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Spiritual Issues and Interventions in the Treatment of Patients with Eating Disorders

Cover Page Footnote

Julie B. Clark-Sly, David K. Anderson

Spiritual Issues and Interventions in the Treatment of Patients with Eating Disorders

P. Scott Richards, Randy K. Hardman, Harold A. Frost,
Michael E. Berrett, Julie B. Clark-Sly, David K. Anderson¹

Abstract

This article examines the roles of religion and spirituality in the etiology and treatment of eating disorders. After briefly reviewing the relevant research, we discuss the most common and significant religious and spiritual issues we have observed with LDS eating disorder patients including negative images or perceptions of God, feelings of spiritual unworthiness and shame, and fear of abandonment by God. We briefly describe process considerations for using spiritual interventions and conclude by describing seven spiritual interventions we have found especially useful in treating LDS eating disorder patients, including spiritual teachings, spiritual bibliotherapy, and prayer.

The role of religious and spiritual influences in human development, functioning, and healing is becoming more widely recognized in the medical and psychological professions (Benson, 1996; Borysenko & Borysenko, 1994; Dossey, 1993; Richards & Bergin, 1997; Shafranske, 1996; Worthington, Kurusu, McCullough, &

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Sanders, 1996). However, the influence of religious and spiritual matters in the development, maintenance, and recovery from eating disorders has been largely neglected (Kroll & Sheenan, 1989; Mitchell, Erlander, Pyle, & Fletcher, 1990), although the small number of studies that have been done in this area support the notion that religious and spiritual issues may be important in both etiology and treatment.

Several researchers have investigated the relationship between eating disorder prevalence or severity, and religious affiliation or devoutness. Although some have found no differences based on religious affiliation (e.g., Garfinkel & Garner, 1982; Rowland, 1970; Ziegler & Sours, 1968), others have concluded that Roman Catholics and Jews may have higher prevalence rates (e.g., Sykes, Gross, & Subishin, 1986; Sykes, Leuser, Melia, & Gross, 1988). Joughin, Crisp, Halek, and Humphrey (1992) found that patients who rated their religion as important tended to have the lowest adult Body Mass Indices (BMIs), whereas bulimic symptomology was associated with a weaker religious beliefs. They concluded that "religion is important to a majority of subjects with eating disorders and that the eating disorder and religious beliefs interact" (p. 404). They also suggested that a patient's "religious belief system" can present a "major challenge for a therapist" (p. 404).

These studies are helpful, but many more are needed to confirm that eating disorders are more prevalent in some religions than in others, or that religious devoutness is consistently associated with the severity of anorexic or bulimic symptoms. Such studies could help us more adequately understand the role of religion in the etiology of eating disorders.

Additionally, several researchers have recently concluded that religion and spirituality may be important in the healing and treatment of eating disorders. Mitchell et al. (1990) reported that "in a follow-up study of patients with bulimia nervosa we noted that the single most common write-in answer as to what factors have been helpful in their recovery had to do with religion in the form of faith, pastoral counseling, or prayer. Since we had not inquired about this system-

atically, we were somewhat surprised by the number of these responses" (p. 589).

Hall and Cohn (1992) conducted two surveys in which they asked 366 women and 6 men what activities had been helpful in their recovery from bulimia and other forms of problem eating. Fifty-nine percent of the respondents said that "spiritual pursuits" had been helpful. Thirty-five percent said that a spiritually oriented 12-step program, Overeaters Anonymous, was helpful to them.

Hsu, Crisp, and Callender (1992) did follow-up interviews of patients who had recovered from anorexia nervosa to find out what the patients believed helped them recover. One patient indicated that her religious beliefs, including prayer, church attendance, and faith in God helped in her recovery. Hsu et al. (1992) acknowledged that the influence of religion on recovery was "an area that we did not inquire about at all in our interview[s]" and that it was thus "unclear whether it played a part in the recovery of others" (p. 348). They acknowledged that this "oversight is perhaps indicative of our indifference to the ethical and transcendental aspects of the patients' illness" (p. 348).

