
A Fictional Case Study Involving Person-Centred Therapy and Transpersonal Psychotherapy in Conceptualizing and Treating Bulimia Nervosa

Une étude d'un cas fictif impliquant une thérapie centrée sur la personne et une psychothérapie transpersonnelle dans la conceptualisation et le traitement de la boulimie nerveuse

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ABSTRACT

This fictional case study explores various components of person-centred therapy and transpersonal psychotherapy as applied to the conceptualization of a bulimia nervosa case study and psychotherapeutic treatment. The strengths and limitations of these theories in the conceptualization and treatment of bulimia nervosa are discussed.

RÉSUMÉ

Cette étude de cas s'intéresse aux différentes composantes des théories centrées sur la personne et de la psychothérapie transpersonnelle, plus précisément à la conceptualisation d'un trouble de boulimie nerveuse basée sur un cas fictif, en vue de l'élaboration et de la planification d'une intervention thérapeutique. Les forces et limites de ces théories, en lien avec la conceptualisation et le traitement de la boulimie, font l'objet d'une discussion.

Bulimia nervosa is a complex eating disorder that is characterized by recurrent episodes of binge eating and purging (Vaz, 1998). More specifically, it is a disorder that involves the hasty consumption of a large amount of food, followed by compensatory behaviours such as vomiting, fasting, or excessive exercise with the intent of thwarting weight gain (Davison, Blankstein, Flett, & Neale, 2014). The *DSM-5* (American Psychiatric Association [APA], 2013) explains that the binge episode usually takes place during a distinct period of time (within a 2-hour period, for example) and that the person who is bingeing experiences a loss of control over their behaviour. In addition, the self-evaluation of a person living with bulimia nervosa is markedly influenced by body shape (or perceived body shape) and weight (APA, 2013).

In this article, a case conceptualization and treatment plan is formulated for a fictional client living with bulimia nervosa, who is also searching for meaning in her life. First, two theoretical approaches are introduced (person-centred therapy and transpersonal psychotherapy), and a rationale for their combination

is provided as applied to the treatment of bulimia nervosa. Second, the client's case is presented, including history and symptomatology. Next, a case conceptualization for this client is presented, employing the two theoretical approaches. A treatment plan is then described, including two therapist-client verbatim sections that demonstrate techniques from both approaches. Finally, a discussion of the strengths and limitations of both theoretical perspectives in the conceptualization and treatment of this eating disorder is presented.

THEORETICAL MODEL PRESENTATION

In the following section, both person-centred therapy and a transpersonal psychotherapeutic orientation are presented, along with a discussion of how these approaches can be integrated.

Person-Centred Therapy

In Rogers's person-centred therapy, a client's strengths and resources are used to foster self-direction and the ability to accept responsibility for their actions (Murdock, 2013). *Incongruence* (manifested as psychopathology) develops when a person's external values are not aligned with his or her own inner experiences or feelings (Rogers, 1980). *Conditions of worth* often arise when children perceive that certain aspects of themselves are negatively evaluated by someone that they consider to be important (Murdock, 2013). Discrepancies often arise between a person's *real self* (i.e., actual lived experience) and his or her *ideal self* (Rogers, 1980), leading to incongruence. This approach depends on the therapeutic integration of the core conditions of congruence or genuineness, empathy, and unconditional positive regard in order to build the client-therapist relationship (Rogers, 1975). A typical treatment protocol focused on achieving these three core relationship conditions in therapy is demonstrated in a verbatim located near the end of this article.

Transpersonal Psychotherapy

A transpersonal approach to psychotherapy is holistic in nature and seeks to integrate the physical, emotional, mental, and spiritual aspects of well-being (Vaughan, 1993). Caring for the soul is an important component of psychotherapy for some transpersonal therapists (Vaughan, 1993). A fundamental assumption of transpersonal psychotherapy is that consciousness is at the heart of what it means to be human and that what we may generally call spirituality is an essential component of both consciousness and identity (Rodrigues & Friedman, 2015). Further explanation of the salient similarities and differences between transpersonal psychotherapy and other approaches may be found within the transpersonal literature (e.g., Hanlon Johnson, 2015; Kaminker & Lukoff, 2015; Roberts & Winkelman, 2015; Rodrigues & Friedman, 2015).

