

**Why food?: An exploration of the psychodynamics of the
use of food in eating disordered clients and the implications
for treatment.**

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Attestation of authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the qualification of any degree or diploma of a university or other institution of higher learning, except where the due acknowledgement is made in the acknowledgements.

Signature

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Date

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Abstract

This dissertation explores the roles of food in anorexia nervosa and bulimia nervosa. The methodology used is a modified systematic literature review. This study examines how food becomes involved in the development of both anorexia nervosa and bulimia nervosa. Empathic failures in the early care-giving environment result in many developmental arrests, including a lack of self regulatory skills, inability to symbolise, and more importantly deficits in self cohesion. In the absence of symbolisation, the eating disordered patient perceives food, the first bridge between a mother and her child, as a representation of the mother together with her love and care. The relationship between the patient suffering from anorexia nervosa and her mother is usually described as engulfing, leaving no room for the daughter to separate and individuate. The patient's refusal of food is, in essence, a way of establishing a sense of self, an attempt to separate from the mother in order to survive psychically. For the patient suffering from bulimia nervosa, her mother is often described as passive and rejecting. The mother of the bulimic patient is not necessarily cold, but the care-giving relationship often lacks warmth and nurturing elements. From the self psychology perspective, inadequate self cohesion means the patient constantly relies on food or disordered eating to provide the selfobject functions necessary for the maintenance of self cohesion. The failure to get her selfobject needs met by human beings during the early development also reinforces her dependence on the use of food, a reliable and controllable selfobject. Treatment implications are discussed and recommendations for future research are explained.

Chapter 1: Introduction

Eating disorders are a group of intriguing and perplexing illnesses with many facets involved in both their aetiological and treatment factors. Recovery is usually a painstakingly long process, and only a small portion of sufferers reach full recovery. Eating disorders are also a group of mental illnesses with the highest mortality rate.

I first became interested in eating disorders when I began my clinical work as an intern psychotherapist at an eating disorders service. As the clients¹ shared their stories, I was perplexed by their obsession with food, or food intake. This dissertation is a result of my curiosity as to why these clients choose food as a way of exhibiting their illness.

Having worked with this client group, I came to realise that food also has a significant symbolic association for me. My life is affected, albeit to a much lesser degree than those of my clients, by food and its meaning. Growing up in a family with a Chinese ethnic background, food holds a strong symbolic relationship with health and happiness. We were never without an abundance of food. When I left my family during my adolescence and had to take care of myself, feeding myself became an almost traumatic experience. Food (and happiness) were gone almost overnight as no one was there to provide it for me. The significance of its symbolic role in my life became very obvious.

The research question stems from this context, food and its significance in anorexia nervosa and bulimia nervosa. I hypothesise that there is a connection between deficits in the early relationship, especially with the mother, and food use in eating disorders. Although, my experience with eating disordered clients has been limited, the disturbance in the relationship with the mother and food obsession seem to be common factors these clients share.

Initial literature searches indicated that the symbolic equation of food in eating disorders appears to have been neglected in literature. In addition, treatment methods have largely focused on other aspects of the aetiology of the illnesses, such as behavioural and psychological factors. This study attempts to explain the functions of food in anorexia nervosa and bulimia nervosa. By gaining a greater understanding of the roles of food and how it is used in eating disorders, treatment methods may become more effective as a result.

¹ “Client” and “patient” are used interchangeably in this dissertation.

In terms of the structure of this dissertation, the research topic is introduced in this chapter. The diagnostic classifications of anorexia nervosa and bulimia nervosa described in DSM-IV-TR can be found in Appendix A. Chapter two explains the methodology used in this study. Chapter three starts with an explanation of the early psychoanalytic contribution on eating disorders, mainly anorexia nervosa, following which the object relations perspectives on both anorexia nervosa and bulimia nervosa are described. Chapter four gives an account of the internal dynamics of anorexia nervosa and bulimia nervosa from a self psychology viewpoint. The findings of the previous chapters lead to the fifth chapter where implications for treatment are discussed. The study concludes with a discussion of the findings. The strengths and limitations of this dissertation are elucidated, and recommendations for future research are made.

