Anorexia Dreaming: A Case Study

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A case study is presented focusing on a dream of a severely anorectic woman. The dream occurred at a point when the disorder had become life threatening. The dream is discussed in terms of its significance in the dreamer's experience, its implications for the use of dreams in psychotherapy, and its relevance for the broader literature on psychopathology and dreams. Archetypal psychology's aesthetic, and phenomenological approach to dreams is presented as a framework for understanding the ongoing significance of significant dreams such as the one presented here.

KEY WORDS: significant dreams, psychopathology, eating disorders, archetypal psychology

"The first thing I wanted to do after I had this dream was tell my therapist. The first thing she wanted to do after she heard it was to put me back in the hospital. I was so angry I said I'd never go to therapy again." So begins the account of a dream that marked a dramatic turning point in the dreamer's life and death struggle with anorexia nervosa.

Stephanie, the dreamer, was a 22-year-old college senior at the time of our first interview. She volunteered her dream for a study of "significant dreams" (for details of the methods and methodology of the study see (Knudson & Minier, 1999; Knudson, 2003), but our conversations about her dream eventually spanned a number of meetings over a period of several months. During her high school and early college years, Stephanie reported that her anorexia had been serious enough to require several hospitalizations; and she also had been in and out of psychotherapy several times. Stephanie reported that she is five feet, six inches tall. As she

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presented her story, at age 15, around the time she identifies as the onset of the disorder, she weighed 125 pounds, or maybe, she added grudgingly, 128 pounds. At the time that she dreamed the dream that is the focus of this article, she weighed 65 pounds, perhaps less! It was summer. Stephanie, 19 years old that summer, was on medical withdrawal from her university studies; but she had refused to reenter the hospital. Moreover, in the weeks just prior to this dream, she had broken off her outpatient psychotherapy; reportedly because she felt that her therapist was doing little other than pressure her to return to the hospital. Stephanie's therapist had warned Stephanie that her weight was now reaching a point where even hospitalization might not be able to reverse the process, so Stephanie was fully aware that her life was literally hanging in the balance. In that context, Stephanie had the following dream. It is noteworthy that Stephanie could not recall any therapist or other helping professional who had ever asked for a dream as part of her therapies or hospitalizations; nor had she ever thought of bringing a dream to a therapist prior to the one discussed here. The dream is recounted here with Stephanie's permission.

Dad Is in a Pink Shirt and There's a Monster in My Room

I sit up from my bed, the big bed I have at home. I'm in the middle and there are no stuffed animals on it. It's my room at home . . . except the furniture is arranged differently. My Peter Pan picture is behind the bed. The bed is facing my window, or where the window should be . . . the whole sidewall of the room is missing. It's as if someone has torn it down, like a wrecking ball came through, and I see jagged remains of bricks and wood. I sense that something is out of place, that a wall really should be there but . . . I am more curious than anything else. I know the wall is gone for a reason . . . that its absence is going to allow me to see something else. Or maybe the window was there but not connected to anything – "Dali like."

With the wall gone, I can look directly out into my backyard. We have a pool out there. I see this weird alligator/dragon monster. It reminds me of one of those Chinese dragons that dance around at festivals the way it's jumping around in and out of the water of our pool. Or like the Loch Ness monster. I am terrified of it but I don't really do anything just then. I swallow hard and am queasy looking down with the insecurity of the wall not there. I don't like heights so I focus on that. I'll throw up if I get near the edge.

Before I can focus on the creature, my dad comes into my room and distracts me. He is dressed so weird, with a pink shirt on and a tie around his head. I asked him why he was dressed like that and he said he had to go to work. It looked like they were having some sort of costume day or something. He didn't seem to notice there was a problem with how he looked and was really upbeat. He totally neglected to see that the entire side of my room was missing and that there was a monster in our pool jumping around. I was so shocked by his obliviousness that I didn't even mention it.

