**On the Being and Telling of the Experience of Anorexia: A Therapist's Perspective**

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At the 1994 Renfrew Conference, I was privileged to speak on a panel entitled: "Perspectives on the Inside Out: Therapists Who Carry the Experience." The invitation to address the notable omission of discourse on being a "recovered therapist" was a weighty prospect that I didn't take lightly. I was fully aware that I was not alone as a recovered anorexic in the community of eating disorders specialists, but the conspicuous lack of similar acknowledgement was a potent silencer. A "don't ask, don't tell" mentality seemed the abiding dictum in our field, compounded by the still pervasive social stigma associated with mental illness in the community at large. The implied hypocrisy fueled the secrecy--a rather anorexic solution to a dilemma of such ample significance, if you will. One blessing of being recovered is that at some point, the need to be real without apology becomes more pressing that the needs to please, resist conflict or maintain the status quo. Ultimately, speaking on the panel was an irrevocably liberating, confirming and healing process. My hunger for a fuller sense of honesty and truth-telling in our field was simultaneously fed and reawakened. I make this point now because "coming out" to my professional colleagues then outweighs any experience I've had dealing with the same considerations with my patients. Relatively speaking, that has been a cake walk, albeit a multidimensional, thoughtfully choreographed one! Once again, I welcome the opportunity to revisit this topic for The Renfrew Perspective.

In keeping with my admonition against the selective silencing of recovered therapists, I feel compelled to preface my remarks with my perspective on recent considerations within the eating disorders community to examine the issue of whether recovered therapists require added scrutiny or supervision within the field. This "issue" was raised by panelists at the recent Academy for Eating Disorders (AED) conference in San Diego and an informal recommendation

was made for an AED task force to further examine this concern. To do so, in my opinion, would be at the risk of perpetuating the insidious stigmatization of emotional illnesses, patronizing those who have successfully negotiated recovery, and/or implying, a priori, that therapists **recovered** from eating disorders (as opposed to other psychiatric illnesses) are somehow deficient relative to their professional peers. As I hope to elucidate below, we are all irrevocably bound, strengthened and shaped by our life experiences and to the degree we embrace and emerge renewed from periods of despair, whatever "condition" it is so named, we chance to bring a humility and grace to our work as therapists that will not be lost on those we treat. Each of our respective professional disciplines holds us to ethical standards of practice to protect us and our clients from harm due to a practitioner's personal impairment. Upholding these established standards eliminates the necessity of singling out the **history** of an individual condition, such as an eating disorder, as requiring special oversight or supervision within our field. If we truly mean to "help our own, " greater good may come from addressing all forms of professional impairment and burnout that therapists are equally vulnerable to encounter. Only a spirit of professional respect, equality and safety will foster such a proactive undertaking, and speaking as one who has risked being "out" in the current climate of our field, we have yet to fully embrace such a quality of deferential regard. This edition of The Renfrew Perspective will hopefully encourage us to take the next step in this direction.

To elucidate the clinical implications of being a recovered therapist, I borrow from the life and work of C.S. Lewis as portrayed in the movie, Shadowlands (1993), adapted from Lewis's book, A Grief Observed (1976). The movie poignantly details Lewis's struggle to make meaning of life's bitter blows, his evolution from atheist to Christian, and his tender awakening to love with his wife, Joy Gresham, after years as a confirmed bachelor. The movie gave expression to the same critical dynamics and existential dilemmas that I manifested in my anorexia, although in a totally different context. Even the title embodied the experience. Living within the anorexic stance is strangely like abandoning the position of shadow-maker and retreating to the seemingly

safer vantage point of the shadow itself--one long, guarded, arm's length from the world.