Chapter 2: Methodology

This dissertation uses a modified systematic literature review as its methodology. This chapter first looks at the components of such a review, followed by the position of the review within the socio-cultural context of the health professions. Secondly, the rationale for using this methodology is explained, and finally the method and modifications used in this dissertation are described.

Generally, within the health professions, evidence-based practice (EBP) is deemed to be the most common and appropriate practice. This is because EBP requires that clinical judgments and treatment are provided based on the best available evidence (Centre for clinical effectiveness, 2006). EBP is a practice based on the objective and systematic amalgamation of best research evidence, clinical expertise, and consumer values (Centre for clinical effectiveness, 2006; Trinder, 2000). It requires clinicians to constantly update and revise their treatment approaches.

EBP is based largely on evidence derived from traditional research practices. These practices are considered to be effective and powerful because they produce results that can be duplicated (Akobeng, 2005a). Some examples of these practices are Randomised Controlled Trials (RCTs), and systematic literature reviews (Roth & Fonagy, 1996).

A systematic literature review is a scientific activity used to establish whether scientific findings are consistent and valuable (Murlow, 1994). It incorporates a thorough literature search and critical appraisal of individual studies to identify the valid and applicable evidence. A systematic literature review employs a formal process to ensure that a vast amount of existing information can be efficiently integrated to provide valid and reliable information for decision making. This process includes: (1) a comprehensive, exhaustive search for primary studies on a focused clinical question; (2) selection of studies using clear and reproducible criteria; (3) critical appraisal of primary studies for quality; and (4) synthesis of results according to a predetermined and explicit method (Akobeng, 2005b).

Systematic literature reviews occupy the highest position in the hierarchy of evidence in EBP (Akobeng, 2005b). The primary source of data for a systematic literature review is RCTs, mainly because of their high validity and reliability. However, psychotherapy is about extremely complex phenomena which are never the same from one moment to the next. Roth (1987) suggests that psychotherapy is both a

science and an art. Therefore, there is a degree of mismatch between the given description of a systematic literature review and the type of research that is predominantly used in psychotherapy. It is almost impossible to employ RCTs, and difficult to use other quantitative methods when conducting research in psychotherapy (Vanheule, 2009).

Psychotherapy, in many ways, is not well suited to quantitative research methods. The only similarity between psychotherapy and quantitative science is that they both form hypotheses. For instance, in psychotherapy, a client's diagnosis is usually formed by a therapist² based on the available information and his/her experience (Caper, 2001). However, these hypotheses in psychotherapy can never be tested or validated by a controlled experiment. Although psychotherapy developed within a RCT format with its clean experimental conditions and good internal validity, enables researchers to draw precise conclusions about the causality of changes in patients, it lacks external validity (Goldfried, 2000; Goldfried & Eubanks-Carter, 2004; Vanheule, 2009). That is, without the restrictive experimental conditions the usefulness of RCTs psychotherapeutic interventions can only be presumed when applied in real life.

Psychotherapeutic interventions arise from clinical practice itself, and not from the laboratory (Goldfried & Eubanks-Carter, 2004; Vanheule, 2009). Hence, there is a lack of validity and reliability of theories in psychotherapy literature. Most of psychotherapy literature comes under the interpretive paradigm or qualitative approach, where the emphasis is on understanding people's experiences and the meaning they associate with them (Grant & Giddings, 2002).

Nonetheless, as clinicians and scientists, psychotherapists are required to practice based on the best available evidence to ensure that the clients receive the best treatment possible (Milton, 2002). This is perhaps why EBP and systematic literature reviews are still relevant, because there is evidence that EBP is useful in terms of evaluating the most suitable treatment type.

Since it is difficult but necessary to use systematic literature reviews as a research method in psychotherapy, it is essential to modify this method. Because most of the psychotherapeutic writings are of a qualitative nature, it seems fitting that this dissertation uses a systematic literature review based on qualitative research literature. Qualitative research, although traditionally considered a "soft" research method, provides extremely valuable data (Henderson & Rheault, 2004). It seeks to understand a

² "Therapist", "psychotherapist", and "psychoanalyst" are used interchangeably in this study.

social or human problem through an inquiry process in a natural setting, and reports the views of the informants in rich details. It strives to explain the extraordinarily complex nature of people and their perceptions of their experience in the specific social context in which the experiment occurs.