Rorty, Yager, and Rossotto (1993) interviewed 40 women who considered themselves to have recovered from bulimia nervosa to find out what helped them recover. Many of the women (25 to 40%) participated in a 12-step program, such as Overeaters Anonymous, Alcoholics Anonymous, or AlAnon, and had found the "spiritual aspects" of these programs helpful. Some had sought out other forms of spiritual guidance. Rorty et al. (1993) concluded that "nonprofessional contacts, such as support groups of various kinds and including a spiritual focus in some cases, are important components of the healing process for many women" (p. 259-260).

Despite the indications that religion and spirituality may be important in the etiology and treatment of eating disorders, little has been written regarding the types of religious and spiritual issues patients with eating disorders may have, or the spiritual interventions that may be helpful in treating them. A few writers have described the use of 12-step approaches that emphasize the importance of patients'

trusting in a Higher Power (e.g., Elizabeth L., 1987; Meltsner, 1993). Although these approaches are a valuable foundation, we have found that other perspectives and interventions are often helpful.

This article shares our views of the role of religion and spirituality in the etiology and treatment of eating disorders. In our clinical experience, we have found that spiritual issues and interventions are often central to the disorder and the recovery. We first discuss the most common and significant religious and spiritual issues that we have observed in working with Latter-day Saint eating disorder patients. Next we discuss some process issues that must be considered when using spiritual interventions. We conclude by describing spiritual interventions that have proven useful for helping LDS eating disorder patients.

Religious and Spiritual Issues of Eating Disorder Patients

In our clinical work, we have observed at least seven important religious and spiritual issues that LDS patients with eating disorders often struggle with: (1) negative images or perceptions of God, (2) feelings of spiritual unworthiness and shame, (3) fear of abandonment by God, (4) guilt and/or lack of acceptance of sexuality, (5) reduced capacity to love and serve, (6) difficulty surrendering and having faith, and (7) dishonesty and deception.

Negative Images of God

Eating disorder patients often struggle with a negative image of God. They perceive God as an angry old man—a judgmental and punishing figure. Believing that God views them as sinful, unworthy, and defective, they feel alienated and disconnected from him, and undeserving of his help. Thus, their relationship with God, rather than a source of love, comfort, strength, and support, is filled with anxiety, guilt, and shame.

Eating disorder patients tend to perceive God much as they perceive their parents. For example, one of our patients, who considered her parents emotionally distant, viewed God the same way. Patients

who experience their parents as rejecting, critical, controlling, angry, devaluing, or shaming often project the same characteristics onto God.

Research has documented a frequent similarity between how people perceive their parents and how they perceive God (Wulff, 1991), so it is not surprising to find eating disorder patients making this connection. The clinician's task is to help patients recognize the connection they have made and help them separate the two by reevaluating and modifying their distorted perceptions.

Feelings of Spiritual Unworthiness and Shame

Many eating disorder patients feel spiritually unworthy, defective, or ashamed. And they believe that God (and everyone else) views them as unworthy. Instead of a healthy sense of their identity and self-worth, they have a cosmic sense of being spiritually and morally bad and sinful, undeserving of God's help.

Many eating disorder patients attempt to compensate for their feelings of spiritual unworthiness through perfectionism, relentlessly striving to meet impossibly high standards—physically, morally, religiously, academically, etc. Their failure to be perfect then confirms their belief that they are unworthy, reinforcing their feelings of shame and spiritual defectiveness.

Eating disorder patients' feelings of unworthiness and shame are often rooted in shaming experiences from their family of origin. Thus, a major clinical goal is to help patients affirm the worth and goodness of their eternal spiritual identity (Richards & Bergin, 1997). We have found it useful to help patients understand the connections between their feelings of unworthiness and earlier family experiences and to explain how religious beliefs may intensify such feelings. With this insight, patients can often challenge and modify beliefs and assumptions that have had a negative impact on their self-image and self-esteem. Spiritual practices such as prayer, meditation, and reading spiritual literature can be powerful in helping patients affirm their spiritual identity and worth.

Fear of Abandonment by God

Many eating disorder patients fear abandonment and disapproval from God. They want God and others to approve and take care of them. Their fear that they have displeased God and will be abandoned by him seems to be confirmed whenever they feel that God has not shown his love by actively intervening in their lives. These patients have difficulty trusting in God's love and providence, viewing him as capricious and judgmental.