The drama that Lewis invited us to consider parallels the fundamental quandary that recovery from eating disorders entails: How to be real, risk connection in a world existentially considered? In Lewis's words, "Why love if losing hurts so much?" In anorexic terms, "Why live if loving hurts so much?" Lewis lost his mother to cancer at age nine, thereafter retreating from the notion of loving anyone again whose loss would outstrip his capacity to renew meaning in his life. Given this unconscious pact, the terrible beauty that was Lewis's love for Joy was that he dared to fall in love with her in the midst of knowing she was dying of cancer. The existential leap this required is not at all unlike the anorexics' consideration of re-embodying her self, fully aware that to do so renders her vulnerable again. Lewis said, "Pain is God's megaphone to rouse a deaf world" (Shadowlands, 1993). Joy, a woman of fierce vitality and unyielding spirit, taught him that he could not love her without fully accepting all there was to lose--in her words, "the pain then is part of the happiness now. That's the deal." (Shadowlands, 1993).

In anorexic terms, recovery demands a willingness to be real **again**, vulnerable **again**, to the full range of human experience, all shades of gray included. Viewed from the anorexic "shadowlands," this invitation appears an absurd request, something like reexiting the birth canal after achieving our full adult size. On the cusp of my own recovery, poised to make the proverbial leap back into the land of the living, I wrote of the terror this prospect held out to me:

*I am lonely for certainty and frightened by how subtly it vanished. No blinking light to signal its transient form. It leaves me in a condition of pure feeling, so emotion-laden that I cannot distinguish one state from another. If such a condition of numbness could embody a color, it would have to be black. Simplicity, it seems, is concentrated chaos...If I extract myself to a different dimension, I can at least be aware of how tortured I am by my turbulent emotional inertia. I wonder, stoically and fearfully, if in like comparison, Sisyphus would have pursued his existential task of rolling his ill-fated rock up the hill had he seen his dilemma from afar? Faced solely with the rock, I too might persist, if only for the purpose of the struggle. But now, faced with*

*both the rock and the weighty awareness of the "Big Picture," I find myself frantically paralyzed. In a frenzy of motionlessness. Falling with my feet stubbornly planted, gathering bruises that refuse to expel their ache. Even more frightening than the prospect of enlightenment, is that first real jolt of sentience, the piercing scream of nerves released from denial's hearty grip. Isn't there an internal gate-keeper, an emotional parachute, that will ensure I don't reenter the realm of my senses free-fall and fragment into so many brittle pieces?" (McGilley, 1980).*

The significance of Lewis and Gresham's story to my recovery and role as a recovered therapist is that both issues were personified in the nature of their relationship. In Lewis, I saw myself as recovering anorexic, emotionally shell-shocked from my own mother's death by suicide, cynically questioning what kind of God could allow such pain in my life, and why I should remain open to it? In Gresham, I saw myself as recovered therapist, passionate about the strengths to be found in vulnerability, encouraging love and other hearty risks, accepting that experience can be a brutal teacher, and still choosing to learn. A brief excerpt from A Grief Observed (1976) captures the juxtaposition of these perspectives. On describing Joy's appetite for living, Lewis wrote:

*"Nothing would be wasted on her. She liked more things and liked them more than anyone I have known. A noble hunger, long unsatisfied met at last its proper food and almost instantly the food was snatched away. Fate or whatever it is, delights to produce a great capacity and then frustrate it. The most precious gift that marriage gave me was this constant impact of something very close and intimate, yet all the time unmistakably other--resistant, in a word, real. Is all that work to be undone?...Oh God, God, why did you take such trouble to force this creature out of its shell if it is now doomed to crawl back--to be sucked back--into it? (1976, p. 18).*

For me, like Lewis, to recover was not about becoming real, it was about becoming real **again** and staying real, despite all that I knew this to entail. After Joy dies in the movie, Lewis returns to the question of why love when losing hurts so much? He said, "I have no answers anymore, only the life I've lived. I was twice given the choice. As a boy, I chose safety. As a man, I chose suffering. The pain now is part of the happiness--that's the deal" (Shadowlands, 1993). I,

too, made similar choices, and having risked love again, would never trade the fullness I feel now in my heart's belly for the absence of any pain later.

