Rapid Remission of Anorexia Nervosa and Unconscious Communication

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Abstract
An alternate framework for thinking about anorexia treatment is presented with a treatment approach that results in prompt remission of anorexia symptoms. Prior treatment of eating disorders using hypnosis is reviewed. A case example illustrating the method is followed by a discussion. The process is described for teaching clients how to nullify the anorexia symptom complex when it is reactivated.

Key words: Anorexia nervosa, eating disorder, unconscious communication, ideomotor signaling, ego-states.

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The treatment of eating disorders (ED) like anorexia nervosa (AN) and bulimia nervosa (BN) pose significant challenges to both affected individuals and treatment providers. Scientific investigation points to significant genetic and heritability factors linked to the ED symptom complex (Bergen et al., 2003; Becanu et al., 2005; Bulik, 2006; Bulik, 2007; Bulik, Sullivan & Kendler, 1998; Grice et al., 2002; Mercader et al., 2007; Ribases et al., 2003; Ribases et al., 2004; Ribases et al., 2005; Devlin, et al., 2002; Gunstad et al., 2006; Frielings et al., 2007; Frielings et al., 2008; Steiger et al., 2006; Javaras, Laird, Reichborn-Kjennerud, Bulik & Pope, 2008; Klump, Miller, Keel, McGue and Iacono, 2001; Kendler et al., 1991). These diseases are systemic in their symptomatic expression and influence on thought, mood, perception and behavior. Much of the AN and BN symptom complex demonstrates trance phenomena (Edgette & Edgette, 1995) that include time distortion, hallucination, catalepsy, amnesia and dissociation (Torem, 1986; Valdiserri & Kihlstrom, 1995a, 1995b; Vanderlinden & Vandereycken, 1990; Covino et al, 1994) with some indications that bulimics may be more hypnotizable than anorectics (Pettinati et al, 1985; Sanders, 1986).

Behavioral management of the ED may keep a person healthy, but clients have reported to this author that it often does little to resolve inner torment from this chronic illness. Given the deep and comprehensive level of psychobiological functioning expressed by the ED (Rotenberg, Taylor & Davis, 2004; Ribases et al., 2003; Mercader et al., 2007; Kaplan, 2004; Klump, Bulik, Kaye, Treasure, & Tyson, 2009), deep levels of functioning must be reached to effect more than behavioral change.

Documentation of ED treatment using hypnosis is largely anecdotal and without supporting empirical research. Pierre Janet (1925) described hypnosis applied to “hysterical anorexia” to inspire a woman’s eating by increasing focus on tactile and visceral sensations (Baker & Nash, 1987). Reports since 1925 reflect direct and indirect suggestive approaches as well as psychodynamic investigation aimed at resolving ED symptoms or uncovering causal factors. Direct suggestion targeting sensitivity to hunger and fullness, body image distortion and involuntary dissociative states was applied with noted benefit (Comani,1992; Pettinati, Kogan, Margolis, Shrier, & Wade,1989). Enhanced self control and motivation regarding binging and purging reportedly resulted from direct suggestion (Griffiths,1989; Vanderlinden & Vandereycken, 1988, 1990). Ego enhancing suggestions, age regression, and hypnotic dreaming reportedly targeted the underlying ED dynamics with some success (Pettinati et al., 1989). Suggestions for increased enjoyment of food, coupled with amplified hunger and food intake, reportedly bore positive results (Crasilneck & Hall, 1975: Kroger & Fezler,1976). Thakur (1980) disclosed success with direct suggestions for healthier eating habits, increased weight gain and realistic body image. Theissen (1993) indicated benefit by hypnotically incorporating fairy tales with the eating disordered. Erickson (Erickson & Rossi,1979) used indirect suggestion and paradoxical interventions to treat an anorectic girl. Yapko (1986) employed indirect suggestion to address family enmeshment, delayed maturity, self-esteem, and body image with an anorectic girl. Some noted hypnosis helpful in the reduction of tension and resistance to treatment, management of ED symptoms, and identification of affect in the eating disordered (Lynn, Rhue, Kvarl, & Mare, 1993; Hornyak,1996). Gross (1984) outlined a hypnotic protocol for enhancing sensory awareness, correcting distorted body image and increasing a sense of self control. Torem (1987,1989, 1992) employs ego-state therapy (Watkins & Watkins, 1997) combined with other modalities intended to establish healthy eating patterns, resolve obsession with food, and relieve body image distortion. Because trance provides a receptive context for corrective thought, hypnosis finds merit as a useful adjunct to cognitive behavioral therapy (Beck, 1976; Ellis,
A different framework for thinking about anorexia treatment

