Voice Dialogue: An Effective Unit As Part of a Comprehensive Therapeutic Strategy for Treating Anorexia

by

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ABSTRACT

Anorexia nervosa is a complex illness and the foci of treatment needs to incorporate many variables including those in the emotional, physical, mental, functional, family, social, and vocational arenas. The intransigence of eating disorder behavior is well known and clinical progress sometimes has to be measured in morsels. How do you maximize clinical outcome?

This paper explores how Voice Dialogue, a Jungian based treatment used internationally in direct practice, can move a client towards increased cognitive flexibility by augmenting the therapeutic process of on-going evidence based practice, in particular Cognitive Behavioral Therapy (CBT) (Beck, 1995.) Voice Dialogue can certainly be considered one of the creative expressive therapies, especially in its ability to enhance awareness and insight beyond “intellectual” understanding. This article introduces how Voice Dialogue (Stone & Stone, 1989) can be used as a tool to enhance different elements vital to psychotherapy including treatment alliance (Davis, 2009), as well as the Rogerian concepts of unconditional positive regard and empathic listening. Included is a case presentation highlighting how this works clinically. Voice Dialogue can be an effective unit of a comprehensive outpatient treatment strategy that may also include

psychopharmacology, nutritional counseling, homeopathy and body healing modalities like acupuncture and massage.

Voice Dialogue was developed by psychologists, Dr. Hal Stone and Dr. Sidra Stone who met in the early 1970's. The theoretical framework is a consciousness model of personality formation referred to as the Psychology of Selves and the Aware Ego Process. In this model an individual is made up of a multitude of different Sub-Personalities, or Selves, that were acquired to protect one's inherent vulnerability. One of the earliest aspects of the personality to develop is the Protector/Controller Self. This Self "integrates parental and societal injunctions by generating internal rules in order to ensure safety and acceptance by others" (Stone & Stone, 1989, p. 15). As Stone & Stone (1989) describe: "each self has its own way of viewing the world, its own perceptions, its own beliefs and rules, and its own specific history" (http://www.delos-inc.com/Reading_Room/FAQs/1WtRSlvs/1WtRSlvs.html). For example, if a client's constellation of Primary Selves is an Inner Critic, Perfectionist, and People Pleaser, that person might predictably be vigilant for perceived flaws, increasing her vulnerability to developing an eating disorder. The Disowned Selves contain energies that have been negated and split off in order to sustain the Primary Self system. They often operate clandestinely, sometimes even out of awareness of the client. They can include Overeater, Purger, Self-Injurer, Disassociator, and others. While Voice Dialogue lacks current empirical support, there is a wealth of clinical and anecdotal evidence to support its use with eating disorder clients.

Originally developed for depression, CBT, a leading evidence-based intervention has been found moderately efficacious for treating eating disorders. It is based on the

supposition that the perception of an event determines thoughts, feelings and behaviors within the ongoing interaction between personal and environmental variables. The result is an idiosyncratic belief system within which all events are construed. Stressors evoke maladaptive responses that are reinforced over time leading to patterns of cognitive distortions.

Regardless of modality, treating the average eating disorder client is complicated. They are often "involuntary." That is to say, they are not court mandated but feel "unfairly forced" into treatment by loved ones. The defended client is terrified he will be coerced to gain weight, to which he is adamantly opposed. He is often resistant to the psychotherapeutic process as he fears becoming more conscious will merely highlight how irreparably flawed he is. "The gap between the current definition of attractiveness and desirable body type in comparison to a person's natural weight and body type can ruin lives by bringing on depression caused by sever Inner Critic attacks" (Koumidou-Vlesmas, 2012, p.157.) Voice Dialogue can be a value-added instrument to "meet the client where he is" and address problems as the client presents them. If he can identify treatment goals he is motivated to work on, it is possible to minimize and even eliminate at least the more dangerous behavioral and medical aspects of anorexia nervosa. As many clinicians and researchers are noting, options that do "not directly challenge the patient to change their eating disorder behaviors" may be attractive to reluctant patients (Raney, 2009.)

Case Example

"Food is one substance that in its misuse is more akin to behaviors that Primary Selves use to protect vulnerability in such areas of life as work and relationships"

(Koumidou-Vlesmas, 2012, p.155.) Ms. A. is a performer who self-referred after being introduced to Voice Dialogue in a creativity exploration workshop. She indicated she wanted help with accessing her emotionality, as her inability "to let go" was an impediment to booking acting jobs. Treatment lasted for three years, meeting most weeks for hour and a half sessions.

