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Recovery

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> For a long moment I stood before my own image, coming to knowledge of myself. Suddenly I saw all I was supposed to be but was not—taller, more ethereal, more refined, less hungry, not so powerful, much less emotional, more subdued, not such a big talker; a more generous, loving, considerate, nurturant person; less selfish, less ambitious, and far less given to seeking pleasure for myself.
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> Now, however, all this came into question: Who, I wondered, had made up this ideal for women? Who had imposed it, and why hadn't I seen through it before? Why, for that matter, did I imagine a slender body would bring me these attainments, even if I decided I actually wanted them for myself? And why, finally, wasn't I free simply to throw off this whole coercive system of expectation and be myself—eating, lusting, laughing, talking, taking?
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> —*The Obsession*, Kim Chernin

I was asked to write this paper from the position of both a professional and a recovered anorexic. I am frequently asked about recovery, both by my patients and those close to me, those who witnessed the transformation that took place in my own life as a result of the recovery process.

I had promised myself that were I truly to recover from anorexia nervosa, I would someday communicate to others who also suffer from eating disorders the "how" of recovery. I had imagined a step-by-step approach that would somehow end the terrible obsession.

My goal in writing this paper is to integrate both my personal and professional experiences. I hope that by discussing my own recovery, as well as describing how that journey now aids me in my work with eating disordered patients, I will provide useful information to the practitioner and hope for patients and their families.

The pain of recovery is difficult to describe, the raw exposure that comes from peeling away layers of feelings. Because no step-by-step approach exists, knowing exactly where to begin is difficult.

I believe four basic ingredients are necessary to provide fertile ground for the recovery process to occur. Acceptance that a problem exists, combined with a desire to get well, inner strength, and hope, were central elements to me, and these same elements are often expressed by other recovered persons. All four may not be present at the start but do surface as recovery progresses.

Acceptance needs to occur at two different levels of understanding: (1) recognizing that one has a problem; and (2) admitting that one cannot deal with this problem alone. For someone with an eating disorder, arriving at these levels of understanding can be devastating. Frequently the eating disordered patient up to this point has offered the persona of the well-put-together individual. This is the persona she feels she must give to her world. Most people accept this perception as true and reinforce it—to be perfect and "problemless" is the only acceptable way to take up space in a world already burdened with so many ills.

I had set up so many expectations for myself and had tried desperately to give everyone what I believed they wanted or needed from me. How could I let them down by expressing how truly unhappy I was, how weak I felt, perhaps even how angry I was that I had to be this person? How could I accept that my way of "being," a way of life that had worked for so long, was not working anymore? This was, perhaps, the primary letting go in the process of recovery.

I should mention here the number of times I have heard patients say: "When I told my parents (doctor, coach, friend) that I thought I had a problem, that I might be anorexic or bulimic, they told me I was overreacting, that I'm too 'put together' for that. Once I relieved some of the stress in my life, I would feel better." Responses such as these only reinforce the fear of disappointing others.

When eating disordered patients first come to me for treatment,

I can appreciate both the difficulty and the pain they suffer as they try to express to me that they no longer can do it alone. Months may pass before a patient can let down her guard. Trusting the therapist does not come easily, especially if that trust has been violated in the past.

Patients often come to treatment because they have been forced or coaxed. They have not yet accepted the fact that they have an eating disorder. Their priority is to be thin, and they believe they are fat. Although this perception of themselves may be distorted, it is their perception. I understand its reality. I shared that perception myself.

I can tell you from personal experience that the attempt simply to erase that perception is neither helpful nor possible. That self-image, that distorted image, is clung to vigorously. To me those perceptions were everything; without them I was nothing. My body was my only way of expressing my dissatisfaction with my life. By not eating I felt a sense of power; by the feeling of hunger, a sense of control. When life felt "crazy" around me, when my parents fought, when my opinion differed from someone else's, when I felt angry and unable to express my anger, I starved myself and felt in control.