Many eating disorder patients were sexually abused as children and believe that God abandoned them during the abuse. They conclude, "A loving God would not have permitted me to be abused, but I was, and so God must not love me. I must be a very bad person because God didn't love and protect me." These patients often have great difficulty trusting God and believing that he will support and help them.

As these patients' perceptions of God are often strongly connected to their perceptions of their parents, many fear God's abandonment because of physical or emotional neglect or abuse during their childhood. Again, the clinician can help patients understand how their childhood experiences have affected their feelings about God, helping them reexamine and modify their perceptions of and expectations for God. If patients' come to view God as a loving, trustworthy, and forgiving being, then they will not be so afraid that he will abandon, judge, and disapprove.

Guilt and Shame about Sexuality

Many patients with bulimia nervosa were sexually abused as children or young adolescents and become sexually promiscuous. Society taught them that their needs for love and self-esteem can be fulfilled through sexual activity; thus, they confuse sex and love. They also believe that all they have of value to offer others is sex or their bodies. Paradoxically, they hate their bodies.

The guilt such patients experience seems to be intensified when they are LDS because the Church has such strong prohibitions against premarital or extramarital sex. We regard guilt as healthy when

patients recognize a harmful or morally wrong act, but do not condemn their whole selves as deficient or bad (Richards, 1991). Guilt over sexual promiscuity can be functional when it motivates patients to avoid such unhealthy behaviors, and we encourage and support patients who consider such behavior morally wrong, to live in harmony with their values. At times we confront them about the discrepancies between their professed values and their sexual behavior. We share the assumption of the majority of mental health professionals that congruence between one's values and behavior is important for mental health (Jensen & Bergin, 1988).

Some patients' guilt about their sexual promiscuity is dysfunctional, being so extreme that they are unable to separate the act from their worth as a person, and deep feelings of shame, worthlessness and deficiency result (Richards, 1991). Guilt is also dysfunctional when it is compulsive, and reoccurring, and when it is not lessened by sincere efforts to confess, make restitution, and change.

Many eating disorder patients do struggle with dysfunctional guilt, part of the pattern of feeling worthless and deficient. When guilt over actual wrongdoings triggers this shame, we try to help them understand the difference between appropriate guilt and dysfunctional shame, guiding them to examine their beliefs about repentance, forgiveness, and grace. We try to help LDS patients accept the notion that the atonement of Jesus Christ applies to them—not just to other people, as they often suppose. We work at teaching them not to condemn themselves over minor human mistakes and frailties.

We have found that religious beliefs of LDS patients with anorexia nervosa can intensify their inability to accept their developing sexuality. In some cases, the dysfunctional messages about sexuality the patients received from their parents went well beyond the Church's teachings. Because the family's rigid and shaming messages about sex was the cause of their sexuality problems, not the gospel or the Church, we help these patients examine their beliefs about sexuality, identify the source of these beliefs, and reexamine them in light of more mature and accurate views. The Church's teachings about sexu-

ality may need to be examined so that patients can recognize the discrepancy between their beliefs about sexuality and those of their religion. Ultimately, we try to help our patients internalize more healthy, mature sexual values, consistent with the teachings of the gospel.

Reduced Capacity to Love and Serve

Many eating disorder patients seem to be deficient in their capacity to love and serve others in a healthy manner. As many patients are codependent, to them love and service means to "let people walk on you" or to "always please others at any cost." Having rarely experienced anything different, they seem unable to understand that they could love and serve others without giving up their identity, preferences, and needs. Some of our patients seem suspicious and fearful of love because the love they have experienced carries heavy expectations and obligations; thus they tend to disqualify or avoid love, whether it be God's love or the love of others, often purposely remaining a victim.

LDS patients may have added difficulty because of the expectations of the church culture to "love and serve" others. Because of their issues, such expectations are uncomfortable for them. If they avoid acts of service, they often feel guilty and unworthy; if they ignore their anxieties and get involved in service, they often push themselves so hard they end up feeling used.

We find that patients' difficulties with love and service, like those with fear of God and sexuality, most often originate in their families, where they have acquired the belief that loving and serving others requires giving up one's identity, needs, and preferences. This unhealthy view of love and service may have even been given a religious rationale. Our clinical goal with such patients is to help them differentiate between codependency, or being "used," and healthy love and service. We do "boundary work" to help them affirm their need and right to their own identity, preferences, and time. We challenge their belief that love and service requires letting others take advantage of them. We teach them that unconditional love and conditional rela-

tionship boundaries are not antithetical and are both present in healthy relationships. We teach and attempt to model that one can engage in acts of love and service without attaching expectations and obligations. We also try to help them learn to stop disqualifying God's love and the love of others when they experience it.