My dad left, and I knew my mom was putting on her makeup getting ready for work too. She wasn't going to dress weird though. I'm still in my bed. All of a sudden, the creature jumps from the pool to my room—jumps in through the space where the wall should be. It takes me by surprise and I fall off the bed. I have one leg on the bed, one on the floor, and I freeze. With the same mentality of a child afraid of the dark and sure there are monsters in her room, I think to myself, "if I don't move, he can't see me," and I stand completely still. The creature is breathing hard and rocking back and forth just a little, but enough for me to see it is alive. It is ready to pounce, and I know it wants to eat me. Devour me. My eyes are open.

I'm stuck. My first instinct is to call for my mother. She is right down the hall and I can see her out of the corner of my eye. She's still putting on makeup and won't know that I am in trouble unless I tell her. But I can't yell. When the creature jumped into my room and startled me, I gulped; and I can feel that nothing would come out if I tried to make a noise. I would have to swallow and clear my throat first, but even that half-second action would

> alert the monster. Though I know mom would come running, I also realize that she can't help me. The monster is too close. My other option is to run. But with one foot on the floor from when I slipped and one on the bed, I know I'd have to make some huge, intentional movements to get stable, to get on some ground. I'm on the side of my bed farthest from the door, so I'd either have to run around the foot of the bed or climb over the bed and run out the door. I would really like to do this—to run— but I think to myself that I am too slow now. The monster is too fast. I don't feel weak but for some reason I just know my legs wouldn't go as quickly as I need them to.
>
> I'm still frozen. And I know that if I keep thinking about what to do—whether to call my mother or to run — I am going to start to panic, because neither option is going to work. So I stand there . . . in limbo, knowing the only thing to do is to stare at the creature and not be afraid, even if I am. I have to deal with the monster, stare it down— because I can't escape it. To get rid of it, I can't be afraid. I start to turn toward it; and then, I wake up.

In the following, Stephanie's account of her dream and its significance is presented as a contribution to the literature on dreams and the role they can play in the process of recovery from serious psychopathology. It is at the same time a polemic against the interpretation of dreams in therapy in favor of what archetypal psychology calls "sticking to the image" (e.g., Hillman, 1977, 1978, 1979). It is equally polemical in its endorsement of Denzin's (1997, 2001) insistence that the epiphany, the life turning point, rather than normative experience, is the appropriate focus for inquiry. The case presented here deals with just such an epiphany, a dream experience that serves as a catalyst for the dreamer's conscious decision to recover from anorexia, to live rather than to die.

A THERAPIST'S RESPONSE

Immediately after dreaming this dream, Stephanie contacted the therapist with whom she had discontinued her therapy earlier that summer. She asked for an immediate appointment, and the therapist was reportedly happy to offer one. Stephanie entered the session excited to tell the dream. Her therapist reportedly listened; but then to Stephanie's reported dismay, the therapist immediately offered an interpretation. Focusing on the image of Stephanie's precarious posture in the dream, one leg on the bed and the other foot on the floor, the therapist suggested that the dream was a representation of Stephanie's unstable psychological/medical condition. Furthermore, the therapist reportedly argued, the conclusion of the dream made it clear that Stephanie was not able to deal with the dangerous situation herself. The conclusion was obvious, the therapist reportedly concluded: Stephanie needed to return to the hospital for inpatient care. Stephanie could not recall the therapist making reference to any other aspect of the dream. When Stephanie rejected the interpretation, the therapist shifted the focus of the session away from the dream and reiterated previous arguments in favor of hospitalization. This was the dynamic that had led to Stephanie's earlier discontinuation of her treatment. Stephanie again rejected hospitalization. She then angrily terminated the therapy.

A cautionary note is necessary here. This account, from Stephanie's point of view, of the therapist's attempt to use the dream as leverage in an ongoing struggle with Stephanie over hospitalization is not recounted here in order to criticize the therapist. It is easy to offer after the fact critiques of what now appear to be

therapists' errors and even easier perhaps to fail to attend to the very legitimate reasons this therapist had for pressing the issue of hospitalization. Mortality rates for anorexia are higher than those for any other psychiatric diagnosis (Gremillion, 2003), so we should empathize with any therapist sitting across the room from an anorexic patient whose weight is perilously low. Surely in this context, the therapist's interpretation of the dream's essential meaning is at least understandable.

