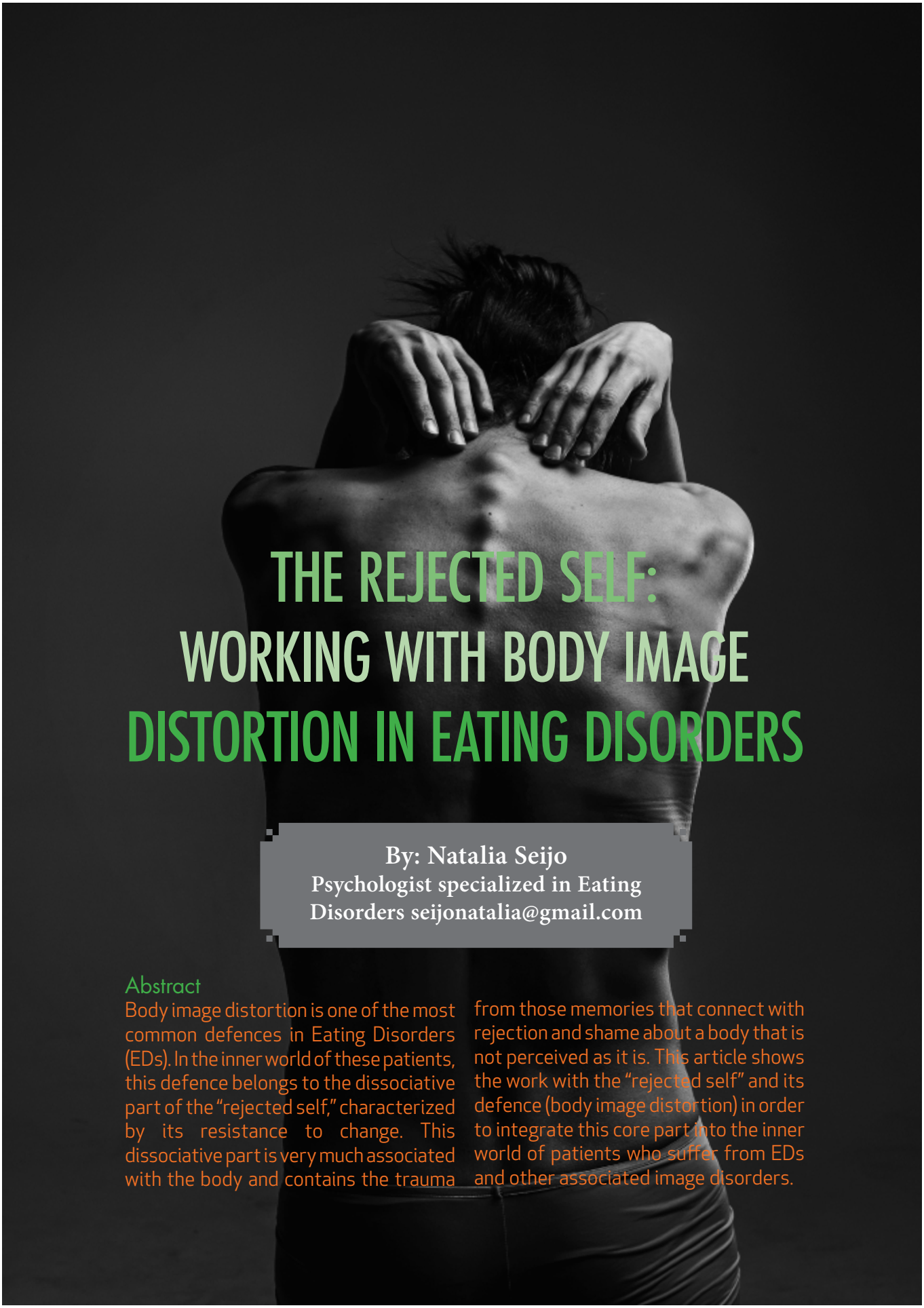

THE REJECTED SELF: WORKING WITH BODY IMAGE DISTORTION IN EATING DISORDERS

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Abstract

Body image distortion is one of the most common defences in Eating Disorders (EDs). In the inner world of these patients, this defence belongs to the dissociative part of the "rejected self," characterized by its resistance to change. This dissociative part is very much associated with the body and contains the trauma from those memories that connect with rejection and shame about a body that is not perceived as it is. This article shows the work with the "rejected self" and its defence (body image distortion) in order to integrate this core part into the inner world of patients who suffer from EDs and other associated image disorders.