Method

This dissertation began with a broad question of how food is involved in the aetiology of eating disorders. Research studies were located in a database, PsychINFO which includes psychological literature from the 1800s to the present. It covers more than 2,450 journals and all material published in different databases, including Psychoanalytic Electronics Publishing (PEP). Table 1 shows the initial keyword searches performed.

Table 1

PsychINFO searches on food and eating disorders

| Search term | Number of articles found | Relevant articles (excluding duplicates) |
|---|---------------------------------|---|
| Eating disorder(s) and psychodynamic(s) | 187 | 25 |
| Eating disorder(s) and self | 12 | 8 |
| Role(s) of food and eating disorder(s) | 2 | 2 |
| Psychoanaly(tic, sis, st) and food and eating disorder(s) | 17 | 4 |
| Food and self and psychodynamic(s) | 14 | 0 |
| Psychoanaly(tic, sis, st) and food | 141 | 11 |
| Eating disorder(s) and psychoanaly(tic, sis, st) | 155 | 43 |

The initial searches revealed a small amount of relevant literature. The search results provided data on many aspects of eating disorders such as body image,

biological factors, and prevalence of eating disorders. However, very little has been written about the role of food in eating disorders. The data was evaluated based on its usefulness in adding to the understanding of the research question. As the search progressed, the decision to limit the focus of this study to include only anorexia nervosa and bulimia nervosa was made, in order to keep within the time and word limitations of the dissertation. In addition, gender differences in the developmental process have also been excluded as they are beyond the scope of this dissertation.

The lack of relevant data means the majority of studies included in this dissertation derive from reference lists within the identified papers. When primary sources are referred to, as much primary literature as possible was obtained to minimise secondary source bias. For instance, the original work of Kohut (1971, 1984) was sourced as many authors such as Barth (1988) and Krueger (1997) referred to his work. Further searches were also performed for studies by seminal authors whose work had been found useful, e.g., Goodsitt (1997), Krueger (1997), and Sands (1991, 2003). Data saturation was reached when no new data was found.

The selection of data was limited to literature published by reputable journals and books. Other exclusion criteria are non English material as well as book and article reviews. Material not available in the AUT library or through interloan was also excluded. Finally, literature was critiqued by the opinions of other authors, my own critique of the literature, and my own clinical experience.

Chapter 3: Psychoanalytic understanding of eating disorders

A review paper on the history of self-starvation indicates that voluntary self-starvation is not a recently developed syndrome (Bemporad, 1996). It also highlights the fact that disturbances in eating behaviour have been observed for thousands of years.

There is plenty of evidence illustrating that many psychoanalysts and psychoanalytically informed clinicians have inferred a number of aetiology theories of eating disorders based on their clinical treatment of patients suffering from eating disorders (e.g., Geist, 1989; Krueger, 1997; Lawrence, 2002). Although the majority of their publications are based on single case studies, their work initiated psychological understanding of, and paved the way to, the psychodynamic views in the multifaceted aetiology of eating disorders.

In this chapter, the major psychoanalytic views of the aetiology of eating disorders and how food fits into the whole picture are described. It starts with the early contributions followed by the more contemporary perspective.

Early contributions

There is no indication that Freud specifically treated patients suffering from eating disorders (Caparrotta & Ghaffari, 2006). However, there are numerous references to eating disturbances in his writings. In 1893 he wrote about an interesting case of “mental anorexia” along with a “brilliant instance of abulia (inhibition of will, inability to act) in a young hysterical mother, Frau Emmy Von W (Meissner, 1981). In this writing, Freud clearly described that his patient ate very little and had the habit of hiding and throwing away food. It was revealed under hypnosis that her refusal to eat was connected to early memories of unpleasant experience of eating. Freud concluded that the patient’s symptoms were the result of unresolved expression of distressing affects caused by traumatic events. He stated that: “every neurosis in an adult is built upon a neurosis which has occurred in childhood but has not invariably been severe enough to strike the eye and be recognised as such”. More specifically, he later postulated that a disturbance of appetite, which may have gone unnoticed in childhood, “laid down the predisposition” to anorexic behaviour in later life (Freud, 1918).

