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EGO-STATE THERAPY IN THE TREATMENT OF A COMPLEX EATING DISORDER

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Abstract

This report describes the treatment of a woman with a diagnosis of binge eating disorder and a history of bingeing and periods of starvation throughout adolescence and adulthood. She had sought a number of different therapies, but not really benefited from any of them. She felt confused about herself and did not have a sense of her identity. She had recognized there were parts of herself that seemed separate from each other. Ego-state therapy with hypnosis helped her to understand the cause of her compulsive bingeing. This was followed by the hypnotic affect bridge which enabled her to access another child part of herself concerned with a fear of starvation and abandonment, and wanting to remain 'solid' but not 'fat'. These phases of therapy produced great improvement in her eating behaviours, which she had not experienced before. By accessing the ego-states, she was able to start an inner communication, and make cognitive and emotional changes. This was reinforced later with cognitive therapy, from which she had not gained much benefit previously. The importance of combining these therapeutic approaches is discussed.

Key words: ego-states, dissociation, eating disorder, cognitive change

Introduction

Mrs Z, a married woman of 42 years of age, was initially referred to the psychology department of a psychiatric hospital for treatment of her binge eating, which had caused her to be overweight. She was 5'4" and weighed 13 stone.

Since the age of 14 she had had episodes of bingeing, which were followed by many months of starving, such that she lost 3 stone in as many months at one stage of her life. She had never abused laxatives or vomited, though she said she had been tempted.

She had sought psychotherapy before and had a course of Gestalt therapy, which she said enabled her to access the 'addict' inside her, but just knowing this was not helpful to her. She had spent three years seeing a therapist at a pastoral foundation and had not found this beneficial. She had also been to Eating Anonymous and similarly found no benefit. Mrs Z commented that during the Gestalt therapy she realized she had 'unresolved issues' which she could not identify and therefore were not addressed. She said she needed to look into this further.

Present circumstances

Mrs Z felt the need for a close friend or confidante and was clearly lonely. Although she and her husband had a harmonious relationship, she felt he did not have the same sexual desire as she had. They had no children (by mutual agreement). Her husband had been made redundant six years previously and she had taken a job working for a charity, which she enjoyed. The couple had also pursued common interests. There was no evidence of clinical depression or anxiety in Mrs Z. She and her husband had sufficient money to go on holiday and enjoy themselves, but these occasions led to her bingeing.

Background history

Mrs Z's childhood was very unhappy. She was the only child of her adoptive parents. She had been rescued at six weeks old, after having been abandoned by her biological mother. She was admitted to hospital in a state of malnutrition. When she was fit enough, she was discharged into the care of Social Services, and then adopted by her present parents.

Mrs Z described her parents as lacking in understanding, love and affection. Her father was very critical and prone to violent outbursts. He was an ex-prisoner of war in World War II, and had suffered a 'mental breakdown' as a result of his wartime experiences. Mrs Z considered he was permanently confused and angry and would not allow her to express her opinions or her emotions. Her father only related to her when she stopped eating, telling her that she would not want to experience real starvation as he had during his stay in a concentration camp. Her mother was shy, and clearly had difficulties dealing with her father, and did not spend much time with her daughter.

There were periods in her childhood when Mrs Z was looked after by her grandmother, whom she also felt did not understand her. Her comment on her childhood was 'nobody related to me, nor showed me where I fitted into the scheme of things'. Mrs Z was quite content in her school life until the age of 14, when she was raped by a boy she knew well. She told no one of this, and started bingeing. After leaving school, Mrs Z took various jobs but was 'desperate' to marry. At the age of 25 she married a man 10 years older and a divorcee. They agreed to have no children. Mrs Z said she was not in a position to offer a child any affection, having been deprived of it herself.

During her adult life Mrs Z had been able to establish relationships and make friends, but none of these were close enough to be a confidante. Thus she had feelings of loneliness from time to time. Otherwise she presented as a friendly, intelligent person with a sense of humour. Her underlying feelings are well conveyed in a written account she presented on first psychological assessment (see below).

Mrs Z's view of the problem on first presentation

Mrs Z described her bingeing as a way of making her fat and unattractive to men. This had commenced after the rape at age 14. She felt there was another reason too, but she was not sure what it was.