Because it is counterproductive to impose my own perception on a patient, I find it more beneficial to address the unhappiness the patient brings into treatment. Often the patient is unhappy for having to seek help. An eating disorder is a symptom of something going wrong in a person's life. Focusing in this direction often engages the patient and offers her an arena in which to explore her confusion, fears, and feelings.

Patience on the part of the therapist goes hand in hand with acceptance. Essentially the therapist also must accept how threatening it feels for a patient to open up.

A part of me wanted my therapist to jump in and save me, to push the treatment along, not just to listen to my sadness. I wanted her to tell me exactly what I needed to do to make everything better. In retrospect, had it happened that way, I never would have learned that the answers and the strengths were within me.

That desire to "jump in" and save my patients is a vulnerability I have to keep in check as I work with them. I often just want to take their pain away. I know how much I needed to feel in control of the

process, a process that was frightening at times. My control over my own therapy is what ultimately empowered me to keep going, to learn about myself and my needs. It was as though my therapist and I joined forces to sift through the "stuff" in my life.

I admit one is tempted at times to take that power away from patients, especially when they present as helpless. Unfortunately this loss of power is often what they have experienced in their lives and within their families. To avoid reproducing this experience in therapy is difficult. Recognizing it when it does occur, however, is essential. Therapists, in their attempt to avoid overprotecting their patients, are often somewhat detached as a result. This is a delicate balance that must be achieved in the therapeutic alliance.

In my experience, feeling powerless created a feeling of helplessness, and underneath it all was a great deal of anger. Anger was a difficult emotion for me to identify, admit, or express. Anger in its most passionate form is rage, which is not considered an attractive trait in a woman. I was afraid of my anger, afraid of how potent it could be. Anger and eating were intimately tied. If I ate I was convinced I would be fat. If I let my anger out, I felt I might explode.

Therapy provided me the setting to explore this very real emotion of anger and this very real part of myself. A long time passed before I could talk about my angry feelings without defending the objects of my anger. I feared that if I expressed what I felt, I would alienate those I needed most, including my therapist. Exploring my anger was difficult but ultimately helped me feel safer and less helpless.

Hope is another essential ingredient to recovery. Exactly where the hope comes from is difficult to explain. For me, the feeling of hope changed and grew in intensity as I changed and grew. Initially it came from without, from the external changes in my life, along with my new working relationships with therapist, doctor, and nutritionist. Eventually it came from within, from all I learned to accept and appreciate within myself.

Some patients go from therapist to therapist or situation to situation searching for hope. I can remember clearly leaving an initial session with a new therapist, the one who ultimately journeyed with me, knowing I felt something different. This was after struggling three years with various therapists and medical doctors. Amid all the confusion and pain, I finally felt some hope. I did not know what it

meant. I certainly could not imagine being free of a food and weight obsession or of being truly happy. I just sensed a possibility that something could change. I did not always feel so hopeful throughout my years of treatment, but I could always be reminded of it as I progressed.

If I examine what else was going on in my life at the time, I can see more clearly why I finally began to see light in what felt like total darkness. Many changes were occurring simultaneously, which were actually providing me with more control and more possibilities. I had made a life choice that was not healthy for me. It followed a long-standing pattern of pleasing others and an inability to look at my own needs. This theme is not uncommon for anorexics or bulimics. Once I decided to reexamine that choice, I uncovered a whole range of emotions and possibilities. This was extremely frightening, as it was a major risk for someone uncomfortable with the unknown. However, it was a step I needed to take in my desire to get well. I understand now that there was much more to me than the pain and confusion I had known for years, or I could never have taken such a major step.

Along with my individual therapy, I also began nutritional counseling, group therapy, and medical observation, which included the use of an antidepressant. All this provided a support system I had never allowed myself. Though I had been struggling for years, I had never fully accepted the fact that I could not handle the situation alone. I was still trying to keep from burdening others. Now I found myself at a different place, the threshold of recovery. I felt afraid, even of the possibility of getting well, but, for some undefined reason, the act of giving in gave me hope.