From the foundational contributions of the above-mentioned clinicians and investigators and from the following scenario, a new way of thinking about unconscious work with eating disorders evolved. An ideomotor signaling technique, while lacking empirical support, can be employed as a type of metaphoric tool that allows clients to extend their own efficacy regarding a problem. Upon using the metaphor or process of questioning an anorexic girl’s unconscious using ideomotor signals (Cheek, 1994; Cheek & LeCron, 1968), this author asked if the anorexia could be fully arrested. An affirmative response led to other questions about when and under what conditions this arrest could happen. Inquiries ultimately seemed to reveal a group of ego-states (Watkins & Watkins, 1997) fully invested in the ED. Trusting the ED could be arrested, ego-states were informed of a pending shutdown of AN which would result in no functional direction for these ego-states. New functions, posited as “jobs,” were created and presented to the ego-states. When all AN contributing ego-states accepted new jobs, the unconscious indicated AN could be arrested. The ensuing arrest resulted in rapid remission of AN symptoms. Refining this approach and applying it to several dozen other clients with similar outcomes resulted in a different way of thinking about ED treatment.

The perspective guiding much of what follows recognizes how unconscious communication can appear to alter physiological experience (Spiegel & Moore, 1997; Erickson & Rossi, 1979; Rossi, 2002; Rossi, 1988; Saadat & Kain, 2007; Stewart & Thomas, 1995; O’Hanlon & Hexum, 1990; Butler, Symons, Henderson, Shortliffe, & Spiegel, 2005), how ideomotor signals are physical expressions of the unconscious (Cheek, 1994; Cheek & LeCron, 1968), how scientific evidence implicates genetic contribution to much of the ED symptom complex, as cited above, and how gene expression can be influenced by factors outside the individual (Owen, Treasure & Collier, 2001; Kas, Van Elburg, Van Engeland & Adan, 2003; Siegfried, Berry, Hao, & Avraham, 2003; Schanberg, Ingledue, Lee, Hannun, & Bartolome, 2003; Weaver, Cervoni, Champagne, et al., 2004; Bittman et al, 2005; Oberlander, Weinberg, Papsdorf, Grunau, Misri, & Devlin, 2008; Dusek et al, 2008). How might a relatively simple sequence of ideomotor questioning disrupt this disease process? The factors at play within the individual during this intervention are unknown at this time and can only be conjectured.

Client reports and behavioral and collateral observational evidence derived from 24 AN cases, display consistent results. A deep level of AN functioning seems to be accessed and arrested through a particular sequence of therapeutic communications imagined to be with the client’s unconscious. This approach employs both ideomotor questioning (Cheek, 1994; Rossi & Cheek, 1988) and ego-state therapy (Watkins & Watkins, 1997). Because application of the method described below seems to nullify the driving force fueling AN symptoms, the client’s internal struggle involving thought, perception and behavior is reduced significantly and therapeutic change is more easily facilitated. Symptom remission most often occurs within four treatment sessions once the process described below has begun.

The case example cited met the diagnostic criteria of the Diagnostic and Statistical Manual for Mental Disorders (DSM IV) (American Psychiatric Association, 2000) for anorexia nervosa and was treated at a multi-disciplinary outpatient eating disorders clinic (Kartini) serving youth up to 22 years old. This author contracts services to the clinic as one part of a team offering medical and pharmaceutical management, physical therapy, yoga and individual, family and group psychotherapy.
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**Intervention prerequisite**

Because starvation significantly affects psychobiological functioning it is essential that the AN patient be sufficiently re-fed before attempting an intervention like the one that follows (Keys, 1950; Meehan et al., 2006; Choma et al., 1998). Re-feeding may occur with supervised meals at home or in a clinical setting or using nasogastric tube feeding. Most psychotherapeutic interventions will have little or no effect until the body has adequate nutrients to restore the pre-morbid, baseline cognitive facility. The following method is best applied after the affected individual has achieved at least ninety percent of estimated healthy weight.