Nonetheless, in hindsight, the interpretation clearly failed in the sense that it lead Stephanie to again break off the treatment. It should be pointed out, at the same time, that the therapist's move to interpret the dream as representing the emotional conflicts being experienced by the dreamer in the dreamer's waking life is perfectly consistent with the dominant discourse of the research literature on dreams and eating disorders. It will be instructive to critically review that literature before returning to Stephanie's narrative of her dream experience.

DREAMS AND EATING DISORDERS: A REVIEW AND METHODOLOGICAL CRITIQUE

The literature on dreams in relation to eating disorders is sparse. In one sense, this is surprising. The literature on eating disorders is extensive—almost a publishing industry unto itself—with literally hundreds of books in print in addition to the journals specifically devoted to eating disorders. Yet dreams are rarely mentioned; and where dreams are discussed, there is little or no systematic linking of dreams to any specific point in either the development of the disorder or recovery from it. This is true even for Jungians such as Woodman (1980, 1982, 1985), whose texts *are* filled with accounts of patients' dreams, yet frustratingly lacking in detail about just where in the process of therapy a particular dream appeared. Recent sophisticated narrative research specifically focused on recovery from eating disorders (Reindl, 2001) curiously neglects to consider dreams at all.

Contemporary empirical investigations of dreaming and psychopathology proceed from the continuity hypothesis, according to which dream content reflects waking life experience. Thus the argument is made that for patients dream content should reflect waking life symptoms. Our search of the literature revealed fewer than a dozen published articles on dreams of individuals diagnosed as anorectic or bulimic, along with an occasional doctoral dissertation (e.g., Levitan, 1981; Dippel, B., Lauer, C., Riemann, D., Majer-Trendes, K., Krieg, J., & Berger, M., 1988; Jackson, Davidson, Russell, & Vandereycken, 1989; Frayn, 1991; Brink & Allen, 1992; Jackson, Peter, Beumont, Thorton, and Lennerts, 1993; Brink, Allen, & Boldt, 1995; Touyz, Jackson, O'Kearney, Thornton, Russell, and Beumont,1996; Goldswain, 1998; John, 2000).

Consistent with the logic of the continuity hypothesis, the standard approach is to collect dreams from a diagnosed patient group and perhaps a control group over a period of days or weeks, and then code the dream content thematically. The themes of the dreams are then related to major symptoms of the disorder. Three broad themes that emerge from this type of study are food/eating, body distortion, and death. At first glance, each has a kind of face validity. That individuals with eating disorders are preoccupied with food and eating and therefore would have dreams filled with food imagery seems to require no explanation. The same is true

for dreams that focus on the size and shape of the body. As for death-related imagery, eating disorders can be and all too often are fatal. This fact has led some authors to theorize that dream content will reflect either a wish for death or alternatively those patients' dreams will reveal a theme of rejecting life. In the latter regard, for example, Bachar, Latzer, Canetti, Gur, Berry, and Bonne (2000) argue that rather than flirting with death, eating disordered patients struggle to restrict their existence to the narrowest possible parameters, in effect rejecting life. In a recent study that differentiates between dreams of anorectics and bulimics, Schredl and Montasser (1999) provide a more nuanced analysis. Their data suggest that anorectics' dreams show themes of food rejection, absence of interpersonal relationships, as well as rejection of the feminine role. Bulimics' dreams on the other hand show increased amounts of food and eating and are characterized by their negative tone.

It is frequently asserted that the fact that dreams reflect patients' waking concerns makes dreams useful for psychotherapy. Several problems with this claim, however, suggest themselves immediately. One, as indicated earlier, is that to date studies of dream content in relation to psychopathology have rarely if ever been longitudinal. Such studies provide little or no information about the status of the disorder for any of the patients in the eating-disorder group. Not only do we not know about severity of the symptomatology at the time of the dream, we are not given such information as whether the disorder had an early or late onset, type and amount of treatment, number of relapses, and so on. As Schredl and Engelhardt (2001) point out, in a recent review of the literature on dreams and psychopathology generally, such longitudinal designs should also begin to consider such variables as personality, cognition, and motivation for dream recall.