INTRODUCTION TO BODY IMAGE

When we talk about body image in Eating Disorders (EDs), we are referring to the epicentre of the disorder, the place where these patients learned to place everything they were not able to manage otherwise.

Schilder (1935) defined body image as the mental representation we each have of our own body; it is how we see ourselves. In addition to the perception of the body and the assessment of its size, this image implies an emotional aspect related to how we feel about this image.

As per Rosen (1995), the concept of body image refers to how people perceive, imagine, feel, and act in regards to their own body. Both perceptive and subjective aspects are contemplated by this definition: satisfaction or dissatisfaction, concern, cognitive assessment, anxiety, and behavioural aspects.

A main feature in Eating Disorders is the existence of a Body Image Disorder, in which self-evaluation is unduly influenced by body shape and weight, generating persistent concern and dissatisfaction. This dissatisfaction stems both from perceptive distortion and unrealistic goals of size and weight. The patient compares her* body with other bodies, looking for defects in her own; defects that must be modified based on established social criteria and familiar aesthetic patterns. Most of the time, the latter are based on physical patterns that have been procedurally learned in the relationship with the attachment figure. The discrepancy between how the person perceives her own body and the ideal body that she would like to have generates this profound dissatisfaction about body image, which in turn generates much worry. This worry increases as the discrepancy increases.

"Worrying about the body is procedural learning" (Fisher, 1986). Procedural learning is one of two ways in which information is stored in long-term memory. It is the information we know at an unconscious level. The therapeutic work implies helping the client elaborate her perception of her body, both at this level and at the declarative (verbal) level. It means putting into words what is not said, what the body shows through either somatization or embodiment of inner experience, using gestures and posture.

During the course of the illness, concern about the weight and shape of the body builds up anxiety, making the patient dissociate from her own body in an attempt to "get out of it." This can be seen in comments such as, "This body doesn't belong to me; I just happen to live in it and I don't want to" or "I feel ashamed of my elephant legs, I can't stand looking at them in the mirror every single day of my life."

We may conclude, then, that the image each person has of herself is not innate, but depends on personal experience and on the image that is projected and perceived by the other. Everything we have been told about who we are is connected to our image (Seijo, 2000). The lives of people with EDs end up revolving around the implicit meaning that lies behind this information.

BODY IMAGE DISTORSION AND THE REJECTED SELF

Thompson (1990) defined body image distortion as a persistent state of dissatisfaction and worry related to some aspect of physical appearance.

It is important to identify the degree of the dissatisfaction that the person feels about her image. Lorraine Bell (2010) indicates that negative body image can range from dissatisfaction about some element of physical appearance to an extreme obsession that limits normal functioning. A body image may be negative to a degree that does not harm the person and may even provide the resource of awareness of the need for self-care and healthy habits. The negative body image that presents problems is the one that has negative repercussions on the life of the person.

*He/him and she/her will be used interchangeably throughout this text.

Janet (1903) talks about "being obsessed with shame regarding the body," which implies fear of being considered ridiculous. Within the inner world of clients with EDs, this obsession with shame towards the body is held in the dissociative part of the "rejected self" (Seijo, 2000). This dissociative part plays a crucial role in the inner world, mostly in cases of anorexia and bulimia nervosa, where their world revolves around body image.

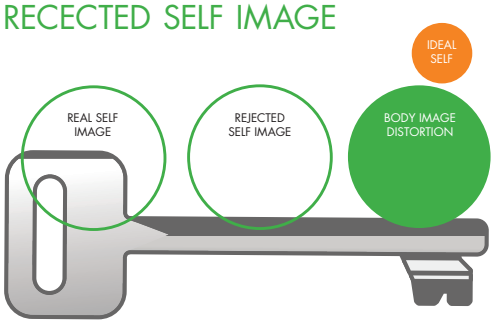
The concept of the "rejected self" may be explained by the idea of who the person never wants to be again, someone who actually existed in the past but who is now rejected and represents the image of what embarrasses and worries her. Dissociation begins through body image distortion, the dissociative defence of the rejected self and the main cause of many blockages in treatment.