The following discussion includes a very brief description of essential elements of transpersonal psychotherapy that are relevant to this particular case conceptualization. Vaughan (1979) made important distinctions between the transpersonal

context, content, and process in this approach to psychotherapy. The transpersonal *context* in psychotherapy is determined wholly by the beliefs, values, and intentions of the psychotherapist (Vaughan, 1993). In addition to being open to a spiritual realm of experience, psychotherapists must set aside the desire to “fix” their client. Instead, therapists fully embrace the mystery and wisdom within each client and honours their discovery process as it unfolds. What distinguishes transpersonal psychotherapy from other approaches is “neither technique nor the presenting problems of the clients but the spiritual perspective of the therapist” (Wittine, 1993, p. 165).

Vaughan (1993) explained that “the content of transpersonal therapy is the life experience of the client” (p. 161), which may be “mythical, archetypal, personal, or transpersonal” (p. 161). Transpersonal experiences include those in which one’s sense of identity stretches beyond the personal, and includes broader notions of life, humanity, cosmos, and psyche (Walsh & Vaughan, 1993).

The *process* of transpersonal psychotherapy is not necessarily concerned with problem solving but rather with cultivating the conditions in which problems can either be solved or transcended as appropriate; healing occurs through the participation of both psychotherapist and client in the process of transpersonal psychotherapy (Vaughan, 1993). The therapeutic process includes three distinct stages: identification, disidentification, and self-transcendence (Vaughan Clark, 1977).

The *identification* stage of the therapeutic process involves clients taking responsibility for themselves and owning their body, thoughts, and emotions (Vaughan Clark, 1977). During this stage, clients are likely to be concerned with increasing self-esteem and letting go of negative patterns of self-invalidation (Vaughan Clark, 1977). In the second stage, termed *disidentification*, the client confronts existential questions of purpose and meaning in life in order to enable him or her to begin to disidentify from “roles, possessions, activities, and relationships” (Vaughan, 1979, p. 106). The transcendence of the client’s ego occurs when the client begins to disidentify from his or her personal history and instead identify with his or her transpersonal self (Vaughan, 1993). The third stage of the therapeutic process, *self-transcendence*, involves a shift in the client’s concerns: the client becomes focused on service to others and on participation in the world rather than on themselves (Vaughan, 1979).

In transpersonal psychotherapy, several specific therapeutic methods are often used to support clients: cognitive reattribution, existential questioning, imagery, and dreamwork (Vaughan, 1993). *Dreamwork* includes, among other things, the use of active imagination and dream analysis (Bogzaran & Deslauriers, 2012; Deslauriers, 2015; Krippner, Bogzaran, & de Carvalho, 2002). Meditation is used in transpersonal psychotherapy (Hartelius, 2015; MacDonald, Walsh, & Shapiro, 2015). Clients are encouraged to participate in physical health practices (i.e., hatha yoga, aikido, and biofeedback) to provide a solid foundation for transpersonal psychospiritual growth (Vaughan, 1993). A transpersonally oriented treatment protocol is demonstrated in the verbatim below.

Potential limitations to a transpersonal approach include the possibility of enabling clients who are avoiding dealing with and healing their psychological and physical pain in the name of spirituality (Boorstein, 2000). Therapists should be well-versed in the dynamics of spiritual bypassing (Masters, 2010). Further, transpersonal psychotherapy is not indicated for clients who are unable to properly communicate in the midst of a crisis situation (Boorstein, 2000).

Integration of Person-Centred and Transpersonal Psychotherapeutic Approaches

There exists a natural connection between person-centred therapy and transpersonal psychotherapy. Transpersonal psychology was born of—and developed in response to—humanistic psychology. Both Abraham Maslow and Carl Rogers, for example, are important figures in humanistic psychology, with a particular focus on growth and self-actualization instead of pathology (Taylor, 1992). It became clear that issues around consciousness, transcendence, and spirituality were neglected in the humanistic movement (Taylor, 1992), rendering it incomplete and necessitating a new vision for a psychological paradigm that recognizes and includes the full range of human experience (Valle, 1989; Walsh, 1993).

Understood in this context, transpersonal psychotherapies are closely connected to humanistic psychotherapies in that the transpersonal approach typically both *includes* and *transcends* what came before. As such, many transpersonal psychotherapists employ a wide range of techniques and approaches (including psychoanalytic, cognitive, behavioural, and humanistic) in the context, content, and process espoused in a transpersonal worldview (Vaughan, 1993). Therefore, a humanistic psychotherapeutic approach like Rogers's person-centred therapy can easily be combined with a transpersonal approach to psychotherapy.