Difficulty Surrendering and Having Faith

Many professionals believe that eating disorder patients attempt to bring control into their lives through controlling their eating behavior, and that they attempt to control or "numb out" unpleasant feelings and emotions by restricting, bingeing, and/or purging behaviors. Many patients also attempt to control their emotions and lives through perfectionism. Unfortunately, these efforts to control their emotions and behavior often become so extreme that they have a problem of *over-control*, which can impair their spiritual growth and well-being.

Many of our eating disorder patients have become so good at controlling or numbing out their emotions that they are unable to experience sensitive spiritual feelings. When they attend church, pray, read spiritual literature or meditate, they still feel spiritually numb or dead. Feeling that something is wrong with them, they often attribute their lack of spiritual feelings to defectiveness or unworthiness.

Many patients also often have difficulty surrendering and having faith and trust in God. The 12-steps program helps addicts admit that (a) their lives have become unmanageable, (b) a Higher Power can help them, and (c) they will turn their will and lives over to the care of the Higher Power (AA World Services, 1980). Many of our patients seem so afraid of losing control that they are unable or unwilling to give up their control over their eating behavior and emotions. They fear and resist surrendering and having faith in God because they see that as "letting go" of control.

A major clinical task with such patients is to help them recognize that their dysfunctional efforts to stay in control actually keep them from being in control of their health and well-being. We help our

patients learn a variety of healthy ways to manage and deal with their pain and unpleasant emotions. With LDS patients, we share our belief that in surrendering some control to God, they will receive strength and courage to learn new ways to cope with and overcome their pain and problems. For those patients who have concluded that they are spiritually unworthy or defective because they never experience spiritual feelings, we help them understand that one of the costs of “numbing out” painful feelings is a reduced capacity to experience positive, joyful feelings. We explain that they have “locked the doors and windows” to their spirituality. We seek to help them give up their dysfunctional over-control so that they can be more sensitive to both their painful and joyful feelings, and so that they can let the spiritual influences in.

Dishonesty and Deception

Another important spiritual issue for eating disorder patients is that of dishonesty and deception. Most eating disorder patients, particularly those with bulimia nervosa, are very secretive about their eating and weight control behaviors (i.e., bingeing, purging, laxative abuse), and experience a great deal of shame over their dishonesty. Religious prohibitions may intensify the shame. A related problem is distrust: because eating disorder patients are secretive and dishonest, they have difficulty believing others are honest; thus, they feel they cannot trust anybody, even God.

With our patients, we attempt to confront the secrecy and dishonesty in a nonshaming manner. We try to help our patients own their secrecy and dishonesty and begin to be more honest with God and others. We help them recognize the consequences of their behaviors (i.e., guilt and shame, social and spiritual isolation, lack of trust). We give them opportunities in individual, group, and family therapy to be more honest, and encourage spiritual interventions such as prayer and spiritual bibliotherapy to strengthen their commitment to honesty.

General Considerations in Using Spiritual Interventions

Before describing specific spiritual interventions helpful in treating

eating disorder patients, we wish to emphasize that they should be used as part of an integrative, multidimensional treatment approach that includes standard medical and psychological approaches and interventions. At the Center for Change, we use a multidimensional, multidisciplinary, stepped care approach to treatment. The four levels of care include (a) a residential inpatient treatment program, (b) an intensive day treatment program, (c) an intensive outpatient program, and (d) traditional outpatient therapy. Our program is multidimensional in that it includes medical and psychological evaluations; individual, group, family, and recreational therapies; art and dance movement therapies; medical and nutrition treatment; spiritual interventions and approaches; an exercise program; and classes educating patients about a wide variety of psychosocial topics (e.g., self-esteem, diet and nutrition, relationships, addiction control, parenting, etc.). It is multidisciplinary in that it employs physicians, psychologists, consulting psychiatrists, social workers, recreational therapists, nutritionists, and nurses. We also consult with LDS patients' bishops when appropriate.