This hope grew as I learned about myself in therapy, in a relationship with someone who gave me permission to be in this frightening and painful place, someone who was not afraid of my feelings, and, more important, was not overwhelmed by me. My therapist gently helped me to peel away the layers of unexpressed emotion and to experience myself and my body in a healthier and more appropriate way. The warmth I felt toward her allowed me to begin exploring what it meant to become a woman. When I sat with her, when I talked with her, when I looked at her, I was less afraid of that potential in myself.

A major part of recovery is learning to tolerate uncomfortable feelings and painful emotions. Somewhere along the developmental line, a person with an eating disorder learns or interprets that these emotions are not okay, that you are somehow defective if you feel or express them. To keep from feeling and to be in control at all times becomes a constant struggle. No wonder patients have difficulty identifying, let alone expressing, what they are feeling. My parents had difficulty seeing me unhappy. In their attempt to protect me from the pains of growing up, they gave me a message: "Don't feel bad." When I did, I felt paralyzed. Their intention was not to be malicious, but the message got muddled up for me. This often happens to eating disordered patients.

I know that patients need to feel that the therapist can tolerate their feelings and accept them. At the same time the therapist needs to be aware of her own reactions in order not to transmit similar messages. Speaking personally, I need to integrate my ability to identify and consequently to empathize with my patients, along with my ability to set limits or boundaries, respecting their needs. This balance, I believe, can provide the hope I have been speaking of.

One goes through stages of recovery, as well as areas or experiences, that need to be addressed and readdressed.

The physical self can no longer be avoided, as the mind and body are so intimately connected. The bottom line for most eating disordered patients is that they need to gain weight or accept the weight at which their body seems comfortable. Sometimes this is essential before true intrapsychic work can be done, and hospitalization may be deemed necessary. One cannot recover without beginning to let go of the symptoms—the starving, the bingeing, the excessive exercising, the purging.

For me, letting go of the symptoms and gaining weight was a process in itself. I can remember literally holding myself down at times so I would not go out and exercise. I also needed to force myself to drink a nutritional supplement to increase caloric intake. The discomfort was frequently intolerable. I often cried. I kept telling myself, "If I can just get through a month of this, then I'll know I won't have to get fat." I had to trust what my nutritionist had told me.

Tolerating this discomfort was the beginning of learning to toler-

ate other uncomfortable feelings, such as anger, anxiety, and dependence. Only after a long while did I not feel the urge to return to old patterns or means of control, and when I did, that too became uncomfortable. Nothing worked anymore. Running from my feelings became as uncomfortable as feeling them. Now I had choices, and this was progress. Progress, however, was frightening. I have often told people that at times my recovery was more difficult than being "sick." The desire to get well is an essential first step, but enduring the treatment can feel impossible at times. Getting better means one has to say good-bye to some very old friends—one's symptoms—and the loss needs to be grieved.

As a therapist, I find that seeking the aid and expertise of a nutritionist is helpful. Personally it was a must in my own recovery. This support correlates to the therapy as the patient is guided through the physical changes that occur and is encouraged to make these changes by someone other than therapist, doctor, or family. Simultaneously the work of learning to tolerate feelings is occurring in therapy.

In the same vein, the eating disordered patient needs to be evaluated and followed by a physician, primarily because of the medical risks. I spoke earlier of the mind/body connection; it follows that the medical, nutritional, and therapeutic means must be integrated. At first I felt that I just needed to feel better physically. I was so entrapped by my symptoms that I could not focus on anything else. This is true for many eating disordered patients. I was so in tune with my physiological self that my digestion and my bloated stomach were foremost on my mind. I believed that this is what made me unhappy. When I was forced to seek out a doctor, several tries were needed to find someone sensitive and aware of what I was experiencing. A part of me knew that I needed to gain weight, but another part needed to be in complete control. Two physicians told me to go home and eat; another said that my stomach problems were the result of stress and worry, so I should stop worrying. Not until I met a doctor who understood that much more underlay my symptoms was recovery made possible. I remember my first visit to that doctor, and asking, "How long will it take me to feel better?" I also remember the response, "Maybe by next summer you'll begin to feel better." I think I felt angry, certainly challenged, but I did not miss my

next appointment. I did not hear what I wanted to hear, but it must have been what I needed to hear. I wanted a quick fix, but when the other doctors offered me that, I felt misunderstood and alone. Finally someone understood. She did not negate or ignore my symptoms. In fact, she focused on them and let me know they were real. She did not stop there. Once I felt listened to, I allowed her to hear my pain and she helped me look at my options. I had wanted my therapist to take away my sadness, as I now wanted my doctor to take away my symptoms.