Body image distortion is the person's dissociation with own body in an attempt to avoid what the body is and what stems from it (what it conveys, feels, or expresses). In the phenomenon of body image distortion, daily experience does not change the person's idea about her body. The representation of the body from the past remains static – unaffected by the passage of time and bodily experiences – as the image of that "rejected self" from the past to which the person does not want to return ever again. The body image distortion goes along with a distorted cognitive filter, which may be seen in examples such as, "When I look at myself in the mirror, I don't see my lips as full as I would like them to be; so that's when I cut them so they swell up and I can have them as I wish them to be" or "I sleep each night wrapped up in plastic, so I can sweat and get rid of my abdominal fat; I won't stop until my hipbones are prominent."

The "rejected self" and the body image distortion manifest when the strongly rejected image from the past stands between the image she sees in the mirror and her current real image. Not wanting to be that person again generates intense concern. The mental representation of the "rejected self" could be, for example, her "15-year-old self" with the same flaws that she had at the time. Towards this part of herself, the person feels rejection, shame, and worry. These emotions are the defences that maintain dissociation. Since she sees herself through the lens of this rejected self from the past, she is unable to see her body image objectively when she looks in the mirror. She does not see the reflection in the mirror; instead, she sees the body of the past, from when she was 15, which is not real and will never be real again.

When a client was asked about her rejected self, she described her 17-year-old self, with fat and deformed legs, flabby arms, and a big belly, even though she was in treatment for AN and her weight was 36 kg. She continues to feel ashamed and concerned, because she still sees her deformed legs and fat belly, just like that rejected image from the past, even though she is now 23 years old and nothing of what she sees in her body is real anymore. Due to her image distortion, what she sees in the mirror is the dissociated image from her rejected self of the past.

While working with the rejected self, we must also keep in mind the work with the "ideal self." This ideal self is the dissociated static image that is usually unrealistic both in shape and size. This element weighs greatly on the part of the rejected self, since she may evaluate her body very negatively given her ideal of how it should be. The ideal self may be influenced by family, social or media factors, among others, or by a combination of these.



Body image perception becomes limiting when the discrepancy between the real image and the distorted image is based on the aversion towards the self of the past that the person does not ever want to be again.

DEFENCES

Defences are mechanisms activated by the inner world when there is a sense of either a real or an imaginary threatening circumstance. If the situation is real for the person, we must take it as such, at least in the beginning of treatment.

The main defence of the rejected self is body image distortion; however three defences underlie this distortion.

- The first one is rejection, non-acceptance, confrontation or opposition to the body and what it represents, including the image and the way the client perceives it.

- The second one is shame. This represents not showing oneself in order to hide what is perceived as negative. In the inner world, it is interiorized by the dissociative part of the hidden self (Seijo, 2012). This part gathers the humiliation of the experiences the client has lived through, and its core belief is "I cannot show myself as I am because when I did, I got hurt." The hidden self is the dissociative part that usually surfaces once we work with the rejected self.

- The third one is worry. This defence protects by not wanting to go back to being what the person was in the past. It is a defence that generates a state of alert and distrust, common in these clients.

BODY IMAGE DISTORTION IN THE DIFFERENT EATING DISORDERS

As previously mentioned, distortion of body image may range from a negative body image – in which the negative assessment of the body is associated with what is called "body dissatisfaction" or "rejection", which causes great unease – to an extreme obsession as in Body Dysmorphic Disorder (BDD), in which the person is overly concerned with an imagined physical defect, which causes discomfort and is not better accounted for by another mental disorder (APA, 2014).

"Eating disorders appear to be relatively common in individuals with BDD" (Ruffolo, 2005). In this disorder, the worry is aimed towards obsessive body checking: pinching the skin, spending too much time hiding any flaws (something that the person perceives as a flaw when it is not one or a defect the person exaggerates due to the distortion), unnecessary treatments and surgeries, self-harm, and even suicide. This worry appears in adolescence or early adulthood; however, BDD is found in people of all ages and both genders (Phillips, 2005).