She felt there were two parts of her. One was the 'higher self' who was well focused, in control and able to cope with difficulties. The other part was the 'lower self' who was out of control, disorganized and unable to cope. This part did all the eating. Being fat gave her security as it was a barrier and protection against male attention and against others making demands on her. She remained unassertive but safe.

In Mrs Z's written account of herself it became clearer how very distressed she was:

> My strongest and most persistent negative feeling is confusion – about myself; my relationship with the world and how I fit in. What am I? – and where does that which isn't me begin and end? – I have always been searching for an identity – a defined outline ... but I have become a blob. My parents and Nan did not serve any purpose for me ... maybe I was there to provide them with something ... but I was never sure what ... I could not put into words this huge thing I knew was missing, that I so desperately wanted and needed ... my physical and spiritual existence always felt perilously fragile.
>
> If my fat had a voice it would scream and shriek in rage because it is very angry fat. It really does not like anybody much – only me ...
>
> ... When I was thin I liked it, I had nothing else to speak for me, so I found I was amazingly good at speaking for myself... but I was never happy ... that I felt more valid just because I looked more valid ... The only way out of this dilemma is to find myself, and where I belong ... When I am valid, worthwhile and comfortable living within my outer shell ... I will be strong enough to take care of myself, and negotiate on my own behalf ... I will be neither manipulator nor manipulated ... I will be hungry and afraid, but I will nurture myself. When that time comes, I will make my own choices and go with what seems right and comfortable. Those choices will extend to the size of the body I live in ... it will serve no hidden purposes ... It will be just what it is – a convenient earthly home for a far more precious spirit ...

Therapy

Phase one

Initially a cognitive-behavioural approach was adopted, since Mrs Z had never tried this, and it has been shown to be effective for binge eating disorder (Fairburn 1995).

Mrs Z responded to this approach initially, and was able to go on holiday with her husband and eat normally without bingeing for the first time. However, on return she started bingeing again. She commented that she could do nothing to prevent the inner urge to binge, and she could only describe it as the 'addict' part of her. At this stage in therapy, it seemed appropriate to consider ego-state therapy with hypnosis as the best option for her.

Rationale and commencement of ego-state therapy

Ego-state theory and therapy has been well described by John and Helen Watkins (1997). For those less familiar with the concept of ego-states, the following is a brief summary.

Our experiences become categorized as we develop through childhood and attempt to find meaning and purpose in our lives. Certain feelings, thoughts, perceptions and behaviours bond together as they relate to particular experiences. These separate clusters of thoughts, feelings, and behaviours relating to different experiences and contexts are known as ego-states. According to Watkins and Watkins (1997: 25) 'An ego-state may be defined as an organized system of behaviour and experience whose elements are bound together by some common principle, and which is separated from other such states by a boundary that is more or less permeable.'

This theory has originated from Pierre Janet's view of dissociation. Janet (1907) believed that there were 'systems of ideas' which were not 'in association' with other ideas in the personality.

This process of dissociation is seen as part of normal, healthy development. However, in the event of exposure to traumas, ego-states may emerge which have partial or total

amnesic barriers between them. Thus the person may have difficulty shifting from one ego-state to another, or even may shift without conscious awareness. This can lead to internal conflicts between the ego-states and more dissociation between them.

Ego-state therapy involves activation of the dissociated ego-states, in order to facilitate co-consciousness and communication between these ego-states. Thus the partial or total amnesic barriers can be broken to create inner harmony and more integration in the personality. This procedure can easily be carried out through hypnosis (Torem 1987; 1989).

When ego-state therapy was suggested to Mrs Z, she related to it well. The first session of hypnosis was for the sole purpose of relaxation in her special, safe place. She also learned self-hypnosis.

In the second session of hypnosis, the ego-states were activated and communication started. The aim was to find ways of meeting the emotional needs of the separate parts in a more adaptive way and thus to reduce the conflict.

Permission was sought in hypnosis to speak to the 'addict self'. Mrs Z responded in the affirmative through ideo-motor signalling. The 'addict self' emerged and announced herself as 'powerful and destructive – I live inside Mrs Z because she's helpless, pathetic and cannot cope. I punish her for being helpless – it keeps her dependent on me. If she is not dependent I won't have anywhere to live. I am a parasite; I feed on her, and she gives me somewhere to live.' The dialogue in hypnosis then continued as follows:

Therapist: Are you happy with this?