A second problem, particularly acute for eating disorders, is that the literature to date fails completely to consider the individual patient's commitment to recover. As anyone working with individuals with eating disorders knows all too well, many patients are hospitalized multiple times, each time determined to "beat the system" by enacting a pseudorecovery that gets them just above the threshold for release, followed by immediate relapse. This had been Stephanie's strategy prior to the time of the dream being discussed in this article.

To make the argument explicitly, we are asserting that knowing only that someone qualifies for a particular diagnosis is not an adequate basis for linking a dream or even a set of dreams to that specific disorder. At the risk of belaboring the obvious, let us recognize that psychological disorders are not constant over time. They get worse. Some get worse than others. They also get better. Moreover, individuals have different "relationships" to the disorder. In the case of eating disorders, individuals may actually consciously embrace and cultivate the disorder, sometimes for years. Not only will they not be motivated to change, they will defiantly and determinedly resist change (here see the literature on "egosyntonic" anorexia, e.g., Vitousek, Watson & Wilson, 1998; Bulik & Kendler, 2000; Serpell, 2000; Serpell, Treasure, Teasdale & Sullivan, 1999; Serpell, Teasdale, Troop, & Treasure, 2004). Just what transforms such a commitment to remain anorexic or bulimic into a desire for recovery is not well understood. Consequently the method of comparing dreams from those who have been diagnosed with a disorder with dreams from those not so diagnosed would seem questionable at best. Methodologically it would seem more appropriate to determine just what the state of the

disorder was and what the individual's relationship to the disorder was at the time of any dream that is to be linked to the disorder.

Equally obvious, but no less significant methodologically, a diagnosis does not define an entire person. Consequently, it is not apparent why a given dream or set of dreams should be linked to a given disorder. Patients with eating disorders often present with histories of sexual abuse, with comorbid diagnoses of depression or obsessive–compulsive disorder, as well as with serious ongoing interpersonal difficulties. In this regard, it is interesting that Schredl and Englehardt (2001) suggest that diagnostic classification is probably *not* related to dream content primarily but rather that dream themes may reflect the severity of the symptomatology.

Perhaps most important for the case being considered here, the dominant approach in which sets of dreams are analyzed for common themes fails to consider whether any one of those dreams may have been experientially significant for the dreamer. Indeed, studies of this sort do not consider the dreamer's response to the dream in any way. The dreamer's experience of the dream is replaced by fixed, written texts to be objectively analyzed for themes.

In contrast, this article advocates a case study methodology in which individuals are invited to contribute dreams that the dreamer specifically *experienced* as related to their eating disorder, especially those dreams that were recurrent or that for the dreamer experientially marked a specific point in either the development of the disorder or the dreamer's subsequent recovery. In advocating for such an approach, we are persuaded by Hillman's (e.g., Hillman, 1986) arguments in favor of studying the exceptional case. As he has pointed out repeatedly, accumulating or amplifying the typical cannot lead to an understanding of the exceptional. This outlook stands on its head the oft-cited methodological maxim that "the plural of anecdote is not data." Here we assert instead that no amount of data from typical cases adds up to an account of the exemplary, the exceptional, and the epiphanic. While knowledge of "ordinary" or typical dream patterns may be very helpful in establishing the context out of which the extraordinary appears, the extraordinary will not be reducible to the ordinary (Kelly Bulkeley, personal communication, 2005). With these methodological concerns in mind, we turn back now to Stephanie's account of her experience of her dream, which we present in the context of archetypal psychology's aesthetic approach to the dream.