Body image distortion as a dissociative defence is also associated with other disorders, which are different representations of how dissociation shows up through the body.

- Vigorexia or muscular dysmorphia. This disorder is characterized by the presence of an obsessive concern about physical appearance and an image distortion that leads to BDD. It is more common in males, though the number of females who suffer from it is increasing. In this disorder, we speak of a "muscular shield" as the somatoform dissociative defence under which its true origin lies. "It is an obsessive preoccupation via delusional or exaggerated belief that one's own body is too small, too skinny, insufficiently muscular, or insufficiently lean; in most cases, the individual's build is normal or even exceptionally large and muscular already" (Leone & Edward, 2014). "Disordered fixation on gaining body mass by devoting inordinate time and attention to exercise routines, dietary regimens, and nutritional supplements is typical, and use of anabolic steroids is common" (Phillips, 2009). It is usually related to traumatic events in the life of the person, such as childhood abuse and humiliation. This body image disorder is associated with EDs, such as anorexia nervosa and continuous episodes of bingeing and restrictions, due to the rigidity of their eating habits, which may at times generate social isolation .

- Fatorexia. This is a recently discovered disorder, not yet included in the scientific

literature, associated with EDs and obesity. It is estimated that for each person that suffers from Anorexia Nervosa, there are ten people suffering from Fatorexia. It is more common among men than women, and is usually diagnosed in people over 45 years old. In this disorder, there is a full-blown distortion between the perceived weight and the real weight. Fatorexia is associated with body dysmorphia, an excessive lack of concern with physical appearance, dysmorphic syndrome, and atypical somatoform disorder.

▶ People who suffer from this disorder see themselves as thin, but in reality their weight is much higher than the weight indicated by their healthy BMI (body mass index.) They deny and dissociate the reality of their bodies. The rejected self blocks and returns a false image of the body's size and weight. They fully deny their real weight: they state that they are thin, even though the scale indicates otherwise. When looking in the mirror, there is a denial equal to that of the scale. The same thing happens in anorexia, but it is exactly the opposite. The image that stands between the real image and the reflected image in the mirror is an image of a thin person, when the weight is actually much higher than what it should be. This disorder may be as harmful as anorexia, since it is coupled with obesity.

A client described how she was surprised to find out that the scale read 93kg, when the last time she weighed herself it read 49kg. She described how she noticed that her size was changing, but was not aware that her body was changing, so she continued eating non-stop since she suffered from hyperphagia (an eating disorder in which the life of the person revolves around food consumption.) Given that the patient saw herself as being fine, she was not worried at all about adopting healthy eating habits, and this could be dangerous for her health.

The rejected self and the body image distortion are presented differently in the different eating disorders that follow:

▶ Anorexia Nervosa (AN). The distortion of the rejected self returns an image much larger in size and weight than the true image in the mirror. In AN, the rejected self generates much distress in the client, in addition to intensification of symptoms, greater risk of blocking treatment and, possibly, worsening of the diagnosis in general. This rejected self is one of the parts that is most resistant to change and generates higher levels of cognitive, emotional, and social disturbance. The person tends to isolate herself in an attempt not to be seen in the way she perceives herself from her distorted point of view.

▶ Bulimia Nervosa (BN). The part of the rejected self contributes to the development and intensification of the full circuit of restriction, binging and vomiting, which is the main symptomatology in this disorder. The client indicates much suffering and aggression towards the body. This aggression shows not only through this food circuit, but also in self-harming and impulsive behaviours, which are key features of this disorder.

▶ Binge-Eating Disorder (BED). Characterized by the fact that the rejected self of the patient is the actual body, which prevents her from looking in the mirror. The perceived image is the same one as the rejected self, and such rejection makes the person decide not to look in the mirror as a way to avoid contact with the body. When these clients show up in therapy and we ask them about their bodies, they have a hard time answering due to the dissociation generated just by naming this. The degree of somatoform dissociation in this disorder is usually high, and the body is perceived as "something I am burdened with" or "something I cannot stand anymore." The distress generated by their rejection of the body makes them resort to food in order to calm themselves, as in BN. However, in BED, the body continues to gain weight because of the lack of compensatory behaviours, so the bingeing actually increases the deformity of the body, making the rejection increase as well. In regards to the rejected self, the same criteria would apply to BED as to

obesity, be it endogenous or exogenous. In these cases, the rejected self is focused towards the actual current body, and this is what we must work on.