**Method**

**Initial Assessment**

Following the development of rapport, assess the client’s motivation for change, and identify the type of change that is desired. Does the client want to continue being controlled by the ED? Proceed with this intervention only after the client convincingly expresses a desire to fully manage the ED or to have more choice about the ED. Be aware that some level of ambivalence will be common for most cases.

The Rating of Eating Disorder Severity (REDS-C) interview (Goldner, 2000; O’Toole, 2000; DeSocio, O’Toole, He, Koeller, Baird, & Lukach, 2008) is administered by the attending pediatrician. This is a 16 item semi-structured interview designed to assess the severity of eating disorder symptoms in children and adolescents. An adult version of this interview (REDS) was originally developed by Elliot Goldner (2000) at the University of British Columbia. Older adolescents and adults were the target age group for the original REDS.

In 2000, Julie O’Toole (2000) developed a child version of the REDS, with permission from Elliot Goldner (personal communications, 1999). The REDS-C revision involved changing the language to make items developmentally appropriate for children and adolescents, e.g. “school” was used instead of “work.” Summation of ratings on the 16 symptom items yields a total child symptom score ranging from 0 to 77. Summation of the 16 interviewer confidence ratings yields a total confidence score ranging from 0 to 64. Most often the REDS-C is done at the beginning of clinical treatment and at a six month interval. The REDS-C has proven to be a reliable indicator of ED severity and predictor of relapse. Information about the REDS-C functional merits has been prepared for publication and will soon be available (DeSocio et al., 2009).

**Communication and rapport with the unconscious**

Body language is a commonly recognized expression of the unconscious (Segerstrile & Molner, 1997). Communication with the unconscious is effectively facilitated by developing a specific, mutually agreed upon body language known as *ideomotor* (Latin roots: ideo=idea/thought & motor = movement) or *ideodynamic signaling* (Cheek, 1994; Rossi & Cheek, 1988; Cheek & LeCron, 1968). Clients are instructed to avoid conscious volition and allow the unconscious to lift one finger to signal “yes” and a different finger to signal “no.”

Inform the client that the unconscious is there to help and is communicating all the time through body language and that such language can be responsive to verbal questioning. Ask the client to rest hands comfortably so all fingers are free to move. Suggest client focus on something very positive or visualize the word “YES” as the unconscious apparently decides which finger is most appropriate to lift up as a “yes” signal, allowing all the time necessary to develop that signal. Scan the hands for any movement and take note of distinct movement in a particular finger as a “yes” signal. As the “yes” finger rests, ask the client to focus on something negative or visualize the word “NO.” A different finger on that same
hand will lift up to signal “no.” Of course, when doing ideomotor questioning, all questions must be geared for a “yes” or “no” response. It is best to keep questions simple. Some individuals will initially require added time for information and experiences demonstrating the function of the unconscious.

Ask the client to allow her (or his) unconscious to respond to questions through the finger signals. Request the client’s unconscious to develop a deep comfort and calm. Await a finger response to indicate this deep calm has occurred. After comfort is acceptably established per client affirmation establish a physical anchor for comfort (Walsh, 1997) so the same experience can be reestablished whenever desired. One option involves asking the clients to touch two fingers together on the non-signaling hand and then asking if the client will access the same experience whenever desired by simply touching those two fingers together and requesting a comfortable experience. An unconscious “yes” response means clients now have a comfort tool.

How can the clinician trust that finger signals are really coming from the unconscious? Rossi (1986) and Cheek (Rossi & Cheek, 1988) have outlined methods for distinguishing unconscious signaling from conscious manipulation. Ideomotor signals sometimes will not develop in the alert client and trance induction may better facilitate this process. For many, some level of trance develops as ideomotor questioning begins and this can often make the client oblivious to finger movements. This procedure requires no formal trance induction but, also, can be applied effectively after an induction.