Addict: It's not satisfactory, but it is safe and comfortable. I am not really powerful but Mrs Z thinks I am. In fact I am more pathetic than she is. I won't let her have a life. I need her more than she needs me. I want to keep her helpless, it's best. I can fool her and manipulate her. She makes me feel powerful, and I don't want her to know that I am not brave enough to be on my own. I have to teach her a lesson when she tries to get rid of me, but I don't actually help her at all. I keep her down. I am an excuse. I am too scared to leave her. I need security, and she is too scared to cope and take risks. I tell her to get into terrible relationships – I used to – but she doesn't do it any more. I feed her things and she stays stuck, and I don't have to move. I am smug, but not happy. I pull strings and make her do what she does – like bingeing. I am not her friend. I am just a manipulator and keep her scared. She does not like me – she fears me – but I am more scared than she is. She doesn't know that! (Silence).

Addict (now addressing the therapist): I don't like you. You ask me questions and I tell you these things – I am very, very frightened! (Addict starts crying).

Therapist: Why are you scared?

Addict: Because you are trying to drive me away and I will be homeless. I will have nowhere to go.

Therapist: No one is going to drive you away. No one is going to make you homeless. We just need to know what your needs are, so that they can be fulfilled in a better way. Do you think you and Mrs Z could work together to this end?

Addict: No. She does not need me. I am so tired and worn out. I don't really need to exist, but what I do need is that she could give me a decent burial, and then I wouldn't be anymore.

Therapist: Are you quite sure this is what you want?

Addict: Yes I am quite sure. I just want a decent burial.

Therapist: You need to talk to Mrs Z and ask her if this is alright. Are you prepared to do this?

Addict: Yes

Therapist (to Mrs Z): Can Mrs Z come forward? The addict needs to tell you something.

Mrs Z: Yes

Therapist (to addict): Would you now speak to Mrs Z?

Addict (to Mrs Z): I am a fraud. All the time you thought you needed me, I needed you. If I didn't have you, I would have to find a new place, but I am getting old and tired. So I have to tell you I am a fraud and a liar. You don't need me. All the awful things I have done made you feel pathetic, so now let me go, then I won't have to go on doing this.

Mrs Z: I am happy to let you go.

Therapist (to Mrs Z): Are you happy to give her a decent burial?

Mrs Z: Yes

Therapist: Then go ahead and let me know when this is completed.

After Mrs Z signalled the burial was finished, the hypnotic session was then terminated with her returning to her 'special place'.

In the debriefing, Mrs Z looked happy and pleased. She said the 'addict self' was a red-horned devil and a 'total wimp', which she thought was all-powerful but was not so. She saw him (a male) as pathetic, and saw him go up in a whiff of smoke. She laughed and said she had a free and light feeling.

A week later she said she felt 'liberated', and she had lost the compulsion to binge. She bought herself some chocolates, and felt she had a choice whether to eat them or not; she was not 'driven' as she had been in the past. She thought the 'addict self' made life easy for her and she did not have to try. Since the Gestalt therapy, when she first became aware of the 'addict self', she felt always there was something like 'an obstacle in her way'. Now she was rid of it, and she felt she could be assertive and express herself, and she decided to do a course in creative writing. Over the next few weeks, she said she was eating too large portions of food, but this was not compulsive bingeing as before. She felt good about herself, and felt free to express her feelings as she had not done before.

It is interesting that she had viewed compulsive eating, which arose from the 'addict self', as a barrier or protection, preventing men from being attracted to her following the rape. The 'addict self', on the other hand, seemed to be responsible for her getting into 'terrible' relationships, and keeping her scared. Although it seems clear that the 'addict self' had been 'born' as a defence and protection following the trauma of rape, it nonetheless was not an adequate defence in the long term, and kept her 'frozen in time' (or 'stuck') so that she could not be free to move on in her life. Her large body size was a protection that failed and an ineffective vehicle for expressing anger. She also did not need to assert her individuality when she was fat because demands were not made on her.

An important point is that one of the rules of ego-state therapy is that one should never get rid of an ego-state. The purpose of the therapy is to facilitate co-consciousness and communication between the ego-states, so they are in harmony and not in conflict. In this case, however, it was justifiable and safe to allow the demise of the 'addict self', since there was mutual agreement between the two ego-states that this should happen. This justification was confirmed later by John and Helen Watkins (personal communication).