Our integrative approach to using spiritual interventions is congruent with findings that eating disorders are complex and that treatment is more successful with a multidimensional, multidisciplinary approach (e.g., APA, 1993; Andersen, 1983; Garner, Garfinkel, & Bemis, 1982; Kennedy & Garfinkel, 1992; Landau-West, Kohl, & Pasulka, 1993; Yager, 1988, 1994; Zerbe, 1992). This approach is also consistent with the recommendations of numerous professionals that spiritual interventions should not be used alone, but integrated with standard psychological and medical interventions (Richards & Bergin, 1997; Richards & Potts, 1995; Shafranske, 1996).

Although the empirical literature on spiritual interventions is limited, several studies have recently revealed that a wide variety are used by professional therapists (Ball & Goodyear, 1991; Jones, Watson, & Wolfram, 1992; Moon, Bailey, Willis, & Kwasny, 1993; Richards & Potts, 1995; Worthington, Dupont, Berry, & Duncan, 1988). The most frequently used spiritual interventions to date are praying privately for patients, teaching religious and spiritual concepts, encour-

aging forgiveness, and referring to scriptures. Less frequently used are spiritual meditation, religious relaxation and imagery, religious-spiritual assessment, and encouragement of private prayer.

There is now considerable empirical evidence that spiritual practices promote physical and emotional healing (Benson, 1996; Borysenko & Borysenko, 1994). Several studies have also shown that psychotherapy with religious clients that includes spiritual interventions in the treatment package is as effective, and sometimes more effective, than standard secular treatments (Payne, Bergin, & Loftus, 1992; Worthington et al., 1996).

Purpose of Spiritual Interventions and Process Suggestions

Spiritual interventions are used to help promote patients' religious and spiritual growth and well-being, thereby helping them to better cope with and overcome their problems (Richards & Bergin, 1997). Spiritual interventions are also often useful for helping eating disorder patients (a) challenge and modify immature and dysfunctional perceptions of God and self, (b) overcome feelings of shame and unworthiness, (c) alter their distorted body image, (d) affirm their spiritual identity and worth, and (e) gain a clearer sense of life's purpose and meaning.

Therapists should inform patients at the start of therapy that, when appropriate, they sometimes recommend spiritual interventions. Before using them, therapists should establish a relationship of trust and assess their patients' religious background to make sure such interventions are not contraindicated. Spiritual interventions are contraindicated when (a) patients make it clear they do not wish to participate in them, (b) patients are delusional or psychotic, (c) spiritual issues are not relevant to the patient's presenting problems, and (d) parents of adolescent patients have not provided written permission for therapists to use them (Richards & Bergin, 1997).

Therapists should also describe specific spiritual interventions they wish to use and obtain clients' consent before implementing them. They should be careful to work within their clients' value frameworks and not impose their own spiritual beliefs. Several recent books are

now available to assist psychotherapists who would like more information about how they can ethically and effectively incorporate spiritual perspectives and interventions into their practices (Kelly, 1995; Richards & Bergin, 1997; Shafranske, 1996).

Specific Spiritual Interventions for Eating Disorder Patients

We have found success with a number of spiritual interventions. Here we briefly describe seven that are particularly useful with LDS eating disorder patients: (1) teaching spiritual concepts, (2) assigning religious/spiritual bibliotherapy, (3) encouraging prayer, (4) encouraging spiritual imagery and meditation, (5) encouraging forgiveness, (6) encouraging patients to seek spiritual direction from their bishops or stake presidents, and (7) encouraging clients to be involved in their ward or branch.

Teaching Spiritual Concepts. Because eating disorder patients have often acquired distorted and dysfunctional religious and spiritual beliefs from their families of origin, a major therapeutic task is to help them become aware of, examine, and modify these cognitions. In this cognitive restructuring process, we frequently teach patients religious and spiritual concepts that are more healthy *and* consistent with LDS theology, sometimes implicitly by sharing our spiritual beliefs and understandings about an issue. At other times, we explicitly refer to scriptures or other religious writings, such as talks by General Authorities and other Church publications.

We may teach our patients a wide variety of spiritual concepts, depending on their issues and religious beliefs: for example, we often teach patients what we understand about God's love and grace, forgiveness, confession, prayer, love and service, honesty, human suffering and imperfections, and so on. Many eating disorder patients are developmentally delayed spiritually; thus, actively teaching spiritual concepts is often crucial to successful psychotherapy.