**Emotional stabilization**

Apply the Goldfinger method (Walsh, 1997; Walsh, 2005) for a temporary clearing of the emotional past. The Goldfinger method is a brief, non-invasive approach to clearing accumulated emotion. After the client develops ideomotor finger signals, ask the unconscious about the presence of any interfering emotion from the past. If the emotion is present, say “Since you have been through all the experience of the past and you have whatever learning can serve you well in the present, will that fear (anger, guilt etc.) now be released and resolved in whatever way is best for you at this time?” Then say “When the resolution is complete and you are free of that fear, the yes finger will lift up as a signal.” After the release, steps are taken to ratify cognition, perception and behavior (Walsh, 1997). The cognitive ratification asks “Is there a place in the past where you can put the various thoughts and perceptions that are no longer appropriate in the present now that you have released those emotional burdens?” An affirmative response is followed by “So that adjustment can now be made and a “yes” finger lifting will indicate the adjustment is complete.” Ratifying perception and behavior is not essential here because it is often consequential to the treatment that follows.

It is important to review the client’s tools for managing anxiety. Make certain the client is familiar with and practiced at tools such as deep breathing, sensory focus, self-talk, imagery manipulation or comfort tool application. It may be necessary to teach some of these methods to the client.

If not already addressed, resolve or disconnect from any co-occurring depression while integrating relevant information. Describe the network of experience that defines depression and ask the unconscious if depression is operational in current experience. If a “yes” response is given, ask if the depression will now be resolved or temporarily disconnected from the current issue by providing the client an awareness of whatever is most important to understand. Solicit a finger signal to indicate the resolution is complete. It is unlikely and improbable that all emotional issues for a client are resolved after taking these steps. It is
possible, however, that clients indicate their willingness to continue because they have made a sufficient, temporary disconnect from the problems in question to consider them without fear.

Using the metaphor of opening a channel of communication with the unconscious initially provides an avenue to expediently resolve potential obstacles to change, like depression. Conditions including post-traumatic stress disorder and dissociative identity disorder (American Psychiatric Association, 2000) will require more time during the emotional stabilization phase to allow for the various contingencies these conditions may require. Any individual who is sufficiently motivated to have greater management over AN can benefit from this method, provided the person does not have a major psychiatric illness (e.g., schizophrenia). Responding to the idiosyncratic priorities of each individual ultimately leads to the intended target for most.

Assess internal ED resources

Question the unconscious to determine how many ego-states are actively engaged in the ED. This step is derived from ego-state therapy (Watkins & Watkins, 1997). To understand ego-state theory and therapy, consider how an individual’s inner reality, that navigating fund of learning, experience, knowledge, perception, belief and inclination, is being constructed piece by piece as the body develops from infancy to adulthood. Through the growing up years, each new experience becomes a piece of the foundation of inner reality. Some pieces of this foundation are held by particular resources created for this purpose. John and Helen Watkins (1997) call these resources “ego-states,” or parts of the greater self. These ego-states contribute to a fluid and responsive interplay of resources useful in navigating through life. Helen Watkins (1993) summarizes ego-state therapy as a psychodynamic approach in which techniques of family or group therapy are employed to resolve conflicts between various “ego-states” that constitute a “family of self” within the individual. Thus, the foundation of inner reality is not only seen as a network of perception, emotion, thought and behavior tied to experience, but also as ego-states that hold, connect, or express experience. The experiential functional flow and communication between these ego-states and their respective purpose determines much about how a person functions.

For purposes of this script, the terms ego-states, parts and internal parts will be used interchangeably with the same meaning. Typically most clients grasp the concept of “parts” a bit easier than an elaboration on ego-states. When questioning the unconscious, the term “parts” seems to require little explanation. Inquiries of the unconscious, using this framework, often seems to reveal how one or more ego-states are invested in AN. Ask “Are there parts of you currently involved in the functions of the eating disorder?” A “yes” finger lifting would then prompt “Is there more than one part involved with the ED?” Continue questioning until the number of ego-states functioning for the ED is determined.