Phase two

Three months later, Mrs Z reported a different problem, although still related to food. She said she always had to carry some food in her bag when she went out anywhere, otherwise

she would panic. She did not feel compelled to eat the food; it was just in case she felt hungry. She said she felt she might cease to exist if she allowed herself to get hungry and starve. She did not believe this was anything to do with the 'addict self', whom she felt had gone. This was not a compulsion to eat; it was a fear of not existing any more due to starving. She thought it was related to her having nearly died at six weeks old due to neglect. She also considered this was reinforced by the comments from her father about his own experience of starvation in the war. She stated that on one occasion in the past she had visited a lay hypnotist who had used hypnotic age regression, which led Mrs Z to this conclusion. Although she could not have any memories for what happened to her at six weeks old, her acquired knowledge of this fact could have had an impact on her. Nevertheless it was necessary to explore the significance and meaning of these fears and behaviours. Another hypnotic intervention that seemed appropriate was the affect bridge (Watkins 1971). This would enable her to go back in time to the period when she first experienced this fear and panic, and thus find the cause.

In the next hypnotic session, using the affect bridge, Mrs Z was asked to imagine herself in a recent situation, feeling hungry and having no food available, and to build up her feeling of panic. Then leaving the situation, but holding on to the feelings of panic, she travelled back in time over the bridge to when she first experienced these same feelings. Mrs Z regressed to being a small baby crying. She began crying desperately and could not stop. I encouraged the adult part of her to enter the scene to comfort the baby. The session continued as follows:

Adult self: The baby is pathetic – I want to love it, I am picking it up and holding it – still crying but calming down. I am saying to her 'I will look after you – you can depend on me – you don't have to be afraid'. I don't think the baby believes me. She has to trust me, and then I can prove to her I will look after her. She is still unsure – she feels let down. I can be consistent and look after her a day at a time.

Therapist: Fine, now imagine looking after the baby at home, and time is going by.

Mrs Z: I have to carry her around all the time. She wants constant contact.

Therapist: Time is going by and you continue to look after her.

Mrs Z: It's two months later – she does not cry all the time, but I think she still does not believe everything will be OK. If I am consistent she will start to trust and believe me.

Therapist: Continue caring for her over time and tell me about her progress.

Mrs Z: She is 5 years old now. She looks happy and chatty, but she still feels 'out of place'. She wants her real mum. It's like she is in lodgings – not her real home. I tell her 'you will always be with me'.

Child self (speaking for the first time): I was not good enough to stay with mum. I am being punished. I am different, and don't feel right. I am out of place all the time. You can't make it right for me!

Adult self: You are special and really matter – you have always got me.

Child self: I need help and support and I am not getting it.

Adult self (to therapist): She is so demanding and I try to be good to her.

Therapist: Tell her she will understand as you continue to listen to her.

Adult self: I think she accepts she will understand but she will take everything out of me! I am propping her up!

Therapist: Time goes by as you continue to care for her. Tell me of her progress.

Child self (aged 14): I have had a horrible experience and I cannot tell anyone. I have been raped and do not know what to do. I cannot tell anyone except you (the adult self).

Adult self: I am listening and trying to help you.

Child self: I want to be comforted and understand why horrible things happen to me.

Adult self: I do not know what to say.

Therapist (to adult self): You can tell her it was not her fault. There is nothing wrong with her. What does she now need?

Child self: I need to be cuddled.

Adult self: I am cuddling her, and telling her this.

Child self: Everyone has taken from me, and no one gives me anything, so I give myself food. It's secret and safe, and no one can take it away.

Adult self (to child): I now need to keep cuddling you and propping you up, but you will grow up and become independent.

Therapist (to the child self): You have these needs for affection and reassurance that others do not see, but there are ways to get these needs met – by working together with the adult self. Are you happy to do this?

Child self: Yes I know I am draining her this way.

Adult self (to child self): Yes I can work with you on this, then it will liberate both of us, but you can always come to me if you need.

Both child and adult selves were content. At the end of the discourse in hypnosis, both child and adult selves came together as one, and returned over the bridge of time to the present, and then entered the Special Place before terminating the hypnosis. A post-hypnotic suggestion was given, that whenever the hurt, abandoned and neglected child needed comfort and reassurance, the 'adult self' would be able to give it, and they would work together.