The psychotherapeutic use of the person-centred and transpersonal approaches was explored in “Person-Centered Spiritual Maturation: A Multidimensional Model” (Kass, 2015). In this article, Kass examined a “person-specific process of psychospiritual development” (2015, p. 53) that fosters growth. In this conceptual model, Kass explained that person-centred spiritual maturation is a multidimensional learning process that can offer a “shared holding environment for people with theistic, transpersonal, and secular humanist worldviews” (p. 67). Kass demonstrated the complementary nature of these two approaches to psychotherapy.

In terms of other similarities between these two psychotherapeutic approaches, both person-centred therapy and transpersonal psychotherapy speak of a human's great capacity for self-healing and the resources and strength found within each individual (Rogers, 1980; Vaughan, 1979). Both approaches also underscore the importance of the attitude of the psychotherapist. Rogers stressed the necessity of an authentic or congruent psychotherapist (Murdock, 2013), while Vaughan (1993) highlighted the importance of modelling authenticity. In a similar manner, Rogers referred to unconditional positive regard (Murdock, 2013), while Boorstein (2000) emphasized the recognition of the Divine within one's client.

A typical treatment plan protocol that integrates both person-centred therapy and a transpersonal psychotherapeutic approach would focus on Rogers's core con-

ditions—congruence, empathy, and unconditional positive regard—while similarly ensuring the presence of an adequate transpersonally oriented psychotherapeutic context. Applying Rogers's core conditions while cultivating a transpersonal psychotherapeutic setting sets the stage for openly receiving the content of therapy (delivered by the client) and fostering growth through the three (transpersonal) process stages: identification, disidentification, and self-transcendence. Accordingly, the integration of these two models can effectively support individuals with a wide range of concerns seeking this type of supportive psychotherapy. In a subsequent section, we will explore the combined use of person-centred and transpersonal psychotherapeutic approaches to support a client living with bulimia nervosa who is also struggling to find meaning and purpose in life.

CASE PRESENTATION: JANICE

In this section, a fictional clinical vignette is presented. It describes and outlines the client's range of symptoms and includes clinically relevant characteristics and traits.

Vignette

Janice is a 25-year-old woman who has struggled with bulimia nervosa for several years. This disorder began quite innocently, when Janice was 15 years of age. At that time she wanted to shed a few pounds, so she and her friends engaged in a weight loss competition. Before long, however, there was a shift in Janice's focus. She became very obsessed with body shape in general, and her weight in particular. It seemed like all Janice wanted to talk about during those years was caloric intake and the necessity of exercise.

As a result of the competition, Janice lost 10 pounds. By age 16, she was at a healthy weight; however, in Janice's mind, she was not thin enough. Due to her negative feelings related to her body weight, she experienced low self-esteem and began to avoid social interactions, even with her closer friends. As she continued to focus on the shape of her body and her weight, Janice decided to severely restrict her daily caloric intake. She would only eat an apple, two diet sodas, and carrot sticks during the day. By evening, she was famished.

This is when the binge eating patterns started. By age 17, Janice would pick up her own groceries once a week on her way home from school or work. These food items often included crackers, chips, peanut butter, bagels, and chocolate bars, which were kept hidden in her room. After restricting her caloric intake all day, Janice would come home and binge on the "secret food" in the privacy of her room. Her binge episodes would usually last 30 to 45 minutes, and during that time Janice would feel out of control, as though she was unable to stop eating the food. It was common for her to consume more than 2,000 calories during such an episode.

After a binge, Janice was consumed with guilt. She felt very ashamed of her behaviour. Accordingly, when the binge eating pattern began, so did the compensa-

tory behaviours—mostly self-induced vomiting and excessive exercise. Although it was at times difficult to engage in self-induced vomiting in her home, Janice developed a system that worked for her. She had bags stored in her room, so when visiting the bathroom was impossible without raising suspicion, she would vomit into the bag and dispose of the contents later.