Pending unemployment

Pose a ruse by implying to the ED parts that, because of current treatment, the ED will soon become fully inactive. This, of course, means inner parts will have nothing to do. Announce that there are actually some challenging and very satisfying jobs now available that provide a great benefit to the entire system. Ask if ED parts would like new jobs before they are completely without any purposeful focus. Creating new jobs for ED parts is a delightful way to address idiosyncratic needs, developmental challenges, and management of symptoms related or unrelated to the ED. Jobs are created to support client needs, goals or potentials and typically enhance the full course of treatment.
Assume that the unconscious, and the various parts that compose it, typically aspire for what is perceived to be in the best interest of the entire psychobiological system. From this perspective, it is important to recognize that any neurobiological disorder like AN or BN activates without conscious or unconscious intention. The disease may recruit or create ego-states to express symptoms. If it is assumed that internal parts develop to serve some function and continue to need a purpose or functional outlet, it is necessary to define various invented “jobs” which are intended to be compatible with and beneficial to the client. Jobs may be set up individually or for a group of parts. Introduce jobs to parts in a permissive manner and contract for a start time. Encourage parts to be patient with themselves (countering perfectionistic inclinations common to the AN client) as they explore effective ways to understand and carry out new jobs. One group of parts, for example, may do a “focus” job which involves helping the individual focus attention and eliminate distractions whenever the individual says “I want to focus on X (desired focus) and nothing else for the next hour (desired length of time).” Another group may take an “information processing” job which involves organizing and categorizing new information coming into the system in a way that makes it easily accessible.

Job supervision

Follow up with parts in subsequent sessions to see if they have followed through with the agreement to start a job. Ask how the new job is going and if any parts need additional help. If more assistance is needed for a job, solicit volunteer parts to help. Again, this can be accomplished with the metaphor of communicating with the unconscious by means of ideomotor questioning.

Turning off the ED

When all parts previously invested in the ED have new jobs, ask the unconscious “Is it now possible to turn off the ED?” With a “yes” response, ask “Will the ED now be turned off?” With an affirmative response, say “When the ED is indeed off that ‘yes’ (or ‘no’) finger will lift up.” If the ED will not be turned off upon questioning, ask if there are other parts contributing to the ED that have not been accounted for. Is there some other adjustment that needs to take place before the ED can be turned off? Questioning the unconscious will usually reveal what themes need attention.

Trigger-inoculation and ED residue

Ask the unconscious if adjustments can be made to clean up the detrimental residue resulting from the previously active ED, i.e. perceptions, behaviors, habits, attitudes, orientation etc. Offer specific examples of these undesirable elements when making the request. Experience has shown how even after the functional disease process has been halted with this procedure, it can be reactivated by a particular circumstance or experience. The following approach can be applied to offset this possibility.

While the ED remains off, ask the unconscious “Will you now be exposed to all known triggering experiences that could possibly activate the eating disorder, as many times as it takes to insulate you from the effect of those triggers?” Ask the “yes” finger to lift when that experience is complete. Conduct this desensitization exercise at least three times in different contexts. The various contexts may, for example, be different locations, varied social settings, or times of year. Trigger-inoculation seems to significantly diminish the
previously detrimental conditioning of triggering events. Recruiting internal parts for a job intended to nullify the effects of known triggers, or alter the perception of triggers, presents a useful backup strategy. There is no way to know exactly what future experiences may trigger the ED to be turned on, but these measures may reduce the likelihood and frequency of that happening.

Adjust to change

AN remission is a major adjustment. Predict a period of “awkwardness” as clients adjust to new experience. Some clients need to move through grief about losing an active ED. This adjustment naturally invites planning for the future. Reflect with clients how they now have charge of the ED instead of the reverse situation and help clients consider how they will orient to future possibilities.

Self-treatment

Once the ED has been turned off, clients should rehearse how to go through the same process on their own. Review how clients can continue to use the idea of communicating with their unconscious and take steps to turn off the ED should it be turned on again. Review all the signs indicating the ED has been activated and rehearse steps necessary to turn it off. Provide a handout with instructions (Box 1) and lead clients to clearly understand the necessary steps involved in making their own self-treatment should that ever become necessary.