THERAPEUTIC APPROACH

Approaching the rejected self and the defence of body image distortion in therapy must take place in an appropriate treatment stage. This is because the rejected self lies within one of the deeper layers of the disorder. Working on it too soon could activate the client's inner world, generating more defences and of greater intensity, which would block treatment. It is also important to keep in mind that there are different parts of the inner world, such as the piranha (pathological critic) (Seijo, 1999), which do not accept the rejected self. Therefore, defences such as rejection, shame, and worry will appear in order to avoid the inner distress generated by this conflict. The client behaves towards this rejected part just as others behaved towards her throughout her life, thus perpetuating dissociation and the defences of the rejected self.

The appropriate time to start working with the rejected self is when the person is stabilized, when general defences have been neutralized, and when judgments and critical comments from the piranha have been channelled and turned into more healthy and constructive comments and criticism. Once this step has been taken, we frame the work with the rejected self and the body image distortion.

The process of working with the rejected self is done from the foundation of the Theory of Structural Dissociation (van der Hart, Nijenhuis, & Steele, 2006) and it may be integrated with different approaches, using different techniques and strategies. This will depend on which is most appropriate for each therapist and the school or approach he or she belongs to. We may work with the Rejected Self Protocol from EMDR therapy (Seijo, 2010) and use the empty chair technique from Gestalt, in which we place the part in one chair and then encourage a dialogue between parts that leads to compassion and integration. Another way of working is with Sensorimotor Psychotherapy, connecting what the person feels towards this part and allowing the somatic trauma contained in the part to become processed, which facilitates a new belief about herself. We may work with Schema Therapy, searching for the function of the part in the inner world, identifying what it is protecting and the schema on which it is based. Overall, we can approach it from the point of view of all these different schools that enable the work of integrating this construct and its defences.

THE MATERNAL FIGURE AND THE DEVELOPMENT OF BODY IMAGE

Self-esteem is built from the need to be recognized. If recognition and validation do not take place, especially from the maternal figure, the concept of the self will be built on a foundation of insecurity and the person will search for external confirmation in order to validate herself internally.

Maternal representations play a key role in the development of body image. Kohut (1977) wrote that the maternal attachment figure plays the roles of validating and accepting, laying the foundation of the construct of the self.

When working with the rejected self, the mother figure is the main issue that emerges as part of the processing. It is the reference figure, probably because it is the physical model from which to learn and model the self. When we work with the rejected self, we also process and repair the relationship with the attachment figure of the mother.

HISTORY TAKING AND STABILIZATION

▶ In order to take the history of the rejected self, we start by asking the client to think about the part of herself, either from the past or the present, that generates rejection and shame, the part of her she does not want to be ever again.

With which past self does she associate it? How old is she? How does she see herself? What happened during that time of her life?

▶ Gathering information about the flaw or flaws that the person finds in this rejected self, regardless of whether they are real or not. We may help with questions such as:

-How old were you when you noticed the problem for the first time?

-Where did you learn that having a particular weight and shape is important?

-When you think about this part of your body, what does it make you believe about yourself?

-How much time do you spend hiding or covering up the area of concern?

-What else was happening in your life when you were first aware of this area of your body?

-Is there someone in your family with the same problem?

▶ Identifying and assessing the defences that maintain the disorder, first taking into consideration rejection, shame, and worry as the three defences most associated with this part, and with which we will work primarily.

▶ Identifying the degree of dissociation that may exist, either with specific dissociation scales or through the clinical experience of expert professionals on the subject.

▶ Checking the different resources of the client, so she may be able to use them if needed in order to prevent dissociative reactions and/or defences as we are working in therapy.

▶ Psychoeducation regarding the rejected self and the body image distortion defence, so the client may understand this part and everything that happened in order for it to develop in the inner world. Psychoeducation about the function of the rejected self that protects the inner world through the distortion of the body image. Thus, compassion may develop, with the goal of integrating the rejected self as the final phase of the process.