My relationship with all three of these helping professionals was unique and powerful. Each was exposing, challenging, and supportive. It was exposing to have to get on a scale. It was exposing to have to discuss what I ate. It was exposing to have to express what I felt. I say all this to reinforce the importance of integrating the mind and body. Symptoms get played out in all aspects of a patient's life. To separate these pieces seems futile.

Discussing one's symptoms in therapy, individual or group, is somewhat controversial. Patients have told me that a previous therapist did not allow or believe it useful to spend time or energy in this realm. Although going directly to the underlying issues can be valuable, ignoring the symptoms and how a patient feels about those symptoms is missing a crucial part of the recovery process. An essential aspect of therapy is respect for where the patient is. Some patients need to talk about their symptoms; others avoid it. No hard or fast rule exists except to flow with the patient.

As I discussed above, initially the obsession, the symptoms, and the behaviors feel like the source of the major discomfort. At times I would go into a session feeling anxious about my weight or I would be thinking only about my desire to eat something. I could not understand how all this connected to my family, my work, my relationships, and so forth. All I felt at the time was desperation. This was the part of me I felt ashamed of, the part of me I hated. I needed to be able to talk about this. Perhaps it was avoidance, but talking about it led me to what I was avoiding. When I didn't talk about it, I felt deceptive, as though I were hiding from my therapist, as I hid from the rest of the world. If I could not talk about it at my therapy session, then where?

As time went on, I more fully understood and experienced the

connection between my symptoms and my feelings, my way of coping. Even with that understanding, I often needed to return and talk about the behavior and the shame. I felt I had let so many people down, including myself.

Sometimes therapy intensified the obsession. Symptoms can get played out in therapy and can be useful to the therapist. This can signal that something is going on in the relationship.

Initially the more dependent I felt on my therapist, the more obsessive I became. Being able to talk about all this helped me to learn, as well as to experience, the connection between my inability to eat and my fear of growing and separating from those to whom I felt attached. This also aided in strengthening an alliance with my therapist, who did not treat me with disgust or bewilderment. Her acceptance helped to ease my shame and helped me to address it.

Therapists must be aware of their own feelings about the behaviors that an eating disordered patient brings to therapy. The therapist's own discomfort may cause the patient to resist talking about such primitive behaviors. One also needs to examine one's own feelings about weight, food, and body image, as these messages can get transmitted.

The patient needs to recognize that letting go of symptoms is part of, but different than, letting go of obsessing. Much more work needs to be done before one can give that up. I would often question whether I was truly getting better since the food and weight obsession, though lessened, still had a place in my life. I recognize now that the obsessing was the last to go. As I became fulfilled in other ways, through my personal and professional life, I no longer needed the obsession.

An outsider, a therapist, a family member, or a friend can easily get excited and hopeful on seeing symptoms decrease, such as when the patient gains weight or reports that purging has ceased. One needs to remember that this is only a part of recovery and that the sufferer may not be as excited or hopeful. A patient has difficulty hearing someone say, "You look good" or "You look healthy." This is often heard as "You look fat" and creates panic. Initially the feeling of being bigger, fuller, is awful. Others need to be sensitive to this.

A patient recently expressed a situation to me that brought back

vivid memories. She reported trying on old clothes that were sizes too small, and consequently very tight. She told me she "freaked out"—cried and screamed for about half an hour, and then decided she needed to get rid of them all. This felt like a turning point. Those tight clothes reflected so many of her fears and gave her the opportunity to emote her anger at having to give up that control, at having to change. She had to look at her struggle with needing more food and taking up more space.