Freud’s understanding of anorexia nervosa describes the link between nutritional neurosis and the underdevelopment of sexuality (Freud, 1954; Scott, 1987). The

nutritional inhibition in anorexia nervosa is equivalent to melancholia, and no appetite means loss of libido: “melancholia consists in mourning over the loss of libido” (Freud, 1954). He also linked psychogenic vomiting to the unconscious fantasy of oral impregnation, and later wondered whether the development of anorexia nervosa in girls around the time of puberty may be an expression of an aversion to sexuality.

Another theory linking the conflict between oral pleasure from sucking and oral sadism after teething contributes to the explanation of the development of an eating disorder (Abraham, 1925; Freud, 1948; Lehman, 1949). From this perspective, feeding inhibition occurs as a defence against the oral-sadistic fantasy (cannibalistic wishes usually occur after teething when eating symbolises an aggressive action against the food, which is, in a way, attacked and consumed, or against the love object that is represented by the food). The cannibalistic wishes are not acceptable in the consciousness at any stage of the ego development, thus the child must reject it by using all the defence mechanisms available. When the defence mechanisms used against these wishes are not completely successful, the child remains anxious about her³ oral sadism, not only in the oral phase but all through life. In the extreme cases, the defence against oral sadism leads to neurotic self-starvation. The mechanism used is that of turning the aggression away from objects to the child’s own body.

The link between feeding inhibition and the fear of oral pregnancy was widely accepted between the 1940s and 1950s (Abraham, 1925; Caparrotta & Ghaffari, 2006; Goodsitt, 1997; Lehman, 1949; Scott, 1987; Waller, Kaufman & Deutsch, 1940). These authors, like Freud, propose that self-starvation is a defence against sexual fantasies of oral impregnation. This view was perhaps fitting during that time as Freud developed this model in the patriarchal, well-defined, well-structured, but sexually oppressive society of the late 19th and early 20th century Vienna (Goodsitt, 1997). Sexuality had always been a somewhat taboo subject, hence it was not surprising that the genital aspect of procreation was repressed during this time. This is perhaps why the fantasy that one gets pregnant by eating was believed to be part of the aetiologies of eating disorders (Lehman, 1949). This fantasy becomes problematic in children with eating difficulties, because it is reactivated again in times of stress, usually during puberty as described by Waller, Kaufman, and Deutsch (1940):

³ Feminine forms are used in this study since the majority of eating disordered patients are female.

...the person in whom certain neurotic patterns of behavior have been laid down in childhood has a tendency to regress to these same patterns in an attempt to solve the new conflicts which have arisen. The fantasies concerning sexuality recur with added intensity and the problem of child-bearing recurs. The neurotic, who is tied with inextricable bonds to the family pattern again revives all the older conflicts and fantasies, among which may be those of impregnation through the gastrointestinal tract. To such an individual, then, the whole concept of sexuality and procreation is at this more primitive level. Activity centering around the mouth has not only the reality value of eating, but also a symbolic sexual significance centering particularly around ideas of procreation. The sexual function of the genitalia may be denied and a rather characteristic personality reaction occurs. All fantasies or activities connected with genitality are reacted to with guilt, disgust, or anxiety.

Despite the large amount of literature suggesting that sexual conflicts during adolescence are causally related to eating disorders, there is very little empirical evidence supporting this notion (see Scott, 1987). Nevertheless, there are numerous research studies indicating that the majority of eating disordered patients experience difficulties in psychosexual development. This means there is a link between sexuality and eating disorders (Reich & Cierpka, 1998; Scott, 1987; "Some difficulties", 1995; Zerbe, 1995). An alternative explanation based on more contemporary theories will be explained in the next section, Object relations contributions.