Religious/Spiritual Bibliotherapy. One way that we teach our patients spiritual concepts is by asking them to read scriptures out of the standard works and other spiritual literature about topics such as forgiveness, transcending parental transgression, grace, love, guilt,

Table 1

Definitions and Examples of Religious and Spiritual Interventions for Eating Disorder Patients

Intervention	Definition	Examples of Intervention
Teaching Spiritual Concepts	Teaching or instructing patients about theological issues and spiritual concepts relevant to their issues.	Teaching patients about scriptural teaching about grace and love. Helping patients more fully understand their eternal spiritual identity and that their spiritual self-worth is independent of their weight and body image.
Religious Bibliotherapy	Giving patients religious and spiritual literature to read	Encouraging patients to read scriptures (e.g., the Bible or Book of Mormon). Giving patients articles about forgiveness, shame, and grace.
Prayer	Therapist private prayer. Encouraging patients to pray privately out-of-sessions.	Praying on behalf of patients that they will develop a better understanding of their eating disorder and the function it fulfills. Encouraging patients to pray that their distorted body image will leave.
Spiritual Imagery or Meditation	The use of guided imagery, meditation, or relaxation with reference to spiritual concepts or images.	During guided imagery, asking patients to visualize being embraced by and speaking with a "being of light." Encouraging patients to visualize, as they look in the mirror how God and Jesus Christ see them.
Encouraging Forgiveness	Discussing the concept of forgiveness with patient; encouraging patient to forgive parents or others	Discussing how to obtain forgiveness when a patient reports guilt about a moral transgression. Encouraging patients to forgive their parents for the messages they gave them about weight, body image, and self-worth.

(Table continued)

Table 1 (continued)

Intervention	Definition	Examples of Intervention
Referral for Spiritual Direction	Encouraging patient to seek spiritual direction from her religious leader to help her cope and work through impasses.	Suggesting that a patient seek direction and/or a blessing from her bishop for assistance in gaining the emotional and spiritual strength to overcome her eating disorder. Encouraging a patient to seek clarification from her bishop regarding doctrinal teachings.
Involvement in the Religious Community	Encouraging patients to participate actively in their ward or branch.	Encouraging patients to return to church and discuss with them how they can worry less about their physical appearance when they go. Teaching patients how to be appropriately assertive as they interact with members of their ward or branch.

trust, spiritual identity and worth, and the role of suffering and pain. Spiritual literature helps patients challenge and modify dysfunctional religious beliefs as they see that these beliefs are not consistent with the scriptures or with other authoritative spiritual writings.

In addition, the scriptures are filled with powerful stories and metaphors about the human condition from which patients can gain insight and inspiration. Some patients find that reading and pondering about the scriptures is an emotional and spiritual experience that helps them feel an inner harmony and peace giving them comfort, perspective, meaning, and strength. Some patients report feeling more secure and grounded spiritually in their feelings of identity and self-esteem after reading the scriptures and other spiritual writings.

Prayer. We often pray privately for our patients and encourage them to pray privately for themselves and others outside of therapy sessions, according to the patient's belief in, comfort with, and desire for prayer. As praying *with* patients in-session can cause role boundary confusion and transference issues (Richards & Bergin, 1997; Richards & Potts, 1995), we generally avoid this practice.

Many of our patients do not know how to pray specifically and directly about their needs and concerns; some feel that they don't deserve to be prayed for. We encourage our patients to pray according to their beliefs. In praying for themselves and others, we encourage our LDS patients to be specific, direct, and honest, looking to God for guidance and validation instead of looking to other people.

Prayer can be a powerful resource to assist LDS patients in their coping, healing, and growth. There is much evidence that people who pray do feel better, both physically and emotionally (Dossey, 1993). We have found prayer to be a powerful practice for helping eating disorder patients become more accepting of their body image. Some of our patients have told us that the only way they could see their body differently, or accept it as God-given, was by praying that their distorted body image would leave. Prayer also seems to help our patients feel less isolated and more hopeful, accepting, and optimistic. At times our patients have reported powerful experiences of insight and healing during moments of prayer.