At times I just wanted to disappear. I felt I was not entitled to take up space because I was imperfect. Losing the weight was like losing myself. I was also sending out a signal that something was wrong. As ashamed as I was, I wanted someone else to see my pain and to help me with it. I wanted to be understood. I wanted to know that I was loved and accepted no matter what. It took a great deal of work—the work of recovery—to allow me to let go of the life-threatening mask I had learned to wear. It took growing, in every sense of the word. "As a child she is praised and rewarded with approval for being 'good' when she puts on a smiling and cheerful face. No attention is paid to the painful underlying misery, of which she too is scarcely aware" (Czyzewski and Suhr 1988).

Growing up is not an easy process, but the attempt to arrest that process is even more difficult. Going forward is often frightening and filled with fear and uncertainty; a person may attempt to stop or interrupt this movement forward.

Growing up means that the body must change and develop. It means separating, taking risks, and moving away from parents. Growing up means making decisions and making mistakes. It means growing into a more sexual being, feeling new sensations, and getting to know one's body in a more intimate way. Growing up is filled with mixed emotions and often mixed messages. It offers challenge, excitement, change, choices, as well as fear, disappointment, responsibilities, and the eventual enduring of many necessary losses. In a nutshell, growing up can be overwhelming and has much in common with recovery.

As I listen to patients talk about their experiences growing up, their concerns and beliefs, their fears about moving beyond their parents, and their discomfort with getting bigger, their struggles make a great deal of sense to me. The world we live in is not such a

safe place, and our own personal worlds may feel even less so. Our culture places many expectations on women; although some of those expectations are changing, we are still caught in the middle, battling the transition.

Eventually I learned that recovery did not mean getting rid of the fears. Instead, it meant moving forward in spite of them. Essentially it meant giving up the need to control my world so tightly. I had to learn to tolerate uncertainty and not to be controlled by the pressures placed on myself as a woman to be thin, passive, and pleasing.

Listening to a patient takes on many different forms. "The most fundamental skill of the psychotherapist is productive listening. Everything else the therapist does needs to be founded on his developed ability to hear on many levels simultaneously. Such listening is much more than passive recording; it is a dynamic alertness which involves many sense modalities plus intuition, reflection, and cultivated empathy" (Bugenthal 1987).

What has become essential in my work as I listen to patients is my ability to also hear what is happening inside me. My own feelings often give me vital information about what my patient might be experiencing or avoiding. This countertransference challenges me to continue my own growth personally and professionally. If used appropriately, it can also challenge the patient.

For example, one patient may come in ready to talk about her discomfort with her body and her fear of gaining weight. She reports feeling out of control and then brings up her fear about moving into a new relationship. Sexually she feels inadequate, yet desirous. She reports having difficulty dealing with her need to please and her guilt about wanting to be pleased. I hear her plight; as we begin to explore her feelings, I find myself feeling angry that we live in a society where women are still confronted with these conflicts. I also feel sad, as I sense the pain that accompanies her fear. I wonder if she feels angry or sad, though at the moment she is only expressing self-disgust at her lack of discipline. "Maybe I am just not hard enough on myself." I do not want to impose my feelings on her; but, for the time being, I make a mental note of the messages I am getting.

Another example is when I feel stuck in a session or a number of sessions. This often means that the patient is feeling the same way.

What is keeping us stuck may be a subtle collusion on my part to avoid moving into some feelings that I, too, find uncomfortable.

This situation occurred recently as a patient was describing her relationship with her now-deceased mother. As she struggled to move through her guilt and shame in order to allow herself to feel angry at this woman who had been unable to meet her needs as a child, I too found myself struggling. I had to struggle to try not to protect her from these feelings, as I had wanted to be protected, nor to protect her mother, who may not have known better, much like I had wanted to protect my mother.