Ms. A., a slim, married 35 year old Caucasian female, revealed in her assessment that she had a 10-year history of anorexia nervosa, which included maintaining an extremely restrictive diet, over-exercise, laxative use, a private nightly ritual of chewing cereal and spitting it out, as well as amenorrhea for three years. She was extremely fearful of "getting fat." Her self-esteem had long been influenced by her perception of her weight. She regularly denied the seriousness of her illness. She described a distorted perception of having a fat stomach, partially as a result of being told repeatedly by her father that, "your tummy is fat and you better be careful…" This was particularly painful in the context of rarely seeing her father due to her parents' estrangement.

Studies show that persons who have first-degree relatives with anorexia nervosa are 11.4 times more at risk than the general population to develop this disorder (Winchester & Collier, 2003.) Interestingly Ms. A.'s artistically and commercially successful father is an untreated "skinny" anorexic, who probably also suffers from Obsessive-Compulsive Disorder. His daily discipline of hours of practice modeled extreme self-control as the path to success. Her mother is of normal weight and is not eating disordered, but suffers anxiety, including panic attacks, phobias and periods of agoraphobia. Ms. A.'s parents divorced when she was 8 years old. Her mother has subsequently remarried several times and is currently divorced. Though beyond the scope

of this article, Ms. A.'s predisposition to anxiety, obsessionality, and phobias laid a foundation for her eating disorder.

Two years prior to Voice Dialogue treatment, Ms. A. had an inpatient hospitalization due to low weight. Despite acknowledging "I lost my life, my friends, everything…" she discharged herself against medical advice after 5 days. She briefly "submitted" to a day treatment program, which featured techniques from Dialectical Behavior Therapy (Linehan, 1993.) Ms. A. endorsed that aspects were helpful, in particular the mindfulness exercises which would briefly alleviate her anxiety. However she left because she repeatedly maintained, "I am not going to be told what to do or to eat."

For slightly more than a year prior to Voice Dialogue treatment, Ms. A. had weekly individual therapy with a psychotherapist specializing in eating disorders. Ms. A. was also diagnosed with depression for which she has taken Lexapro to good effect for many years. Pertinent clinical features of anorexia nervosa include "feelings of ineffectiveness, a strong need to control one's environment, inflexible thinking, limited social spontaneity and perfectionism" (Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, 2000, p.585.)

Her innate stubbornness contraindicated any confrontational approach, in order to avoid a power struggle that would jeopardize treatment by potentially triggering premature termination. As a disciplined, controlled, over-scheduled urbanite, she felt "it missed the point" to focus on a number on the scale or on the measurement of food "I am not going to eat anyway." She felt that "if anything was going to work" it was to explore the issues sustaining her disordered eating behaviors.

The biggest worry Ms. A. articulated was "Voice Dialogue might give me multiple personality disorder and turn me into Sybil!" She was assured that Voice Dialogue reflects the phenomenon of growing up in a particular household where certain aspects of your personality are rewarded and others are rejected. The natural result is the development of both Primary and Disowned Selves. Psychoeducation was also provided that, "…considerable evidence, including recent brain-imaging studies, suggests that some people really do shift from one self to another, and that the selves have different memories and personalities." (Paul Bloom, 2008. p.94)

In Voice Dialogue facilitations, the client and the therapist choose a Primary Self with whom to communicate, for example The Perfectionist. Moving to a different place in the room, Ms. A.'s Perfectionist Self might discuss how she enforced her rule that Ms. A. cannot eat anything until 8 pm. In addition to her salad of undressed lettuce and green pepper she is allowed to have an apple, but only if she has exercised enough during the day! After a brief return to the Aware Ego position, Ms. A. moves to a different section of the room and might facilitate a Disowned Self she coined the Kid. The Kid revealed that every single night Ms. A. secretly chews cereal and spits it out.

The therapist engages each Sub-Personality and uses a form of investigation similar to the Socratic method used by CBT practitioners. This technique helps clients draw their own conclusions about the way things actually are, or are likely to be in the future, in contrast to their customary negative interpretations. Inherent in the facilitation is modeling nurturance, support and acceptance.

When the Kid finishes her communication, Ms. A. returns to the Aware Ego position and the session is processed. Ms. A. disclosed that the Kid's behavior has led to

many difficulties including marital conflict. When the toilet overflowed, her husband (who has been with her since before her inpatient hospitalization) recognized a blockage of coagulated cereal and was furious. The Kid simply grew stealthier.

