and explaining the reasons for regular eating led on to Sally addressing her over evaluation of shape and weight and then her poor evaluation of herself.

Decontamination.

Decontamination enables the client to make fuller use of her Adult, by "scraping away" the contaminations of Parent and Child ego states. Where there is sufficient Adult available, which may not be the case in people with very low weight, the provision of educational material enables the client to question long held assumptions which maintain the disorder and to start to take some risks, by experimenting with different eating patterns.

Family meal times in Sally's house were dominated by father's intrusive

criticism about the eating habits of family members, and he modelled preoccupation with his own weight problem. Her Adult was contaminated by Parental precepts such as "To be successful you have to be slim" which were reinforced by images of women as portrayed in women's magazines. Her Child contamination held beliefs like "If I start eating like other people, my weight will continue to increase until I am enormous", "starchy foods will make me fat"

Decontamination begins from some pertinent questions in the early sessions which call into question the client's perceptions "Do other people think you are overweight?" and continues throughout therapy. In the programme in which I am involved there is an important emphasis on educational material which strengthens the client's Adult and challenges misconceptions such as "carbohydrate is fattening" and "fat is bad". Information from the Minnesota study (Keys et al 1950) and discussion about the role of the media in promoting dissatisfaction with one's body shape are relevant here.

Sally came to realise that her main method of evaluating herself was by her appearance, whereas she valued her friends for their personal qualities. I confronted her thinking with : "So for some reason you judge yourself by a much harsher set of rules than you judge others."

In Cognitive Behaviour Therapy (CBT) this is referred to as challenging "irrational or automatic thinking" in much the same way that TA practitioners challenge Parent or Child contaminations. CBT has been researched and found to be effective in treating bulimia in 40 -50% of cases and is currently considered the treatment of choice for bulimia nervosa

(Wilson, Fairburn and Agras 1997). Further research is currently taking place to evaluate its effectiveness in treating anorexia.

Although decontamination is generally seen as an early stage in treatment in my experience there needs to be sufficient functioning Adult for decontamination to be effective. Clarkson (P106) describes how in some cases work may need to be directed at deconfusing the Child before decontamination can happen, as some people may need their Child to be heard before they can think clearly in the here and now. Nevertheless a certain amount of decontamination enables the client to say "I know what I need to do even if I don't know how to do it". This sets the scene for the therapist to help the confused Child.

Deconfusing the Child

Deconfusion is a process in which the client "learns to take responsibility for her decisions and discovers how she uses her present behaviours to maintain her script" (Woollams and Brown, p.262). As such it is likely that eating disordered behaviour becomes less of a focus at this stage, rather its function as a racket is being explored, to help her to understand how the eating disorder was an attempt to meet unmet needs. This lays the foundation for future Redecision work, when she feels secure enough to make a new set of decisions.

As Sally took the risk of eating regular meals in place of dieting her feelings became more accessible. She was confronted by feelings which she did not understand and believed that she

should not be feeling. Her injunctions against feeling anger, sexuality or closeness produced conflicts which she would have previously dealt with by using eating disordered behaviour. In deconfusion work the therapist needs to be Potent, Protecting and Permission giving (Crossman 1966 cited in Stewart 1989, p.6). The client needs the presence of a powerful and affirming "other" in order to experience being seen and heard and having all her attributes accepted, even - or especially - those she considers unacceptable. In this phase early scenes may be revisited and her childlike conclusions questioned. Her conclusions at the time of the events contributed to her script decisions about her lack of worth or the danger of expressing needs, and she came to see her circumstances in a different light.

In this transcript Sally recalls an episode from when she was fourteen and had stopped eating completely.

S : He's shouting at me and trying to force me to eat. I don't know what's wrong with me, he says I'm breaking the family apart.

Th : What do you want ?

S : Stop it, stop it. Leave me alone. I feel horrible inside

Th : What's horrible like?

S : Angry with him, angry with mum for letting him do this

Th : Tell them

S : Why don't you help me , why don't you try and understand me. I want you to see how miserable and alone I am

Th : You felt miserable and alone and they didn't see that. You were trying to show them what you felt, because you couldn't tell them.

Her fourteen year old self had followed the injunctions against being herself, being a child and showing feelings, but her Little Professor had found a way to

communicate her feelings through restricting food.

Building a Nurturing Parent

Once there is sufficient decontaminated Adult and sufficient awareness of her Child needs, the client can integrate new elements of Parent ego state, sometime borrowing from the therapist's Parent and incorporating health enhancing messages and learning to develop positive nurturing and controlling aspects within her own Parent. The therapist can model the positive aspects or alternatively the client may choose a real or imagined benign parental figure to "consult" internally in times of pressure (James 1974).