Since exercising was seen as a positive habit in her family of origin, it was very easy to include physical activity in her daily routine. She exercised daily, often for hours at a time, but after a binge she would also engage in other physical exercise in her room. For example, Janice would perform hundreds of push-ups and sit-ups not long after a binge episode to compensate for the food she had eaten.

Janice's cycle of bingeing and purging went on for several years, although the severity of the symptoms varied along the way, and at one point they even disappeared. When Janice was 18, she shared her struggle with her family doctor, who recommended she see a psychotherapist at an eating disorder clinic. It was then that a formal diagnosis of bulimia nervosa was given to Janice by the clinic's consulting psychiatrist. At that time, she also shared her secret with her parents.

After seeking help in the form of weekly cognitive behavioural sessions with the psychotherapist from the eating disorder clinic, Janice went into full remission. However, around her 22nd birthday, she experienced a breakup with her boyfriend, and all of her former symptoms returned with a vengeance. The bingeing and purging took place twice a week at first, and then, by the time she turned 24 years of age, Janice's binge eating episodes and the compensatory behaviours of self-induced vomiting and overexercising took place 15 to 18 times a week. Although her weight remained normal, Janice began to experience menstrual irregularities. Finally, she withdrew herself from university and reached out for help once again. Janice was placed in an inpatient program at the Ottawa General Hospital, which lasted 3 months. This was very beneficial for her. Over the course of the program, her symptoms diminished and eventually, approximately one month after the completion of the program, she went into full remission for a second time.

Janice is now 25 years old and has been out of the inpatient program for 3 months. Although she remains symptom-free, Janice has recurring dreams and frequent thoughts about bingeing and purging. She is also struggling with issues of self-worth again. At times she feels ashamed. She believed that by this age her eating disorder would have been conquered, nothing more than a distant memory. Sometimes Janice pretends to be completely fine and fully healed. She tries to convince family and friends of this because she wants to make them proud of her and her recovery. Sometimes she fools herself, too.

Janice also returned to school following her inpatient treatment. She reported being inspired by one of her university professors, a Roman Catholic priest. Although baptized as a Catholic, Janice stopped practicing many years ago; however, this professor and her current courses have stirred something inside of her. She now seems to be questioning both the meaning of life and the purpose of her own life as she continues to be consumed with pervasive thoughts about her body

shape and weight. In the last few weeks, Janice embarked on a spiritual search for the answers to these questions about existence. She reports feeling called to something greater in her life.

After speaking with a good friend, Janice decided to seek help, but this time she wanted to do something different, and so went looking for support outside of the eating disorder clinic. She reports wanting a different approach to healing; namely, she considered the cognitive-behavioural therapy approach from both the eating disorder clinic and the inpatient program to be quite mechanical, despite its benefits. For this reason, she is seeking psychotherapy with a local therapist who uses a person-centred and transpersonal approach to psychotherapy. She hopes to get more clarity about why she is in this position and why this disorder has happened to her. She wants to break free from the psychological imprisonment caused by bulimia nervosa. She hopes to work on severing the ties that this disease has had on her mind, body, and soul for that past several years. She is highly motivated to move on.

CASE FORMULATION—APPLYING THEORETICAL MODELS TO JANICE'S CASE

Psychotherapy remains the pillar of treatment for most women with bulimia nervosa (Mitchell, Agras, & Wonderlich, 2007). Quantitative studies suggest that the most effective treatment is a type of cognitive-behavioural therapy (CBT) focused on modifying specific behaviours and ways of thinking that maintain bulimic cognitive and behavioural tendencies (Fairburn & Harrison, 2003; Mitchell et al., 2007).

In this case, it is important to note that Janice previously received CBT, which helped her to manage her bingeing and purging behaviours. When her symptoms were at their worst, CBT was a beneficial and effective treatment. While Janice successfully completed the inpatient program and remains asymptomatic (despite having dreams and thoughts about bingeing and purging), she is now searching for a different kind of support. For this reason, she is hopeful that an approach from a different paradigm (in this case the humanistic and transpersonal paradigms) will further support her healing and growth. The integration of person-centred and transpersonal psychotherapies will allow her to acquire the tools, skills, and kind of support she needs to move forward on her healing journey.