Through psychoeducation, we explain the difference between self-esteem and self-concept, and the repercussions of negative self-evaluation.

-Self-concept: The image that each person has of herself, as well as the ability for self-recognition. Self-concept includes evaluating all parameters that are relevant for the client: from physical appearance to skills. Self-concept is not innate, but it develops through experience and the image that is projected and perceived by others. It is dynamic, which means it may be modified with new data.

-Self-esteem: Group of perceptions, thoughts, feelings, and behaviours directed towards ourselves, our way of being and behaving, the features of our body, and our character. It is how we value ourselves. The importance of self-esteem lies in that it affects our worth and our way of being in the world. Self-esteem depends on what you think of yourself, not what others think of you.

As more information surfaces, the key question used in this phase of treatment is, "Where did you learn to see yourself in this way?" The answer will offer us crucial information that will lead us to the origin. By doing it this way, we may conceptualize the work from the past that must be developed.

WORKING WITH THE DISSOCIATIVE PART OF THE REJECTED SELF

Once the process of history-taking and psychoeducation is complete, along with checking resources and presenting the main defences that are part of body image distortion, we proceed to work with the rejected self.

Ask the client to think about her rejected self, the part of the past or the present, which she rejects and of which she is ashamed. We give her enough time so she can allow this image of herself to come to mind. On many occasions, clients describe this part with feelings of disgust or contempt, and indicate that it has been there throughout the years as an imprinted image of what they do not want to be again and through which they see themselves when looking in the mirror. Most of the time, the image of the rejected self comes up immediately, since it accompanies the person all the time.

When the rejected self comes up, we ask for detailed information about it, with questions such as:

-If you could give an age to this rejected self-part, how old would you say she is?

-How do you visualize her? (If the person is able to imagine it.) What clothes is she wearing? What does she look like? Where is she? Do you feel she is sad or happy? Is she alone or with someone?

-When you see your rejected self, do you feel rejection, shame or worry? (Or any other emotion that has not been named.)

We then ask the client to visualize the rejected self just as she sees and feels it, and we start the work. The goal is to create an inner dialogue between the current part of the person and the rejected self. This leads us to processing the main defences that prevent adequate integration of this part in the inner world and generate the distortion with which the person perceives herself.

During the therapeutic process, it is important to work on validating the rejected self at any opportunity. This validation is offered in order to meet those needs that were not met and which created an injury we are now trying to repair. Through validation, the person feels seen, recognized, accepted, and loved, and receives everything that she needed from her attachment figures, but did not receive in her past. Examples of this validation could be:

-It's OK to be who you are

-No one deserves to learn to feel that she is only worthy if she is thin

-You are much more than your body

-It must have been hard to think that you are only lovable if you are pretty

Another important point is getting to know the belief system that guides the inner experience of the client, which can block the therapeutic process if it is not taken into consideration (beliefs such as, "I am worthless," "if I'm not pretty, no one will love me," "my body is not OK," "I am fat.") In this way, we work on the invalidating beliefs which must be substituted for healthy beliefs that can change this inner experience and help the person perceive reality in the inner and outer worlds in a healthy way.

In developing the work with the rejected self, we know the processing is working if the defences of rejection, shame, and worry are substituted for the sadness that starts emerging towards the rejected self. Defences are neutralized and give way to the emotions contained in this part, finally moving from grief to compassion and acceptance, which will lead to integration.

THERAPEUTIC GOALS

Overall, the therapeutic goals that lead us to therapeutic success are the following:

1. Identifying the body as one's own

2. Accepting the body as one's own

3. Processing the trauma contained in the rejected self, both at cognitive and emotional levels

4. Substituting body image distortion for acceptance

5. Learning to respectfully feel and take care of the body

6. Integrating this dissociative part that represents the rejected self and its defence (body image distortion)

CONCLUSION

When working on the rejected self, we are integrating not only one of the parts most resistant to change in Eating Disorders, but also the body and everything that led to dissociation. Integrating this part implies a great step forward in the treatment of the disorder.

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