Two chair work can be used to allow the Child to receive parenting from the client's own decontaminated Adult, which also continues the process of deconfusion. In this example Sally is talking to her seven year old self who is represented by a cushion on a chair.

"People do say nasty things sometimes, although they shouldn't. I can understand that you feel hurt, but I want you to tell me about it and not go and eat biscuits on your own. It's OK to feel sad or angry and to let me look after you."

Emotional Fluency

The theme of permissions underlies the above process – permission to be a child, to be oneself and to feel one's feelings. Permissions are implicit in the behaviour and transactions of the therapist. The "I must not feel" injunction is apparent in the guilt experienced if feelings of anger or jealousy come into conscious awareness. On the other hand, a whole

range of unacceptable feelings can be transformed into a physical sensation expressed by "I feel fat". Levenkron (2000) suggests that this is a kind of shorthand, an "abbreviation" in the absence of emotional fluency, which in some cases manifests as body image distortion. The consequence is that, as in racket theory, this substitute for a feeling prevents adequate problem solving and reinforces script beliefs.

I have found it useful to teach the concept of four feeling groups : **Glad, sad, mad and scared** (Stewart and Joines, 1987, p 213) and to enquire : "If "feeling fat" is a substitute for an unidentified or forbidden feeling, which of these words could you use instead ?"

Once the feeling is identified, exploration of the function of the feeling can follow – the feeling indicates an underlying need which may be an archaic Child need or a more immediate relational need. For example, Sally experienced herself as fat when in the company of other women. Exploration of what else she was feeling led her to realise that she felt inferior, less attractive and less lovable. She made a connection with her childhood experience of being bullied but not telling her mum. In therapy she accessed her feelings of anger at the other children and despair because she could not expect support from her mother.

Where the need is in the present, the client may need to learn problem solve or express feelings in an appropriate way in order to avoid the racket system. For example Sally avoided confrontations particularly within her circle of friends, and rather than talk to her friends about any perceived hurt she withdrew, cried and comforted herself with a massive intake of food later in the evening. She came to

understand that her binges were a way of cashing in her “hurt” stamps, a pattern which she had developed in response to being discounted by her emotionally absent parents.

At this stage it is often appropriate to encourage people to learn skills in other settings such as assertiveness training classes or anxiety management which are more likely to be effective where there is sufficient uncontaminated Adult.

Redecision

Redecision takes place when someone changes an aspect of script. This is a new decision made from the Child ego state, the source of the original script decision, and can occur consciously or unconsciously.

Sally had learned through her life that others would not understand her needs and as a consequence decided that her feelings were shameful things that she should keep to herself. Now, by using her Adult she reasoned that there was someone who might respond to her needs, her current boyfriend, and despite the anxiety in her Child she took the risk of disclosing to him the fact that she had bulimia. His sympathetic and supportive reaction enabled her to redecide that it can be OK to share feelings and to trust others, which later widened to certain friends.

My experience of people who have eating disorders is that redecision occurs more frequently as an accumulative process following deconfusion work rather than as a result of two chair work. This may be related to particular personality structures, as Mellor (1980 p.331) suggests that for people who have been underparented, a heightening of feelings as in the facilitation of

rededecision, can be counterproductive. He suggests that where there is insufficient Parent ego state, reparenting is indicated. Redecision therapy as practised by the Gouldings (1997) is indicated where there is overparenting. I understand much of what takes place in the deconfusion process as involving parenting by the therapist in the form of potency, permission and protection which can be enhanced by the contractual use of spot reparenting as described by Osnes (1974). Redecisions occur where the Child is sufficiently empowered by deconfusion and incorporation of a healthy Parent.

Relearning

Change can be observed by the therapist and reported by the client in sessions, but people come to therapy to find a way to live their lives differently and improve their relationships outside the therapy room. Redecisions need to be integrated into everyday living and this in itself is an important stage of therapeutic change. For the person recovering from anorexia or bulimia change will be apparent not only by the cessation of symptoms but in thinking patterns and transactions. Sally expressed her feelings and opinions more readily at work and became more assertive with friends, giving more importance to her own inclinations before accepting invitations or suggestions. She had learned to attend to her own needs rather than block them out by bingeing and vomiting. A significant moment was reached when she learned that her fiance was to be working away for a period of some weeks and she started to binge once more, but stopped herself, rang a friend and arranged to go out for the evening. She now realised that she was in control.