This perspective illuminates the essence of what it has meant for me to be a recovered therapist. Being recovered does not lend me exclusive rights as an expert on eating disorders, nor does it afford me a special "in" with the patients I treat. As with Lewis's metamorphosis described in Shadowlands (1993) and my retreat into the shadow of myself, it is an inherent and inevitable human experience to seek and create meaning in the context of our life circumstances. For some, the complexities of this process become tangled, manifesting in a singular, tangible form, such as the anorexic web and body. For others, the fabric of their lives unravels smoothly, becoming richly textured by multifarious threads that carry and weave their experiences into a meaningful whole. In this way, we are all "wounded healers" in some sense, bringing to our work the communal challenge of meaning-making with our patients. Our history is a part of who we are, whether or not we ever speak to the particulars that contributed to our sense of meaning in the world. Our patients feel this in us, they sense it in the way we talk, how we listen, how we experience our bodies. To the degree we are real, embodied, and in Pat Fallon's terms, "respectful witnesses" (Fallon, 1994) to their growth, we demonstrate the blessings of recovery whether or not we have experienced the illness first hand. Clearly, for those who have carried the experience, the imperative to be centered and grounded in one's own recovery before undertaking in the treatment of others is explicit in this perspective.

There are distinctions in how we know what we know as therapists, but each perspective has its own blessings and pitfalls. None of us are essentially or inherently more gifted to guide in the travel. And aren't we in some real sense just that--guides and navigators in our patients' journeys into health? Regardless of how we come into being healers or what experiences we carry into this role, the critical therapeutic challenge is how we go about sharing that knowledge, **who** we are as much and **how** we are in relation to the people we treat. Recovered or not, that's the deal!

Finally, with regard to self-disclosure, the question is more when and how than whether I tell my patients. I have no pat formula, no hard and fast rules for sharing this part of my history. It only makes sense **not** to lock myself into any rigid guidelines because the therapeutic relationship, as I conceive it, is a dynamic, unique and intimate connection in which exchanges occur as the relationship allows and demands. To the extent that we are genuine, spontaneous, and wholly present with our patients, we can model and foster the very openness and trust we're encouraging them to consider in order to recover and "be in the moment." In this way, whether or not I ever speak to having recovered, by **being** recovered in my ways of relating, I essentially convey the same messages I would hope to express by actually telling a patient that I had carried the experience.

I can not tell other therapists if or when to share their own life stories out of context. I can only say that **in** the therapeutic context, the integrity and authenticity of the relationship will signal such openings. We can then make spontaneous, albeit informed decisions about the kind, depth and timing of intimacies shared in that connection. Feminist-oriented therapy does give us some guideposts in this process by encouraging a collaborative relationship in which equality and authenticity between members is honored. As we become more seasoned therapists, having better learned the art of timing and the rhythms and tides of therapeutic change, we will more intuitively "know" the ifs, whens, and hows of bringing our experience into the therapeutic relationship. I have told most of my own patients that I was anorexic, at varying points in the therapeutic process. To my knowledge, the self-disclosure was not damaging to our relationship or my patient's recovery. In fact, I've asked many of my patients what it has meant for them to know about my history, and there is one consistent and resounding refrain: **HOPE!** In apt metaphor, Joyce Carol Oates wrote, "Hope is the healer that lets us survive when our soul is as thin as a playing card." As therapists, we are the guardians of hope. Our patients want to know there's a way to navigate through this seemingly impossible maze. They want to know there is something better on the other side of recovery worth the emotional, if not physical stretch marks their bodies and souls must then

bear. They want to know if "body/weight/food" will remain their daily mantra. They want confirmation that there is more than this shadow of themselves, that there is meaning, safety and purpose in being a woman of substance. Self-disclosure of therapists who have been through the recovery process can be a powerful tool to instill these hopes as our patients realize others have made similar leaps of faith and found the risks well worth the taking.

References

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