Protecting my family felt much safer than looking at what my body was telling me. It was a challenge to let myself feel angry and cheated, since I feared losing my parents' love and admiration. How could I be so disloyal to the two people who loved me the most? More important, how could I survive if I were to lose that love? Participating in a therapy group facilitated this process for me. Being in a supportive environment that at times felt like a family, I was able to express and test out what I was genuinely feeling.

I believe my parents did the best they could and never meant for me to suffer in any way. Unfortunately, at certain critical points in my development, this was not enough. Do I blame them? No. But I did need to explore the impact these crucial relationships had on me. I needed to give myself permission to deal with what was lacking, what was not so positive, before I could recognize the strengths that were given to me as well. That I was capable of building a positive alliance with my therapist was proof that I was already using one of my strengths, a way of relating to another, who at the time was very much like a parental figure. Though, as Hilde Bruch would point out, while many misconceptions about myself needed to be exposed and corrected, some very positive aspects of my personality also needed to be recognized and owned.

As a therapist, I sometimes have difficulty bringing a patient back to painful memories or experiences that may have fostered these misconceptions. I am not immune to these experiences, and although they do not have the same power in my life, they do hold a place. I recognize this even more since becoming a mother. Many issues that seemed to have been laid to rest through my own therapy begin to emerge again in a new way.

My pregnancies and mothering have had a significant impact on my work as a therapist. During my pregnancies, I once again had to experience my body growing and changing. Much of the time during the early months of pregnancy I had little or no control over how I felt physically. This brought back horrible memories and feelings at a time when I was supposed to be happy and full of life.

Once again, I experienced the disappointed looks from those who loved me and found it difficult to tolerate my feelings. I recognized how easily I had slipped back into taking so much care of everyone else. The difference this time, as a recovered person, was that I could call on the resources I had developed through therapy; I knew I needed to take care of me, whatever the cost. My response to the situation was a healthier one, though the conflict was just as painful.

I did not immediately inform my patients when I knew that I was pregnant, although some of them appeared to be keenly aware that something was different. I seemed less available, and some patients felt I had abandoned them. I felt guilty that my emotional energy was now turned inward and that others were getting less of me. Of course, this is true for all of us in this profession at different times in our lives. Again, it is a matter of learning how to use these significant times productively with patients.

Clinical supervision was essential for me during both my pregnancies as it helped me sort out my feelings. Initially I defended my position on a subtle level with patients. In doing so, I avoided the emergence of important material. Once I worked these feelings through, I was better able to help patients deal with their own feelings of abandonment in their lives.

Abandonment is a frightening and painful issue and resonates with many eating disordered patients. The fear of being left, especially if one is not perfect or deserving, is very real. I became even more empathic toward my patients' feelings about abandonment after the birth of my second child. At the time I was intimately involved with my first child's feelings of being pushed aside. I could also understand on a deeper level what I must have experienced as a child, being one of six children. How much I wanted to protect my firstborn from such painful feelings, yet I knew I could not. As I have mentioned before, the same holds true for my patients. Often I want to protect them in the same way. Instead, the best I can do is to sup-

port them consistently through the very human experiences that are part of any meaningful relationship.

I think it is important here to describe briefly the experience of being pregnant—of growing bigger, of watching my belly, my thighs, and my breasts expand. Although it may be hard for eating disordered patients to believe, it was a wonderful experience for me. As the uncomfortable physical symptoms subsided, I began to feel full of life, in every sense of the word. I enjoyed my round belly and full breasts, parts of my body I had spent years punishing myself for. I felt sensual, a feeling I had worked hard denying. My being exposed in such a sexual and feminine way created anxiety on the part of my patients. It also fostered openness. Some patients were able to begin talking about their own sexuality, their own desires and fears. I, too, was less afraid to venture into this intimate area of concern.

I believe my fond feelings toward my body as it continued to grow were evident. This in itself, I feel, was a gift to some of my patients, an opportunity to see that other ways exist of viewing and embracing one's body as a woman.