The relearning stage is an opportunity to enhance self esteem and personal power and to reassess the sense of identity. As described above the issue of identity is a major factor in eating disorders and giving up an eating disorder means the client being confronted with who she really is. If the eating disorder has been present since puberty it will mean discovering herself as a woman, with a woman's body and the implications of this. She may have missed an important developmental stage which she then undergoes belatedly and I have frequently heard people recovering from eating disorders (or others around them) say that they seem to be going through adolescence.

Termination

Therapy can be seen as a process of growing up, but with the support of a person who is different than the biological parents. A form of dependence develops to enable the internal Child to attach and gain support where there is a conflict with a powerful negative Parent. Separation is an important task in therapy as it is in adolescence and the therapist models a healthy parent, validating the young person's steps towards independence. As the client developmentally grows up, the therapist becomes less relevant in her life until she is ready to terminate therapy and end the relationship.

Conclusion

I see the psychotherapy of eating disorders as a process in which the patient gradually discards the rackets which defend her from her own needs and sense of identity. In this process she comes to accept her underlying

needs and allow them to be met in a healthy way. Protection is vital in the delicate balance of enabling the person to risk change by facing her fears of food and weight gain and this will need at least minimal medical involvement. Throughout therapy an understanding that adequate and regular nutrition is an essential part of treatment will need to be reinforced and revisited. This expectation is compatible with Transactional Analysis psychotherapy as the therapist confronts the discounts by which the patient maintains her disorder. An example is given by Kline (1985) who describes how in a TA residential programme the restoration of body weight was given priority in an environment where the client is given structured support to learn self care. Treatment in the community will need to include the same expectations and may include parental behaviour from the therapist in order to ensure safe boundaries.

Within safe, life preserving boundaries, the task of the therapist is to nurture and encourage the real self which has been hidden beneath a sophisticated level of adaptation. The clients task is to discover who she really is and develop a sense of self. In place of using rigid control, she can be helped to identify her own wishes and needs and to make decisions based on these, rather than on her restrictive view of herself and others.

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Please note that the client described is a composite created to illustrate commonly occurring symptoms, designed to illustrate a therapeutic approach to issues that the reader may encounter.