In addition to the drive conflict model, Anna Freud describes a connection between the disturbance in eating disorders and the ambivalence of the child towards the mother (Caparrotta & Ghaffari, 2006; Freud, 1948). Eating, more than any other bodily function, is closely tied to the child's emotional life and used as an outlet for libidinal and aggressive tendencies (Waller, Kaufman & Deutsch, 1940). The infant, being totally dependent for the gratification of her needs upon the external world, develops psychological relationships to the people attending to her needs, especially the parents. The need for food, although originated from physiological basis, becomes closely related with psychological factors and may develop a symbolic significance without any primary relation to the problem of survival. The intake of food, or its rejection, becomes a significant expression of various emotional factors representing the child's varying emotional patterns. Frustration may lead to hostilities which are expressed in the rejection of food.

Freud (1948) described the phenomena of infantile feeding as the stages of object love. In her view, the first stage of object love is "Narcissistic love". In this stage, the infant possesses no ego ability to sooth herself, thus, her instinctive needs (e.g., hunger) are of overwhelming nature, and require the caregiver or mother to provide

immediate relief: “Where hungry infants or toddlers are made to wait for their meals, even for minutes, they suffer acute distress to a degree which may prevent them from enjoying the meal when it finally arrives”.

The second stage of object love occurs when the development of the ego progresses and the infant is able to distinguish between her self and the environment. At this stage, the infant’s love is directed toward food. In the third stage when the infant is more perceptive, her love is transferred from food to the person who provides it (mother). In the final stage, as the infant progresses from oral and anal to the phallic level, object attachment loses its egoistic character. The qualities of the object increase in libidinal importance, while the immediate benefit from the relationship becomes less important. At this level, “altruistic love” occurs when the infant is able to love the object regardless of its benefit (Freud, 1948).

Although food and the mother are different in the child’s conscious mind, the identities between the two entities still remain fused in the unconsciousness (Freud, 1948; Lehman, 1949; “Some difficulties”, 1995). In other words, food is equivalent to the mother. The disturbance in the child’s eating pattern, then, stems from conflicting emotions toward the mother, which are transferred on to food. In eating disordered patients, over-eating and refusal of food may be an expression of ambivalence toward the mother (Winston, 2009).

The relationship between feeding and oral pleasure seems to give a good explanation of bingeing behaviour in an eating disordered patient (Abraham, 1925; Freud, 1948; Schwartz, 1986; Tschuschke, Volk & Koltzow, 1984). As feeding provides the infant with satisfaction, both from the appeasement of hunger and stimulation of the mouth, bingeing is a concrete expression of the longing for the oral mothering. Bingeing, then, represents a primitive way of self-soothing, as described by Abraham (1925): “This primitive way of obtaining pleasure (sucking) is never completely abandoned by human beings; on the contrary, it persists under all kinds of disguises during the whole of life, and even experiences a reinforcement at times in particular circumstances.”

Object relations contributions

A more systematic and careful observation of the mother-infant relationship and further understanding of organisation of the self, led to the development of object

relations theories (Caparrotta & Ghaffari, 2006; Goodsitt, 1969). For object relations theorists, the emphasis shifts from the need for biological relief to the need to integrate various representations of the self and objects.

Klein, following Freud, believed that human development and behaviour were primarily understood as a function of instinctual drives. However, for her these drives are inherently attached to part-objects and later to whole objects, and their equivalent unconscious fantasies of self and object representations (Caparrotta & Ghaffari, 2006; Hinshelwood, 1994). Based on her clinical observations, she concluded that the infant's relation to the mother's breast is sadistic and devouring from the first feeding experience. If left unresolved, the oral sadistic phantasy may result in eating difficulties later on (Freud, 1948; Lehman, 1949; Masserman, 1941; Moulton, 1942). Hence, eating phobias are caused by the inhibition of oral aggressive tendencies.

From a more contemporary object relations standpoint, eating disorders are rooted in unresolved conflicts caused by early deprivation in the parent-child bond (e.g., Birksted-Breen, 1989; Boris, 1984; Castelnuovo-Tedesco & Risen, 1988; Charles, 2006; Jacobson, 1988; Lawrence, 2001; Lehman, 1949; Masserman, 1941; Newton, 2005; Williams, 1997; Winston, 2009). The relationship between the mother and the child is often described as both engulfing and distant but never fulfilling (Bemporad et al., 1992a; Charles, 2006; Lane, 2002; Williams, 1997; Winston, 2009). The mother is experienced as preoccupied, demanding, unempathic, and unattuned to the child's needs. When the mother fails to receive and modify the projections (e.g., prosecutory anxiety) of the infant, not only is the child left to reintroject her own unmodified anxiety which is often of an overwhelming nature, the child may also become the recipient of the projections of the mother (Bion, 1962; Lawrence, 2002; Williams, 1997). The unbearable projections from the mother are experienced as a "foreign body" or an intrusive object.