Becoming a parent has been yet another experience that has helped me grow and let go beyond my wildest imaginings. It has also pushed old buttons, as well as given me new vision professionally. Since I have become the mother of two enchanting daughters, my ability to empathize has grown stronger. As I watch them grow, I often wonder if my struggle to support them through their developmental stages would be different had they been sons. My response is, I hope not, yet I cannot help but wonder. Contradictions abound today. How do we teach our daughters to be assertive, strong, expressive, and confident, as well as nurturing, kind, respectful, and compassionate? How do we teach them that when striving not to be selfish, one does not have to be selfless?

Today we tell our children that it is okay to have feelings, that it is okay to be angry. But do we really give them the freedom to express that anger as they move through stages of growth and assertion that are filled with frustration and confusion? I believe many mixed messages are conveyed to young girls today.

I listen to patients' pain around growing and separating. I hear them say: "I used to be so good, so nice—everything seemed perfect. Now I hate myself and it's an effort just to smile."

They seem to be living proof of that very contradiction, and nothing anyone can say will make it easier. Now they work at defining themselves in a new way, feeling terrified of who they might become. I see their strong wills and gentle souls trying to merge—strengths that have become an illness because the conflict is too much to bear.

I see beautiful women, young and old, loathing their bodies because they do not quite meet society's standards for thin and firm.

I wonder how I will protect my daughters from all this. How do I help them embrace who they are and know they have something wonderful to contribute because they are both strong and sensitive—in essence, how do I protect them from all that I struggled with as a young woman and continue to confront as a mature woman in today's society?

Having daughters has made me recall some of my own struggle at different stages in my life. In turn, it has helped me to be more sensitive to my patients.

I have come to understand more fully the pain of a parent who has to learn, as I do, that we cannot protect our children from everything. Knowing when to protect or support or guide or let go is a complex part of parenting, as our own desires to have had these needs met in our own childhood may surface.

A bit should be added here about the family's struggle. Initially, eating disorders may get translated in families as just a problem involving weight loss and food. Parents feel helpless, frustrated, responsible, and often angry at the control being exercised by the child because of her illness and symptoms. They need to be helped and often educated about anorexia and bulimia.

Patients often report feeling guilty about how their eating disorder is affecting their family. At the same time they are crying out for help—for themselves and for their family. In therapy they may talk about the pressure they feel to be the model child or their desire to make everyone happy. They want to be separate yet fear the thought of it. They have a difficult time owning their right to life and enjoyment, despite their parents' plight.

I thought that getting the perspective of a mother who experienced recovery through her daughter might be helpful. I asked my own mother for her insight. She expressed the helplessness I spoke

of and the fear that I would never be well again. She told me: "It was a nightmare. You just looked so forlorn, so unhappy. All I wanted to do was hold you and tell you it would be okay. That upset you even more, because you knew I could not possibly understand the complexity of your illness, what you were going through. Your illness consumed me. The frustration was that I had no idea how to help you, so I had to get help for myself."

She also expressed feeling responsible and guilty. She recalled: "I had to struggle with the guilt I felt all the time, knowing that even though it had not been on purpose, somehow I was related to the cause of this dreadful illness. I did not know what I had done wrong, but I suffered the fact that I was involved by something I had or had not done, however inadvertently."

Families can also recover and be helped through this process. To quote my mother again, "As I look back now I realize that this was a journey you needed to take—I felt that the day you could laugh at yourself and your imperfections was a great step, and something to celebrate."

Every patient's story is unique. It is possible that relationships with family members cannot be healed in the same way that mine could. This, however, does not mean that healing within the individual is not possible.

I have given a few examples of countertransference, whereby what I began feeling in a session gave me information about my patient and about myself. I would like to add that what I find myself taking on or experiencing with a patient can also give me essential clues about how a person interacts with others, what kind of feelings she may evoke in them.

Relating to a resistant teenager who was in treatment with me, I found myself feeling angry and helpless at times. When I was able to engage the family in treatment, it was telling to see these same feelings being enacted by the parents and siblings. Along with that, I needed to recognize my own feelings of helplessness when I have no control over a situation, some of my own memories of being a teenager, and my patient's desperate need to be in control. I needed to understand my own reactions more clearly so I could better understand my patient, and thus respond more appropriately, and perhaps differently, than the rest of her world.