Person-Centred Therapy

From a person-centred perspective, the client is experiencing “conditions of worth” (Murdock, 2013) and incongruence. She is fully aware of how her parents worry for her well-being. Janice wants to make them proud, and she feels as though her recovery is contingent upon this fact: her complete recovery from bulimia nervosa is a condition of worth. Therefore, in order to earn her parents’ approval, their pride, and at times even their love, Janice pretends that all is wonderful in her life. Janice opted not to mention her dreams and recurring thoughts of bingeing and purging to her parents for fear of disappointing them. She reported that

sometimes she does such a good job at convincing others of her wellness that she even fools herself.

Incongruence manifests itself between Janice's real self and her ideal self. Although symptom-free in terms of behaviours, Janice's real self continues to struggle with some residual effects of bulimia nervosa. This is evidenced in her dreams and thoughts about bingeing and purging, including her feelings of shame, and her issues of self-worth. Her ideal self, however, is quite different. Janice's ideal self is completely free of an eating disorder. Freedom from this illness is something she had hoped for and expected by now. Understood in person-centred terms, she believed that her ideal self would no longer be consumed by pervasive thoughts regarding body shape and weight and that she would instead be liberated from them.

Transpersonal Theoretical Orientation

In their comprehensive book, *Spiritual Approaches in the Treatment of Women with Eating Disorders*, Richards, Hardman, and Berrett (2007) described the loss of spiritual identity and worth associated with bulimia nervosa. In their clinical work, Richards et al. also maintained that there are several recurrent spiritual issues or dysfunctional beliefs that women with eating disturbances pursue, including the idea that eating disorders can provide a sense of identity, meaning, and purpose in life. Erroneous beliefs or notions, such as this one, are often at the expense of women's relationship with God, with themselves, and with other people in their lives (Richards et al., 2007).

For several years, Janice's eating disorder has defined her. Her episodes of bingeing and purging fostered a superficial sense of meaning and purpose in her life; it basically took over her life. These unhealthy behaviours gave Janice a sense of power and control and reinforced her all-consuming quest for thinness. Presently, Janice struggles with finding a new identity, new meaning, and new purpose to fill the void left by the absence of the mental fixations and dangerous behaviours associated with bulimia nervosa. Janice is now searching, asking questions about her existence, and feels called to something greater in her life. She feels ready and willing to embark on a more spiritual journey to discover the answers she seeks and to shift away from unhealthy patterns in order to embrace a new focus for her life.

Janice is growth-oriented, an important factor in the suitability of transpersonal psychotherapy (Vaughan, 1993). Having found a psychotherapist who is open to the spiritual realm of existence—one that recognizes the link between spiritual issues and psychological health—Janice is now ready to move forward on her healing journey. In this case, two conditions of transpersonal psychotherapy have been met—the establishment of a transpersonal psychotherapeutic context on the part of the psychotherapist and the transpersonal content of the client's concerns—and as such, the process of transpersonal psychotherapy can begin.

Integration of Person-Centred and Transpersonal Psychotherapeutic Approaches

A transpersonal approach to psychotherapy is born of a humanistic orientation (Taylor, 1992). It is therefore logical that the humanistic person-centred model

and the transpersonal model can be used together. Frances Vaughan, a well-respected psychologist, has a shared interest in both humanistic and transpersonal psychology; in fact, at one point she was both the president of the Association of Transpersonal Psychology and a field faculty member of the Humanistic Psychology Institute (Vaughan Clark, 1977). These two approaches to psychotherapy are complementary in nature; they are reasonably combined in general and in the case of Janice, specifically so.

Given that person-centred psychotherapy is anchored in Rogers's core conditions of congruence, empathy, and unconditional positive regard, it is understandable that these conditions would permeate each therapeutic session with Janice, along any stage of the process. These attitudes toward Janice remind her that she is authentically cared for, listened to, understood, and prized as a human being. Her authentic self is celebrated and respected.

As person-centred therapy is client-directed, this integrated model would encourage Janice to lead the way with regards to the topics she wishes to discuss. Thus, once an alliance has been formed and trust established between Janice and the therapist, it is likely that the therapy sessions would move forward with great flexibility. For example, one session might focus on the incongruity between Janice's real and ideal self, while in the next session, the focus might shift to this client's desire to disidentify from her relationship with her eating disorder.