Following this session, Mrs Z said she now did not feel in opposition to the child within. She had not realized before that she could nurture and parent the emotionally starved inner child, who was afraid of both loss of love and loss of life. She also had not appreciated before that food had been a substitute for love.

This further insight enabled her to focus on her present situation, and the absence of demonstrative affection in her marriage. She then sought further help with this.

Phase three

Mr and Mrs Z were seen together for couple therapy. They both accepted this willingly. They agreed that they did not talk about their feelings and their needs. Mrs Z was surprised to learn her husband had sexual needs to the extent she did, but often did not communicate them.

After a few sessions of sex therapy their relationship improved considerably. Mrs Z also became more assertive both at work and at home. She had controlled her eating, did not binge and had no fear of starvation.

Suddenly her father became ill, and her distress at the seriousness of his illness made her vulnerable to occasional bingeing. Otherwise she felt she had resolved the major issues of her lifelong eating problem.

Some more sessions were devoted to changing her negative perceptions of herself arising from her childhood. Following ego-state therapy and couple counselling, she

engaged with cognitive therapy a lot better, and finally she felt she had come to terms with the possibility of her father dying.

Booster sessions and outcome

Mrs Z was discharged, but returned to the Service about three years later. Major changes had taken place in her life. Her father had died from cancer and she felt the loss greatly. She had developed a very good relationship with him and felt she understood him better. She wished she had had more time with him before he died. Her only comfort was that she had stopped hating him while he was still alive. She became fearful of losing her husband too.

Mrs Z's own health had deteriorated; she had fybromyalgia and thyroid problems. This handicapped her somewhat, and produced changes in her sleep pattern. She commented that she still did not have any close friends with whom she could share her troubles. There was a sense of loneliness and a reminder of her childhood. She had lapsed into bingeing, which she described as an 'anaesthetic'.

Mrs Z was offered our group therapy for binge eating disorders, which has a cognitive-behavioural format with hypnosis. Here she would have the support of fellow sufferers, as well as the chance to come to terms with her unfortunate circumstances, so she did not need her 'anaesthetic'. She readily joined the group.

She made dramatic progress over 12 weeks of group sessions. During this time she said she realized that she had believed her illness was a punishment and that she was not meant to survive as a child. So now she was getting what she deserved. Suddenly she understood during the group sessions that this was a form of self-abuse; the adult was punishing the inner child, who had survived. What she needed to do was to nurture and comfort the child. Cognitive and emotional changes were made between the two ego-states, when she once more paid attention to these 'inner voices'.

Summary and comments on the phases of therapy

The first hypnotic intervention using ego-state therapy revealed the nature of Mrs Z's addiction to bingeing and becoming obese. Fat was for protection, and a barrier against unwanted attention from men, and unwanted demands of others. It was also a way of expressing her feelings (particularly anger) through her size. Later she discovered that food itself was a substitute for lack of love too.

It was surprising when her fear of starvation emerged after the demise of the 'addict self', since she had written in her first account that when she was thin, she had been assertive, and felt and looked 'valid' to others. The affect bridge revealed the inner deprived child, and the negative side of starving and thinness. This was a time in her life when she had no sense of identity and self worth. She could die emotionally and physically through lack of love and lack of food. The starving child had to assert herself and be noticed, but was in danger of not existing.

This child part only emerged after she had dealt with the bingeing and the 'addict self'. As she was no longer hiding behind the fat, she was ready to address the neglect, abandonment and finally the abuse from the rape.

Hypnosis with ego-state therapy played a major role in dismissing the 'addict self', who no longer served a purpose. She was then able to access the inner child and scan her childhood and teenage years and to parent the inner hurt child. Resolving the issues of the past in this way led her to seek solutions for the present problems and the future.

Mrs Z was able to benefit rapidly from cognitive therapy, which she pursued after the hypnotic interventions. Previously cognitive therapy did not have much impact, perhaps because she did not hear the 'inner voices' of the 'addict self' and the inner desperate child. Watkins and Watkins (1997) have commented that cognitive therapy addresses the thinking patterns of which the person is aware, but cannot probe deeper to an unconscious, emotional level of which the person is not aware (Watkins and Watkins 1997: 158). Ego-state therapy can achieve this, and cognitive and emotional changes take place. Mrs Z had not previously been aware of her inner child, and she commented that she had never realized she could do her own inner parenting.