Self-disclosure remains a highly controversial issue. This fact needs to be mentioned at this point, as the very process of writing this paper has made me expose myself in a very personal way. I have also spoken to groups about recovery and, in doing so, have disclosed a part of myself to patients. This adds another dynamic to the therapeutic experience.

Alan Ivey (1983) talks about self-disclosure as a skill, one that is utilized whenever a therapist uses an "I" statement or expresses a personal thought or feeling: "It is a form of self talk, and the complex task is in making this self talk relevant to the client."

Some patients seek me out because they know my history. My presence alone creates a sense of hope for them. This, however, can turn into competition, even hostility, especially when therapy becomes more difficult. It is important for me not to avoid these feelings. Avoidance on both our parts would certainly hinder our relationship and our ability to work productively together.

Some patients who have this so-called advantage of knowing my history (and even some who do not) will ask indirect questions or make general comments, as if searching for something. It is as though their connection to me will somehow magically make things better. I often have to work harder with patients who know about my recovery, to maintain appropriate boundaries and not attempt to fix their problems quickly.

I also find that self-disclosure has advantages. Patients have expressed having less difficulty with openness earlier in treatment. They expect that because I have been "there," I will understand and make sense out of it for them. I tell them, "Yes, I understand, but I cannot make sense out of it without you. That is our job together."

When I speak to interest groups and support groups, my goal is to provide hope and helpful information, as well as to be a positive role model. I find that this can transfer to therapy.

Some patients express both relief and frustration that they cannot hide from me, especially in terms of symptoms or defense mechanisms. I do not think this is entirely true, but it certainly adds more grist for the therapeutic mill.

Throughout this paper I have been discussing basic understandings as well as underlying themes that seem to resonate within individuals suffering with, and recovering from, anorexia and bulimia.

However, many stereotypes and generalizations clearly get overplayed and overused. They can also be offensive. I am always angered to hear a colleague make derogatory statements about an eating disordered patient or to read material that does the same; for example, the statement "I hate working with these patients; they are so manipulative and deceptive" or "All eating disordered patients are borderline."

On one level I admit that it hurts and saddens me that this disorder is so misunderstood. Perhaps the basic drives and fears that must be addressed in therapy provoke too many uncomfortable feelings. Perhaps the patient's feelings of worthlessness are too much for the therapist to bear. Whatever the reasoning, I believe we should be more cautious when responding to one another, checking our own reactions before speaking or acting them out. We owe this respect to our patients and to one another.

I began this paper by stating that I am often asked about recovery. More specifically, I am asked how I knew I had recovered. One of my hopes in writing this paper is that the reader will come to understand the complexity of that question.

Had I recovered once I gained back enough weight to have my menstrual cycle return? Had I recovered once I could tolerate wearing bigger sizes? Had I recovered when I happened to glance at my chart in the doctor's office, which read, "Diagnosis—Anorexia Nervosa/Recovered"? Had I recovered when I could express anger appropriately? Had I recovered when I could start making important life decisions based on my needs? Had I recovered when I could listen to my hunger? Had I recovered when I could tolerate uncomfortable feelings without starving myself? Had I recovered when I could laugh again?

The best answer I can offer to all these questions is that all these experiences were a part of my recovery, and not necessarily in the order I wrote them. They happened. Through therapy, through commitment to my own well-being, and through support, recovery happened! By dealing with my pain, facing my fears, it became possible for me to grow—in every way.

I also need to say that full recovery is possible. Patients need to stay committed to their work even after symptoms disappear. The journey is long but one that does have a light at the end of the tun-

nel. All that I feared, the hurts I felt, even the desire to be on top of things, have not disappeared. I am, fortunately, still a human being but one who is living life more fully, thankful for the privilege of being a part of other patients' journeys, and especially thankful for the great gifts of faith, hope, and laughter!

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