STEPHANIE'S DREAM EXPERIENCE

In both the interpretive move made by Stephanie's therapist and the literature reviewed above on dreams and eating disorders, the assumption is that dreams are best understood as examples of representational symbolism (Hunt, 1989, 1995). In this type of symbolism, the connection of the symbol to the referent is fixed and singular. This is the approach taken by Freud, who interpreted the dream as if it were a book, a text that symbolically represents unresolved conflict in the patient's life narrative. The continuity hypothesis too starts from the assumption that dream content is representational. Hence it can be coded thematically or otherwise analyzed just as one would analyze a text.

At the heart of his discussion of what he provocatively called the "multiplicity of dreams," Hunt contrasts the representational symbolism of texts with the pre-

sentational symbolism of the arts. Hunt repeatedly emphasizes how in presentational symbolism symbols may have multiple meanings rather than a single, fixed interpretation. Such meanings emerge directly from an experiential absorption in the medium of expression itself (e.g., Hunt, 1995, p. 216).

Hillman makes the same point when he writes of the dream not as text but as context, as scene, as mood—a place that in the experience of dreaming we enter into and in turn are embraced by. As Hillman writes, "It (the dream image) doesn't lead somewhere else like a story. Thus the mind's activity can find nowhere to go but more deeply into the image" (1978, p. 160). Sticking to the image, then, for Hillman is in service of *animating* the image. As he writes in a marvelous little chapter titled, "A snake is not a symbol" in *Dream Animals* (Hillman & McLean, 1997):

> Animating the image—that is the task today. No longer is it a question of symbolic contents of dreams . . . both Freud and Jung made a move that we no longer want to repeat. They both translated (dream) images into crystallized symbolic meanings. They didn't let what appeared express itself enough, but moved toward satisfying the rationalizing—and often frightened—dayworld mind. 'This *means* that.' (p. 29)

For the study of dreams, both Hunt and Hillman insist that the experience of the dreamer, the dreamer's "experiential absorption" in the dream, is essential for understanding the meaningfulness of the dream, its significance in the life of the dreamer.

It was precisely this, Stephanie's experience of the dream that Stephanie never got to tell her therapist. Though the dream might appear to have been a terrifying nightmare, Stephanie reported that her first reaction upon awakening was not fear but relief. The dream *had* been terrifying; indeed she had felt nearly petrified with fear of what she referred to in a later interview as "the jumping alligator monster." Moreover this response was something she felt intensely throughout her body in the dream. It was precisely this, however, her intense bodily reaction in the dream that led to her reaction of relief. As Stephanie went on to explain, throughout the summer leading up to this dream she was fully aware of the possibility that she might die from her disorder. Her parents, she believed, had already given up on her in the sense that they no longer insisted or even encouraged her to continue in therapy. She herself had begun to wonder seriously whether it would be possible for her to recover. She experienced herself increasingly as inhabiting a state of consciousness utterly disconnected from her feelings, from passions of any kind. She had begun to wonder whether in some sense her body had already died. In this context, the experience of the dream was truly epiphanic. As Stephanie reported that experience, she awoke with the immediate realization that if she was capable of such intense feelings in her body, albeit her dream body, then she must not be dead just yet! It was this news she couldn't wait to tell her therapist. Her message in essence was, "I am *not* incurable. I *can* still feel things in my body. I *can* recover!" Her therapist never heard this message, of course; but Stephanie left the therapist's office determined to recover on her own. She began to eat, gained enough weight to convince her university's administration to readmit her to school in the fall, and resumed her studies. At the time of our first interview, she further detailed the areas of her ongoing recovery. She reported that she had continued to gain weight; she was more comfortable with her body in public situations and felt less and less need for wearing shapeless, loose fitting clothes; she felt more comfortable as well

with her sexuality and her sexual needs; and she was in a serious romantic relationship. At our later interviews, she continued to report improvements along these dimensions. Throughout, Stephanie remained determined to proceed without professional therapy.