Spiritual Imagery and Meditation. Spiritual imagery, meditation, and contemplation require a trusting, passive attitude of release, surrender of control, active focusing of thoughts, awareness of task, and relaxation of muscles (Martin & Carlson, 1988). Spiritual imagery and meditation can be therapeutic for many eating disorder patients, as such practices put them more in tune with their inner emotional and spiritual feelings. Patients have experienced powerful affirmations and flashes of insight into their spiritual identity and worth. Much empirical evidence confirms significant healing effects on the mind and body from spiritual imagery and meditation (Benson, 1996; Borysenko & Borysenko, 1994).

A guided imagery tape produced by Harold Frost (Frost, 1988) which makes reference to a "being of light" that embraces and communicates forgiveness, love and acceptance to the patient, has been an effective diagnostic and healing intervention for us. Some patients feel undeserving of this love and acceptance, but others are able to accept it and experience a sense of love and affirmation. The patient's

reaction provides the therapist with important material to explore in therapy, and the tape sometimes profoundly influences patients' sense of identity and self-esteem, increasing their ability to accept their body image.

Another helpful meditative/imagery intervention is to ask patients, when they look in the mirror, to visualize how God and Jesus Christ see them. Some have found that this helps them begin to alter their body image and become more accepting of it. Since patients often use their body image as a barometer of their self-worth, we encourage them to visualize their bodies as divine gifts from God and teach them to treat their bodies with more reverence and respect.

Encouraging Forgiveness. Much has been written recently about the importance of forgiveness in healing and therapy. Research indicates it is one of the most frequently used spiritual interventions in psychotherapy (Richards & Bergin, 1997). Helping our eating disorder patients to forgive others (e.g., parents, their abuser), themselves, and God is important in the healing process. Many patients find it hard to forgive parents or others who have hurt or abused them, or to acknowledge that they feel disappointment, resentment, and anger toward God; thus, it is often helpful to frame forgiveness as a gift or choice, not a requirement or condition.

Some patients have particular difficulty with self-forgiveness, feelings of shame, and spiritual unworthiness, which cause them to believe they do not deserve to be forgiven. We try to help these patients receive God's forgiveness and mercy instead of denying it. The gospel contains many teachings about the love and mercy of God, so when it seems relevant, we emphasize such teachings to our patients to help them understand self-forgiveness as a healing process that includes responsibility and accountability, but not self-punishment.

Forgiveness should not be rushed: intense feelings of hurt, disappointment, anger, and rage must often be acknowledged, re-experienced, and worked through before patients are ready to forgive. To "foreclose" on these emotions and prematurely forgive often gets many patients into trouble emotionally, as they must deny their feel-

ings of hurt, disappointment, resentment, and anger over what they have suffered. Many of our eating disorder patients are already repressing their emotions; prematurely encouraging them to forgive others would exacerbate this problem. Once patients have worked through the difficult emotions associated with their abuse and severe neglect (i.e., shock, denial, awareness and recognition, hurt, shame, grief, anger, and rage), forgiveness becomes possible. The most profound healing and peace occurs when patients are able to forgive themselves and others.

Seeking Spiritual Direction. We have encouraged many of our LDS patients to seek guidance and direction from their bishops and/or stake presidents. Patients' bishops have often referred them for treatment, and a trusting relationship existed between them before psychological treatment began. It is often helpful for such patients to experience their bishop's caring and support during their treatment. Because of their role authority, bishops can sometimes influence reluctant patients to stay in treatment or comply with therapeutic recommendations. Bishops can provide meaningful spiritual and emotional guidance and comfort to clients, as well as assist in correcting faulty and dysfunctional religious beliefs. They can provide assessment information for therapists on patients' functioning outside of the treatment context. When in-patient treatment is completed, bishops can significantly assist in relapse prevention by mobilizing social and emotional support in the patient's ward or branch.

Of course, not all religious leaders are helpful or therapeutic with our patients. Some bishops relate to patients in a shaming and/or controlling manner. Others reinforce simplistic and dysfunctional religious beliefs that exacerbate patients' emotional distress. Sometimes bishops who know little about eating disorders unknowingly reinforce unhealthy eating behaviors. For example, one bulimic LDS patient reported that her bishop said, "Well, I guess it's better for you to vomit once in a while than to become overweight like many of the women in our ward." Other bishops are too busy or preoccupied to assist. Furthermore, some eating disorder patients do not want or are not

ready for spiritual guidance from their leaders due to unresolved feelings of resentment and anger toward religious authorities.