The therapist would rely on his or her clinical assessment skills as well as his or her intuition in order to determine which therapeutic tool would best support the client at any given time. From a transpersonal psychotherapeutic perspective, the therapist can engage in dreamwork with Janice when discussing Janice's dreams, for example. If this client wishes to discuss the topic of pervasive negative thoughts, the therapist can support her with the tool of cognitive reattribution. By tapping into his or her own spiritual wisdom, the therapist can assist Janice as she examines the spiritual and existential realms of life, while accessing her inner resources and strength that promote growth.

TREATMENT PLAN RECOMMENDATIONS

For those familiar with the person-centred and transpersonal approaches, the term *treatment plan* or *treatment approach* may seem antithetical to the very foundational assumptions of these perspectives. It is important to note that both of these approaches honour the whole person and essential being of each client and do not seek to "treat" them in the sense commonly used in the cognitive-behavioural clinical literature, for example. That said, these terms are often used in the humanistic and transpersonal literatures when discussing treatment approaches for clients, such as in the *Textbook of Transpersonal Psychiatry and Psychology* (Scotton, Chinen, & Battista, 1996), which is consistent within the larger field of clinical psychology and psychotherapy.

A treatment plan integrating both person-centred and transpersonal psychotherapeutic approaches is described below. An essential element of successful

psychotherapeutic treatment is the quality of relationship or the alliance between the therapist and client. From a person-centred perspective, it is believed that the client will move forward on her journey of healing and change when the therapist provides the sufficient and necessary conditions for this therapeutic relationship—congruence, empathy, and unconditional positive regard (Murdock, 2013). From a transpersonal psychotherapeutic perspective, it is important that the context of therapy be appropriate (Vaughan, 1993). In this case, the therapist is open to a spiritual realm to therapy and would fully respect Janice's discovery process. This openness allows the therapist to authentically listen to and receive Janice's story and experiences, which include some transpersonal content.

With a strong therapeutic relationship established, and with an appropriate context to therapy, Janice's treatment plan includes several goals. These goals, however, are determined by Janice (as is consistent with a client-led, nondirective approach) and might not necessarily follow the order listed below. Therapy sessions would move forward with great fluidity and flexibility, which is consistent with both psychotherapeutic approaches.

Below is a five-step treatment plan to support Janice, which incorporates the person-centred and transpersonal approaches and is organized as follows: Step 1; Step 2; verbatim (person-centred); Steps 3–5; and verbatim (transpersonal).

1. *Examining incongruence.* Janice strives for congruence in her life. By recognizing and working at eliminating conditions of worth (e.g., Janice's idea that in order to earn her parents' love and approval, she needs to be completely healed), there will be greater congruence between her real and ideal self (Rogers, 1989). This might necessitate a curiosity on behalf of the psychotherapist who asks about ways in which Janice's parents have shown their love over the years. Janice might come to realize that her parents' love is not contingent on where she is at on the healing journey. Through discussion, exploration, and time, this client will hopefully reconcile the differences between her real and ideal self.
2. *Experiencing the authentic self.* By examining her experiences, Janice will assess how any inconsistencies or contradictions in such experiences (e.g., her efforts to convince herself and others that she is well) make her feel (Rogers, 1989). More specifically, Janice will realize that healing from an eating disorder takes time. She will be supported to experience her authentic self and therefore refrain from wearing a social mask of feigned wellness. When Janice is successful in this endeavour, she and the psychotherapist might discuss what impact being authentic has on her well-being, her attitude, and her life. They might also explore how liberating it can be to be truthful to one's self. And when Janice shares moments where authenticity is a greater struggle, the psychotherapist will be fully present for this client, recognizing the inner resources within her that allow her to take responsibility for her situation and to self-direct, and will share these insights with Janice. The psychotherapist will identify the actualizing tendency that is propelling Janice forward, driving her to grow, to heal and to live a more authentic life.

Verbatim

The following verbatim highlights Rogers's core conditions of congruence, empathy, and unconditional positive regard. This is Janice's fifth visit, and already a strong alliance has been developed between her and her therapist. Today, Janice seems to want to discuss issues related to her incongruence, along with her desire to find meaning in her life.

Therapist: Welcome back, Janice! It's so great to see you again. Sit wherever you like.

Client: Thanks, it's good to be here! (Pause as she sits in her favourite chair.) I'm a bit frustrated though! I still find myself oscillating between what I call my head and my heart, and what you named my real and ideal self, last week. I so want to be that person who is free!