Mervyn Brunt February 2005

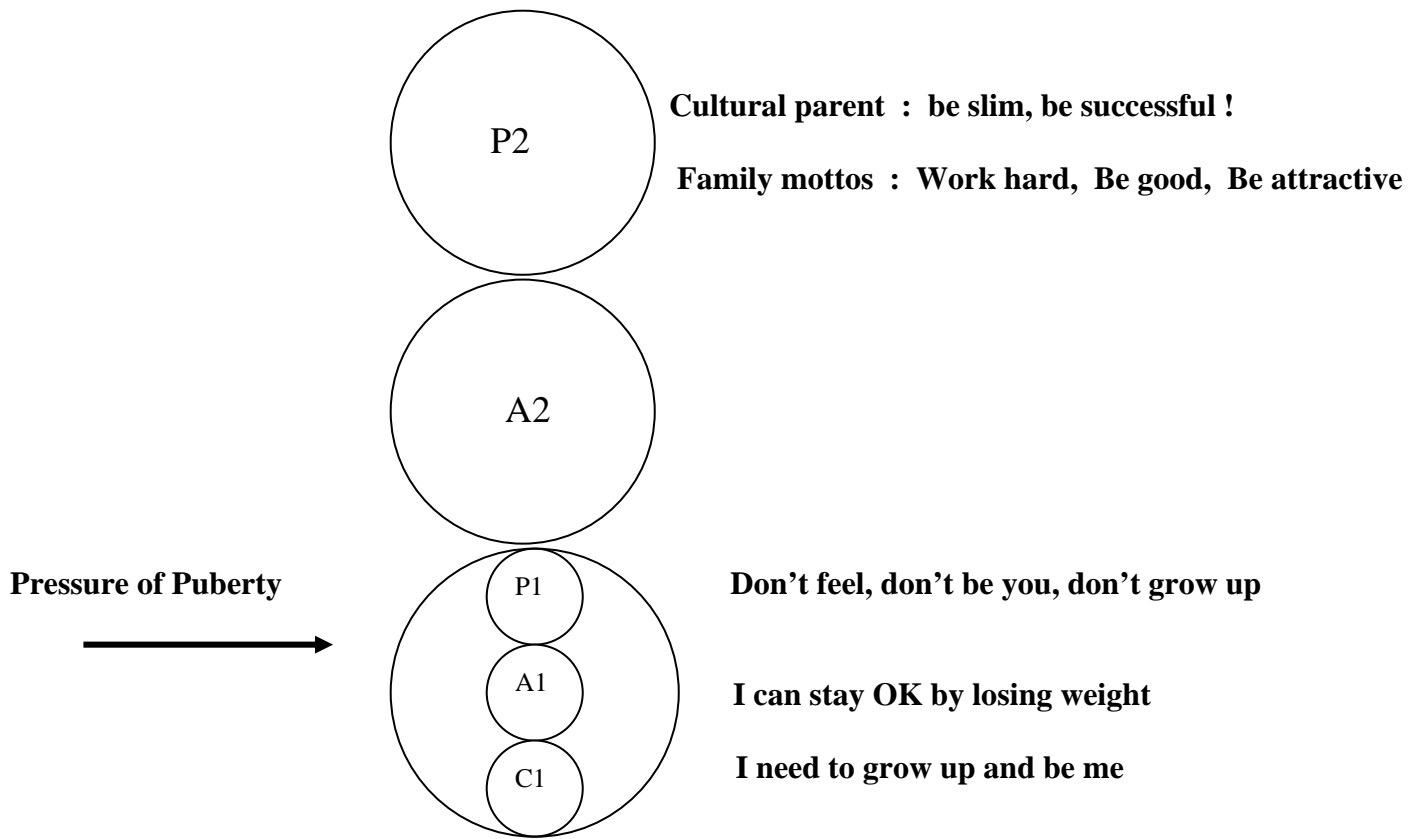


Figure 1

Sally's Racket system

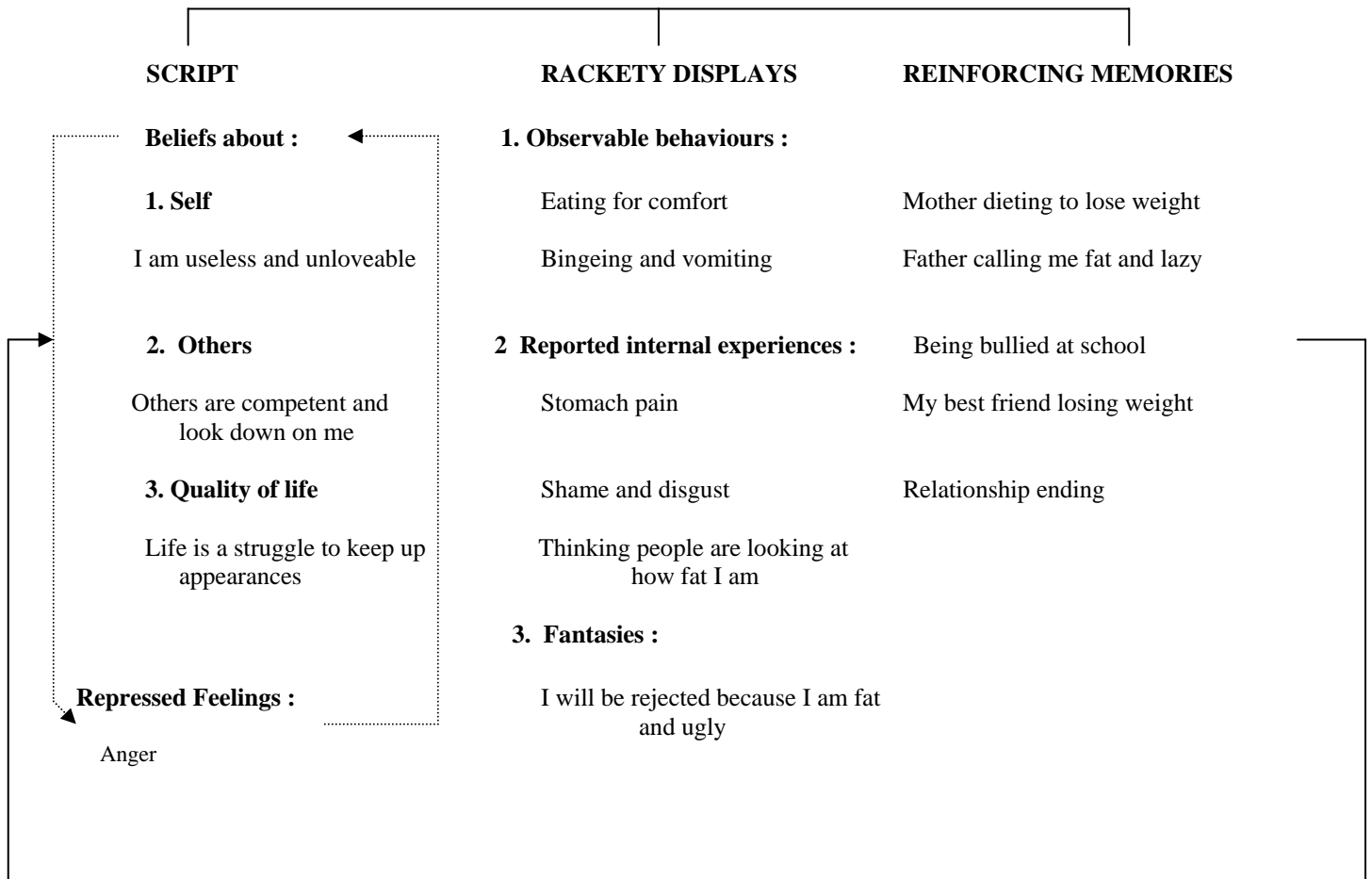