The goal of Voice Dialogue is to increase the Aware Ego process. This is accomplished by providing opportunities for a client to tolerate the opposing points of view of different Sub-personalities. A typical illustration might be, "I am so fat I should die" and "I am okay and many people like me." This highlights both cognitive dissonance as well as the double bind of ambivalence. By adjusting her cognitive processes and altering her selection of input, she opens up to the potential enhancement of her overall cognitive flexibility. Learning the underlying concerns of a Self may reduce cognitive rigidity and possibly strengthen central coherence, the ability to process information globally (Raney, 2009.) During times of peak performance expectations in her field, for example, Ms. A. voluntarily boosted her protein intake. This self-initiated caloric increase represented a real step forward and confirmed for both patient and therapist the value of Voice Dialogue.

Another tenet of CBT that can be supported by Voice Dialogue is relapse prevention. As treatment progressed, Ms. A. became aware that each of her Sub-Personalities (regardless of how destructively they may operate) served to protect her vulnerability. The Perfectionist wanted her to be thin and attractive in order to keep her personally and professionally desirable and safeguard against experiencing the shame of rejection. From "the Kid's" point of view, she is offering a self-soothing ritual at the end of each torturous day.

Ms. A. was also taught many aspects of CBT. She began "to see" how different Selves enforced core negative beliefs. For example, through automatic thoughts in the form of constant rebukes to improve, her "Inner Critic" projected the judgment that she "does not measure up." Ms. A.'s "Inner Perfectionist" picked up the baton to enforce restrictive eating in a dysfunctional attempt to dispel the notion she "does not measure up." As the client establishes some distance from her Sub-Personalities, who are activated by specific stimuli, she can come to appreciate they only represent a portion of her personality and not her complete identity.

Integral in CBT and Voice Dialogue is the generation of multiple perspectives as data is collected. Guidance to pay attention to different stimuli is sometimes offered by varying Sub-Personalities, which is supported by the therapist. Information processing errors, as conceptualized by CBT, can also be addressed through Voice Dialogue. These include absolutistic thinking, overgeneralization, arbitrary inference, personalization and magnification/minimization, all of which are especially relevant with eating disorder clients. Most CBT approaches emphasize gradual change through frequent practice of new, more adaptive actions. One way to support exposure to a behavioral intervention, and address the resultant anxiety, is to suggest that a different Sub-Personality "take over" for a particular situation. Body image distortion was dealt with indirectly when Ms. A. realized that "not all of me considers me fat!!" This was a crucial development in treatment. Another powerful turning point occurred when she discovered that her brutal Over-Exerciser was only secondarily related to anorexia nervosa. Upon facilitation, she realized the main function of her Over-Exerciser was to elevate her mood and keep her depression at bay. As her Aware Ego Process continues to develop, Ms. A. will now

sometimes choose a self-soothing activity instead of acquiescing to the demands of the Over-Exerciser to handle sadness and despair, feelings she related to abandonment anxieties attributed to her parents' narcissism.

By experiencing and naming Sub-Personalities in a non-judgmental environment, this strengths-based intervention offers a client a greater range of options for coping. In the spirit of collaboration and active participation, Voice Dialogue may skirt the on-going resistance an eating disorder client has to expectations of cognitive and behavioral change. Ms. A. still struggles with eating disorder behaviors but they are reduced in number, duration and intensity. We treated her initial complaint of needing to "let go and access vulnerability and sexuality to be a successful actress" and subsequently attained other clinical goals. Throughout treatment with Ms. A., especially as she undeniably progressed in her chosen field, we repeatedly highlighted the fallacy of one of her most entrenched core beliefs - that she is "always second choice." Although she still struggles with this schemata, the parts of her that celebrate her progress are becoming more dominant. An important element for consideration is that success can be interpreted as a stressor, which may contribute to impairment of cognitive processing and trigger maladaptive coping responses (i.e., recent purging through laxative use when Ms. A. received good notices.) In terms of Voice Dialogue, approval can terrorize the Perfectionist because the pressure for a repeat performance is "almost unbearable." Awareness of this double bind has helped Ms. A. maintain a slim but non-anorexic weight, while she accomplishes many important life goals including marrying her long-time boyfriend, and advancing significantly in her profession.

In conclusion, Voice Dialogue is a powerful and experiential modality that is compatible with many theoretical orientations. Empirically tested components such as empathy, and the quality of the therapeutic relationship may be the foundation for the effectiveness of Voice Dialogue. Cognitive restructuring may also be a key aspect. Voice Dialogue may also serve as non-reinforced exposure for extinguishing automatic avoidance and affective responses. Developing an Aware Ego process creates an inner vantage point that helps melt black and white thinking and illuminates specific content and cognitive processes activated by different Sub-Personalities. Voice Dialogue can also motivate the therapist, who may often be, understandably, frustrated by the painstaking rate of progress when working with many clients with eating disorders.

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