Therapist: I hear what you are saying, Janice. I understand how difficult this must be for you. I urge you to be gentle with yourself. I think you are doing a fantastic job. Remember that you have lived with bulimia nervosa for a long time and therefore reaching your ideal self—a self who is healed and free—will take time. It's a process. I am here to journey with you.

Client: I know that you believe in me. I think that inspires me to come back here each week. And what you say makes sense. I guess I just get impatient with myself. You were right, though, when you spoke about baby steps last week. I suppose I should celebrate my baby steps. Last night I was honest with my mother when she asked how I was doing. I didn't wear a mask, for once, and instead told her that I had been consumed by negative thoughts and was having a tough day. She simply hugged me!

Therapist: Congratulations, Janice! I'd say that's more like a big step! Good for you!

Client: (Nods and smiles warmly.)

Therapist: What was that like for you to speak that truth, and to be loved for it?

Client: It was difficult and scary.... But I'm happy I did it.

Therapist: It sounds like you took a pretty important first step, despite your fear.

Client: Well, I suppose so! Oh yes ... I also wanted to tell you about my course on Tuesday. My professor spoke once again about finding meaning in our lives. My thoughts began to race. I felt both inspired and doubtful. How can I find meaning beyond this disorder?

Therapist: Janice, I see the strength that is within you. Over these past weeks, you've often referred to the things that inspire you. You have spoken about a stirring within you and a sense of awakening to something greater. Trust in yourself.

Client: That's hard when I'm feeling worthless and ashamed. It's such a paradox!

Therapist: I realize that, Janice, and I see the paradox, too. Next week, if you like, we can practice a few disidentification exercises to help you realize that just because you have a thought or an emotion doesn't mean that you become one with that thought or emotion. There is so much more to you than this eating disorder. I am here to help you find your greatness within!

3. *Identification.* Janice will assume responsibility for herself and the consequences of her past choices. In the process, she will develop greater autonomy and self-determination (Vaughan Clark, 1977). Through cognitive reattribution, for example, the therapist can assist Janice in shifting her perspective (Vaughan, 1993). More specifically, the client will consider her past and current challenges (e.g., pervasive thoughts about bingeing and purging) as learning experiences. This will help to release the shame and guilt associated with these painful events and hopefully promote freedom and compassion within the client (Vaughan, 1993). In essence, the goal at this stage is to support the client as she shifts from negative patterns of self-invalidation to an attitude of acceptance and accountability.
4. *Disidentification.* Janice will confront questions of purpose and meaning in life and learn to disidentify from relationships and emotions associated with the ego (Vaughan, 1993). In this case, she will learn to disidentify from shame, from worthlessness, and from her relationship with her eating disorder. Through disidentification exercises such as "I have emotions, but I am not my emotions" (Vaughan, 1993, p. 163), Janice will begin to tap into her inner strength, wisdom, and resources. With time, Janice will begin to recognize that she is so much more than this eating disorder and that by letting go of that identity she can create an inner space in which she may welcome and embrace new meaning and purpose for her life that will shape a revised identity. By disidentifying from the eating disorder (and its associated shame), Janice will also begin to recognize her own inner resources that will help shape her changing self-concept.
5. *Self-transcendence.* Janice will embrace a shift in the sense of her identity (Vaughan, 1979). The awakening of a new level of consciousness—achieved through meditation, for example—will allow her to consider ways of reaching out to support those around her (Vaughan Clark, 1977). Increased self-awareness as well as self-kindness may develop from these practices. They may also lead to a natural shift of attention from a strong self-focus to a more balanced self—and other—focus that includes, for example, volunteering at an eating disorder clinic to support and inspire others on a similar healing journey. Various practices designed to foster self-transcendence may lead to new insights and awareness that prompt Janice to rekindle her relationship with God. With a new sense of self and awareness, she may conceptualize the Divine and her relationship with it quite differently than before.

Verbatim

The following verbatim highlights the process stage of identification in transpersonal psychotherapy, where cognitive reattribution is used. It is important to note the ways in which the therapist prepares for her sessions with Janice (and all clients). As part of her daily spiritual practice and as a way of fostering deep presence with her clients, the therapist meditates each morning before going to work. Also, approximately 10 minutes before her client's arrival, the therapist disengages from her paperwork, dims the lights in her office, sits in a comfortable chair, and closes her eyes in order to focus on her breath and reconnect with the subtle feeling of aliveness within her body. This practice helps her to get out of her head and into her whole self. These few minutes of focus and reconnection bring the therapist a sense of peace and alignment with her authentic self. Afterwards, the therapist adjusts the lighting for the session and then welcomes her client into her very comfortable therapy room.