Figure2

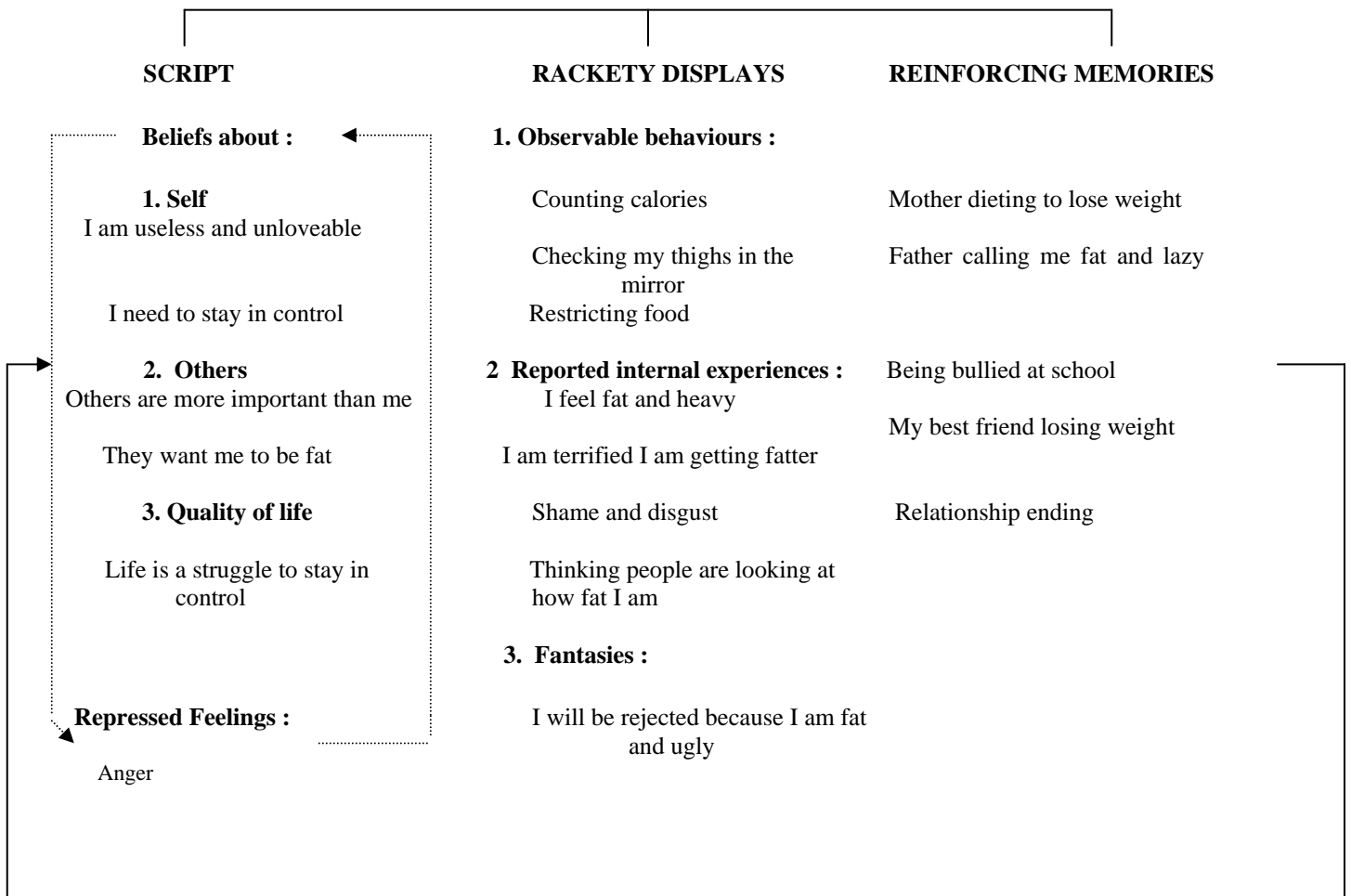


Figure 3

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