The lapse into bingeing after several years was resolved when she once more realized the inner conflict between the ego-states. She then spontaneously implemented an alternative inner dialogue of comfort and reassurance. This change was prompted by the cognitive therapy group. It is doubtful that this rapid improvement would have occurred if she had not previously accessed the 'inner voices' of her ego-states and the underlying emotions. There would seem to be a strong case for ego-state therapy with reinforcement of the cognitive and emotional changes, particularly where childhood trauma is addressed. The emotions of a neglected or traumatized child are intense and deep-seated, and below the conscious awareness of the adult.

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BOOK REVIEW

TIME DISTORTION IN HYPNOSIS: AN EXPERIMENTAL AND CLINICAL INVESTIGATION

By: L.F. Cooper and M.H. Erickson

Crown House Publishing, Carmarthen, Wales, and Williston, VT, USA. 2002. (First published 1954, second edition 1959) Pp 206. Price: £17.50. ISBN: 1-899-83695-0

Reviewed by Peter Naish

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I was delighted to be asked to review this book, as the topic is one of particular interest to me. At the same time I was puzzled, because I had never come across any reference to the work in the literature; the request was the first I had ever heard of such an early investigation of hypnotic time distortion. The earliest normally cited work is by Bowers (1979).

One does not need to read many pages to discover why this book does not feature in the reference sections of recent studies of time distortion. Although the title refers to an experimental investigation, the presentation has little in common with the norms of experimental reporting. The bulk of the book, written by the first author, has an anecdotal feel and, in this reviewer's opinion, reads less like formal science and more like the jottings of an excited enthusiast who wants to dabble with a new idea. It is significant that there are fewer than twenty references, and that a quarter cite the author's original articles, on which the book is based.

So, what produced Linn Cooper's excited enthusiasm? Well, it turns out to be quite intriguing material. These days, hypnotic time distortion is usually associated with the common observation that a subject's retrospective assessment of the duration of a period of hypnosis is generally a gross underestimate (St Jean, 1988). This has been attributed to the slow-running of an internal clock (Naish, 2003). In contrast, Cooper's work is concerned with the speeding-up of subjective time. His subjects were given instruction in achieving this effect, and they were offered the label 'special time' for the experience. They could then be given a suggestion (in hypnosis) such as, 'I am going to give you ten seconds of world time in which to prepare a meal, but in your own special time you will have all the time that is necessary'. Following the brief interval subjects were asked about the imagined experiences during their 'special time'. Typically, one who had been given the meal-making suggestion would describe having fitted in all the procedures associated with preparing a dinner.

An obvious explanation for claims such as the above is that the subject generated the story at the point of being questioned, or recounted an actual event that they could remember. Perhaps the imagination phase simply comprised unexpanded 'headlines', such as 'prepare vegetables'. Cooper was of the opinion that subjects were reporting what

they believed to be actual experiences, and even subjected some to a polygraph 'lie detector' in support of the claim. However, subjects were unable to perform faster-than-normal mental arithmetic during their telescoped time periods. A mathematician tested in this way described the calculations as being difficult, because they 'lacked continuity' and comprised 'disconnected points'. This experience would appear to lend support to the headline hypothesis.

Towards the end of the book is a section by Erickson, discussing the use of the accelerated time technique in the therapeutic context. This largely comprises case histories, written in typical Ericksonian style. An example is of a musician who had difficulty in making time for practice. Allegedly, he was instructed in the use of special time, into which he could squeeze long periods of rehearsal. The outcome, we are told, is that his performance improved beyond recognition. One wonders whether the headline phenomenon was taking place, perhaps with the result that he played one note per bar, or one bar per page. The result would certainly be beyond recognition! To be serious, Cooper also describes a case of this sort, where the subject's spouse, also a musician, apparently attested to the resulting improvements.

The book concludes with a few more pages by Erickson, added at the time of the second edition. They refer to the more common experience of time distortion: i.e. retrospectively, very little time appears to have passed.

For my taste, this book is over-wordy and insufficiently critical. Nevertheless, the effects described are certainly intriguing, and deserve rigorous investigation. This is probably not a book for anyone other than a researcher considering conducting such an investigation, or a therapist who is particularly desperate for a source of new ideas.

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