Box 1: Turning Off ED

If you are experiencing ED thoughts, perceptions, behaviors or inclinations to any degree, do the following:

1. Verify your ‘yes’ and no finger signals if you are not already clear what they are. Position the hands so the fingers are all free to move and visible to you. Ask the unconscious to lift the ‘yes’ finger as you focus on something positive. Then ask the unconscious to lift the ‘no’ finger as you think of something negative. Patently await finger movements which may be a lifting or a slow, jerky movement or a vibration.

2. Tell the unconscious you want to ask it some questions and have it respond through those fingers.

3. Ask “Is the eating disorder currently turned on?” A “yes” response then raises the question “Are there any parts of me currently active in the ED?”

A “no” response allows you to move to #4.

A ”yes” response prompts “Did this part or parts previously have a different job?” If so, then ask the part(s) if it would like to return to that other job now, before the ED is completely turned off. (All parts need and want a purpose or function). If necessary, create a new job for that part(s) that assists you in some way. Get confirmation that the part(s) is engaged in the non-ED job through a finger signal.

4. Ask “Will the ED now be completely turned off?” With a yes response, ask for the yes or no finger to lift up when the ED is completely off.
If you get a no response, ask “Is there some other adjustment needing to happen before ED can be turned off?” With a yes response, ask “Will that adjustment now be made?” With a yes response, ask for a finger signal when the adjustment is complete and then start at the beginning of #4.

Another possibility with a no response involves asking “Is there something important I need to understand before ED can be turned off?” With a yes response, ask “Will that information now come to conscious awareness so I can benefit from understanding it?” With a yes response, simply await that awareness and then go to the beginning of #4.

5. Once the ED is turned off, thank the unconscious and ask if it will help insulate you in the future from whatever trigger(s) was responsible for turning ED back on recently.

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**Case Example**

Dara is a 19 year old binge and purge type anorexic with a history of depression, self harm, and suicidal ideation. She had undergone a combination of inpatient and outpatient ED treatments since the age of sixteen. Dara’s most recent hospital admission followed a prescription medication overdose suicide attempt. Dara arrived at the hospital with orthostatic hypotension, bradycardia, amenorrhea, intractable vomiting, and food refusal. Once sufficiently re-fed from a pre-hospitalization weight of 116 pounds for her 67 inch frame and medically stabilized, she left the hospital and started the day treatment unit (DTU) with major depression, anxiety and a powerful attachment to her ED. Medications were adjusted to a selective serotonin re-uptake inhibitor and a low dose atypical mood stabilizer while hospitalized. I began individual treatment with Dara upon her second week in the DTU.

We focused the first two sessions on stabilizing Dara’s mood. This involved developing ideomotor finger signals, a comfort tool, soliciting help from the unconscious to unload or avoid the emotional burdens of the past, and resolve depression. Anxiety was high for this client and she learned tools to manage it.

Upon questioning the unconscious, as indicated by ideomotor responses, the following interaction developed. Fifteen parts invested in the ED were identified. Five parts took an “information processing” job involving the organization and categorization of new information coming into the system. While doing ideomotor questioning Dara appeared to have developed trance, as evidenced by eye flutter and closure, a slowing of breathing, and a smoothing out of facial muscles. Trance facilitated the application of a reality lens intervention (Walsh, 2008) in which Dara encountered a full length mirror with two pair of eye glasses beside it. One set of glasses had ED lenses while the other had reality lenses which allowed Dara to see her body realistically. She liked what she saw through the reality lenses. Five parts took the job of applying the reality lenses full time. Three parts took a “restricting” job which “guarantees the body will never get fat” as parts limit food type and quantity to the prescribed healthy meal plan. Two parts took a job exercising assertiveness skills.

During the next session Dara explained how eating was much easier and she had less anxiety. The unconscious agreed to turn off the ED and a finger signal confirmed this change. Another adjustment to keep the ED off was solicited and confirmed. The next session found the ED turned on and one part having abandoned its new job. Upon questioning, the part found the “reality lens” job too difficult and agreed to help with the “restricting” job. The ED
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was again turned off and Dara went through a trigger inoculation exercise. The following week Dara reported managing triggers well and seriously thinking about future occupational plans. All parts doing new jobs reported acceptable experiences. Dara went through the trigger-inoculation exercise again. Dara presented no ED thoughts and a good body image.