This is Janice's ninth session. Over the past 2 weeks, the client's negative emotions (shame and worthlessness) and her thoughts and dreams about binging and purging have substantially diminished. She arrives today, however, looking sad and discouraged. She is disappointed in herself. She has had a challenging week.

Therapist: Hi Janice, so nice to see you again! You seem a bit sad today. I look forward to our session together. Sit wherever you like.

Client: (Janice sits in her favourite chair, pauses and then throws her hands in the air.) It was a tough week this week. (Janice then shares some specific details about how her week went.) I feel like I take two steps forward and then three backwards. I am feeling sad. I'm also feeling very disappointed in myself. I'm sure you are disappointed in me too? I had two good weeks, and now this!

Therapist: Me disappointed in you? Not at all! I think you are brave!

Client: Brave?! How can I be brave? Today I feel weak and broken!

Therapist: It's okay to feel that way—it's just a feeling. And yes, I do indeed consider you to be brave and strong too! (Pause to let her words be heard by Janice.) What if this past week was simply a bump in the road?

Client: What do you mean?

Therapist: I'm hearing your devastation about this challenging week, and I'm wondering if it might be possible to look at this challenge differently? (Pause.) Maybe this challenge is not so devastating after all? Maybe it can simply be considered a "tough spot" that prompted you to turn to your inner resources? Might that be a possibility?

Client: Humm ... I guess. (Pause.) I never thought about it that way. I suppose that perspective could be taken ... maybe?

Healing from bulimia nervosa is a process that takes time. Similarly, embarking on a journey to find new meaning and purpose in life and discover inner strength and resources is also a demanding and time-consuming process. Janice and her therapist will meet once a week. The way they move forward in treatment will be Janice's decision. Depending on this client's motivation and openness, the process to healing and growth will take from several months to several years to achieve.

DISCUSSION OF STRENGTHS AND LIMITATIONS

The approach to psychotherapy presented in this case has a number of strengths and limitations. In order for a hybrid treatment model that includes person-centred and transpersonal psychotherapies to be effective, the clinician must be competent in both approaches. In addition, a good client-therapist alliance is essential to its success. The client must be a good fit for this approach in that she or he has (a) a desire for self-growth and change; (b) an ability to self-reflect; and (c) both a capacity for and interest in contemplating and engaging with questions of meaning, identity, and purpose. Given the fundamental humanistic assumptions in both approaches, there is the potential for unlimited growth and healing within the therapeutic process, assuming the prerequisite conditions are met, as discussed above.

Should the client in this case experience a significant regression in her symptoms of bulimia nervosa, a return to an inpatient program with a CBT model that worked well for her previously would be indicated. In such an instance, it is recommended that the humanistic-transpersonal psychotherapy be continued in tandem with the other approach, if the structure of the inpatient program allows for it. This would provide the client the ability to maintain a broader perspective on the disorder during intensive CBT treatment and provide continuity of therapeutic care before, during, and after treatment.

CONCLUSION

In this fictional case conceptualization, Janice's presentation of bulimia nervosa and her quest for meaning were examined through the lens of a person-centred and a transpersonal approach to therapy. The two theoretical models were discussed individually and applied in an integrated manner to Janice's case. A treatment plan and a verbatim between the therapist and the client, demonstrating therapeutic techniques, were also presented.

Given the client's longstanding experience of this disorder and her current state of recovery, she is well suited to an integrated approach to therapy, one that combines a person-centred and transpersonal approach. Optimally, Janice's thoughts and dreams about bingeing and purging will diminish substantially or cease and her self-esteem will increase, allowing her to be far less focused on weight and body shape. Lastly, a new, positive identity will be established, involving a changed worldview in which the client finds renewed sense of meaning, purpose,

and joy in life. After being encouraged to tap into her vast inner wisdom, Janice will reconnect with her sense of spirituality and will be naturally moved to serve others. This is Janice's journey, witnessed in part by her therapist, who effectively provided and modelled the unconditional positive regard that is known to catalyze this kind of profound inner growth and change.

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