Thus, therapists should carefully assess their patients' willingness and readiness for spiritual direction before recommending it. Therapists should visit with their patients' bishops to make sure that they are willing and capable of providing emotional and spiritual support and understand how before involving them in treatment. Of course, therapists should obtain written permission from their patients to contact religious leaders before doing so.

Encouraging Involvement in the Religious Community. Many of our patients report that their activity in their ward or branch is unpleasant, controlling, and shame inducing. As patients often feel ashamed and spiritually unworthy, going to church services can exacerbate these feelings. We often encourage religious patients who have drifted into inactivity to return to activity and fellowship—after we have helped them to experience their religious involvement as more positive. Patients who are active but not “happy” or “healthy” in their religious involvement can be taught how to experience their ward or branch in a more positive manner.

We generally help our eating disorder patients move from an extrinsic (social and personal gain) religious orientation to a more intrinsic (internal, devout, service and worship oriented) one (Allport & Ross, 1967; Donahue, 1985; Richards & Bergin, 1997), and to be less concerned about being physically “on display” at church services and more focused on their spiritual feelings, behaviors, and needs. Sometimes we help them learn to be appropriately assertive and to set boundaries and limits with those in their ward or branch who might attempt to control or manipulate them.

Involvement in a church includes much that is healthy: opportunities for worship, ritual, charitable service, and social support and fellowship (Benson, 1996; Pargament, 1996; Levin, 1994). Once patients learn healthy participation, this involvement can significantly help them in their efforts to cope, heal, and grow.

Letter from a Patient

Although there is not space to include a full-length case report in this article, we present the following letter from a former LDS patient at the Center for Change. She wrote it for women who struggle with eating disorders, and it illustrates her belief that faith in God and spiritual healing were crucial in her recovery. We use it with her permission.

A few months ago, I realized that I needed to seek medical help for my eating disorder, bulimia. But the more I thought about it, the more impossible it seemed that anyone could help me. I had no hope and absolutely no faith that I could overcome my eating disorder. After all, I had wasted and ruined the last four years of my life, hadn't I? I'd been so obsessed with myself and trying to escape my problems with a temporary solution that I was so unhappy. I was addicted to my eating disorder and thought that there was no hope in anyone being able to help me. I would be a terrible, miserable, worthless sinner forever.

Then something changed. One night, as I was feeling so depressed and so alone, a dear friend encouraged me to pray and to read my scriptures. I thought to myself, "no way." Like this will really do anything for me. But then I decided that it couldn't hurt me. So I knelt on my knees and cried to Heavenly Father. I told him how worthless and hopeless I felt and that I didn't know what to do with myself. Then I pleaded with him to comfort me. I asked that if there was anyway that I could find someone to help me to please let me find them. I expressed the feelings of doubt and hopelessness I felt about the possibility, but I did know that He knew all things. For the first time, I had a slight ounce of hope and faith that night. I was totally relying on God to save me from my darkness and hopelessness. Before I even ended my prayer, I started to feel a warm and comforting feelings and I strangely knew that there was hope and that everything would turn out okay and that I would find help to overcome my bulimia. I thought that maybe there really would be a light at the end of the tunnel; the darkness would soon be gone.

Now that I have gone through therapy and inpatient treatment, I've learned that you have to have hope and faith in yourself and God and Jesus Christ. It's the only way to win the battle. Without it you can never overcome any kind of obstacle. It is

essential to have hope and faith in order to find true happiness. Believe in yourself. Believe in God. If you do that, you can overcome anything that stands in your way. I've been doing that. And because of that I have found the light at the end of the tunnel. Now I must venture into the light to continue my journey with hope that brings happiness.

Conclusions

Religious and spiritual issues are frequently intertwined with the pathology of our eating disorder patients. Religious issues can contribute to, exacerbate, and help maintain eating disorders. However, religious and spiritual resources and interventions are frequently instrumental in our patients' healing and recovery. We hope that the information in this article will be helpful to AMCAP members in furthering their understanding of, and ability to help, eating disorder patients in their recovery process.

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