Seven weeks later Dara had a very distressing experience involving a close friend’s medical condition. This seemed to activate the ED with no inner parts actively involved. The ED was turned off and stayed off until Dara became ill with the flu, lost some weight, and recognized ED symptoms. The ED was turned off promptly.

Dara received a handout (Box 1) for self-management of AN. Upon initial ED hospitalization Dara scored 51 on the REDS-C interview. She received a score of zero six months later on the same test. At twelve months, Dara was maintaining a healthy weight of 125 pounds, a body mass index (BMI) of 19.1, a good body image, having regular menses and continuing the same course of medication she started in the hospital.

Conclusion

Relapse

In most cases, when the ED gets triggered back on it does so within a week or two after it is initially turned off. The trigger is usually some crisis, real or perceived. Clinicians need to question the client’s unconscious to assess the ED state and determine if any parts are actively contributing to the ED. If there are parts invested in the ED, find out how many and ask if any are parts that abandoned new jobs. If parts have not been dealt with before, offer a new job. If parts abandoned their new job, find out why. Once all AN parts have non-AN jobs, the AN can usually be turned off.

Sometimes there are no parts contributing to AN when it is turned on. The unconscious may indicate something else needs to change before AN can be turned off. This was the case with a client who needed to resolve depression before AN could be turned off. For this client depression was a powerful AN trigger.

Personality style and developmental orientation tend to have significant influence on relapse frequency and even a willingness to turn off the ED. When the ED is active, clients often say “This is who I am.” This identification with the ED typically becomes “Now I can be the real me without the ED” after ED ego-states engage new jobs and symptoms remit.

Intrapersonal and interpersonal support

Because other clinicians treat the clients seen by this author, successful treatment outcomes cannot be credited solely to the intervention described here. Other clinicians teach, monitor and rehearse client coping strategies, as well as reinforce healthy changes. AN symptoms have been shown to abate quickly with this method, but these changes often rest upon a bed of useful information and experience derived from the day treatment unit and parental cooperation in maintaining a safe and healthy home environment. Symptom relief needs to be supported and reinforced by various treatment providers and families.

This method can be an important part of treatment regimen which ideally adds facility and expediency to the rest of the process. Diminishing the symptomatic force of AN seems to take the physiological resistance out of AN treatment. When the sympton driver is off, regardless of how it is deactivated, much of the client’s inner struggle is pacified. The client will still need to adopt new behaviors around food, change old habits, and adjust to a new way of operating in the world. Adjusting to the absence of a constant, dominating companion (AN) that touches every aspect of life is significant.
The premise guiding this work is an assumption that ego-states are functioning at the expressive level of the ED and that the functional force directing these ego-states can be muted once all ED ego-states assume a different function. Extracting ego-states from the ED role and muting the ED force then results in remission of the ED symptom complex. The treatment intervention targets the entire symptom complex as opposed to focusing on single symptoms or presumed underlying causal factors.

Following the application of this intervention, the overall course of treatment depends greatly upon client personality style, client belief system, level of motivation for change, and family dynamics. It is a step that accelerates the course of ED treatment and gives the client an added sense of choice and control. Client reports, objective measurements, testing and observations from clinical sources all support AN being inactive or non-expressive in the clients who may be said to have “turned off” the ED. Something appears to be changing when the unconscious agrees to turn off AN. Without knowing how the unconscious turns off the symptom complex of AN, real experiential change is taking place which allows full client management of AN.

Questioning the unconscious
While there is as yet no empirical evidence to support the unconscious communication by ideomotor signaling theory, it is a potentially promising area with a rich clinical history. Ideomotor signaling is used clinically as a medium to help promote change as shown here as, perhaps, a metaphoric vehicle for therapy. It is also hoped that it may provide among readers an understanding of this lens for further investigation. While greater research is desperately needed to answer some of these questions, that research may have to wait for improved means of measuring many of these variables and the impact they have on one another.

References
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Kartini Clinic for Disordered Eating: Portland, Oregon.


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