Stephanie's experience, we argue, illustrates and illuminates the Hillman/Hunt view of the dream, here in relation to life threatening psychopathology. Understood in terms of presentational rather than representational symbolism, the dream provided a bridge between Stephanie's conscious mind, purged of all passions, and her starving, increasingly numb body. In that bridging, the dream reanimated both! This is of course the deeper implication of Hillman's call for "animating the dream." The life of the dream is not something produced by our interpretive efforts. Rather it is the dream that arrives fully animated and, if only the interpretive impulse can be postponed, that has the potential to animate the dreamer's experience. For Stephanie, it was the dream as dreamed, *prior to* any interpretation, that was revivifying, rejuvenating. In Stephanie's view, the dream was enlivening and in the context of her anorexia may well have been life saving.

The mythologist Joseph Campbell (1988) once said

> People say that what we're all seeking is a meaning for life. I think that what we're seeking is an experience of being alive, so that our life experiences on the purely physical plane will have resonance within our innermost being and reality, so that we actually feel the rapture of being alive.

In concert with Campbell, what Stephanie needed was not an interpretation of her dream, a meaning. It was the experience of being alive!

CONCLUSIONS AND CAUTIONS

Stephanie's epiphanic dream experience has implications beyond the purely personal. Clearly it had a salutory effect on her dissociative disembodiment and her motivation for recovery. In a broader sense, however, Stephanie's account suggests a corrective for the therapist's (and by extension psychotherapy's) detached, interpretive stance inviting renewed attention to embodiment, engagement, and experiential immersion in dreams—both by dreamers and therapists. Moreover, it presents a trenchant critique of the abstracted focus on meaning and representational symbolism that dominates the research literature, suggesting the need for a corrective emphasis on the truly exceptional dream and the epiphanic dream experience.

Nonetheless questions clearly remain. In particular, one might ask whether what we have presented here as the dream's animating power was purely a function of the form of the dream—its intensity, its vividness, or its surreal bizarreness. In that case, would *any* vivid, intense, bizarre dream have had the same effect on Stephanie; or was there something very specific about the content of this particular dream that was essential to its significance?

In many schools of thought, dream content is crucially important. To give just one very brief example, Woodman's (1980, 1982, 1985) argues, based in Jungian theory, that self-hate in the eating disordered patient is rooted in disconnection from the Great Mother. Woodman has described the mothers of eating-disordered

patients to be "negative animus dominated" while finding at the same time little evidence of "the healthy masculine" in the fathers of such patients (for a related argument, see also Spignesi, 1983).

It is not overly difficult, even for the non-Jungian, to recognize how Stephanie's dream content might be mapped onto such theoretical concepts. There is the image in the dream of the father as oblivious, clown-like, an image that might easily be read in terms of absence of the healthy masculine. There is too the image of the mother, visible but too far away to be of help.

As many readers of drafts of this article have suggested, an obvious interpretation of the dream, and one that does not require theory, would read the monster in the dream as symbolic of anorexia itself. In this light, Stephanie's decision to turn and stare down the monster could be understood as symbolizing her readiness to face her anorexia directly and change it. Stephanie herself had considered this interpretation prior to our interviews. She further reported, however, that the interpretation left her feeling both disappointed and dissatisfied. As she put it, the interpretation did not seem to help with her fear either of the monster in the dream nor her fear of anorexia. While the dream had played a powerful role in her decision to get better, she reported still feeling considerable fear that she would never "fully recover" and she went on to express some sense of confusion over just what full recovery would even mean for her. Moreover, the image of the monster was still very much alive in her imagination and a source of real fear. One of the things that motivated her participation in these interviews was her desire to deal with this fear.

How one might approach such a fear inspiring image in the spirit of Hillman's admonition to "animate the image" requires an explanation too lengthy for this article. In a forthcoming paper, I will detail this approach and how Stephanie and I used it to approach her dream monster.

Let me conclude, however, by acknowledging that the richness of the imagery of this dream clearly does invite representational interpretation. This admittedly polemical argument against interpretation is not intended to one-sidedly suggest that all such interpretations are useless. As Kelly Bulkeley (personal communication, 2005) has argued, what we seem to need is a more integrated approach that overcomes a strict, and he argues artificial, division between representational and presentational perspectives on dream symbolism.

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