The mother's failure also results in many developmental arrests including inabilities to recognise the self, to distinguish one's own wishes from those of others', and to self-regulate. In the absence of self-regulation, the child attempts to self-soothe by attuning herself to the mother and her mother's needs, in order to create the experience of being together, a defence against the "fear of breakdown" (Winnicott, 1974).

The child is left with an internalised conflict. She needs to be attuned to her mother which results in self-annihilation, while also needing to preserve her own

psychic survival which means preserving her self from her mother (Charles, 2006; Goodsitt, 1969; Krueger, 2001; Lane, 2002). The child attempts to resolve this conflict by splitting, idealising the mother and all the mother's negative affects as goodness, whilst perceiving herself as all bad. There is a sadomasochistic dynamic in this relationship. The child sees anything that causes the mother pain and suffering as her own fault (masochism), whilst trying to deny her own murderous rage to the mother (sadism) and the mother's to the child's self. The more rage the child feels, the greater she sees herself as evil and bad.

Faulty maternal attunement also has a very substantial effect in the child's ability to symbolise (Bourke, Taylor & Crisp, 1985; Charles, 2006; Hinshelwood, 1994; Krueger, 2001; Lane, 2002; Ritvo, 1984; Schwartz, 1986). The lack of symbolisation has a two-fold implication on eating disorders. First, insufficient mirroring and reciprocal interactions with the mother means the child is unable to recognise and to describe her own emotions (alexithymia). The inability to put feelings into words means that the child must find another way to regulate basic affects. Since the body self is the core foundation of the psychological self, and somatic experiences the first form of affect, the body is used as a mean of self-regulation (Freud, 1923; Krueger, 2001), as explained by Freud (1923): "The ego of an individual begins first and foremost as a body ego...The ego is ultimately derived from bodily sensations, chiefly from those springing from the surface of the body".

Secondly, the psychic enmeshment between the mother and the child also prevents the needed space for symbolisation (Charles, 2006; Hinshelwood, 1994; Jacobson, 1988; Newton, 2005). This required space allows the child to create a transitional object (not me but an object in my control) from the illusion of good mothering. In other words, the transitional object indicates the child's ability to symbolise. Without the space, the object (symbol/mother) becomes confused with the mental content of the child. Meaning and symbol become identical and "symbolic equation" occurs (Segal, 1957). For eating disordered patients, the early symbols (food) are not felt by the ego to be symbols or substitutes, but the original object itself (mother). Food equates to the mother and her love (Birksted-Breen, 1989; Winston, 2009; Zerbe, 1995). The lack of symbol formation has a pronounced effect on thinking in a sense that if symbols are exactly the things they symbolise, they must be used in the way the thing is used (Hinshelwood, 1994).

As mentioned, the deficits in the early relationship, e.g., insufficient attunement, and enmeshment, result in a fundamental confusion between the self and other. In an anorexic client, self-starvation is viewed as an attempt to separate her self from her mother, as describes by Lane (2002): “These patients who feel crushed, unable to move, paralysed, have to establish themselves in some manner and do this by being different”. This is especially true during puberty since the client’s body is developing into womanhood, which can be experienced as becoming the mother (Birksted-Breen, 1989).

Self-starvation is also seen as a way of controlling a “bad” object, lest it may become overpowering (Boris, 1984; Newton, 2005). As food equates to mother, food is refused because food is perceived as dangerous and eating results in psychic annihilation. In addition, having low weight, and possessing a thin and erect body may be a defence against the psychic intrusion (Lawrence, 2002; Ritvo, 1984; “Some difficulties”, 1995; Winston, 2009). The phantasy of possessing a male body, straight and lean, without obvious openings, is often found as an aspect of the phantasy of anorexic patients.

The following summarises the internal dynamics of anorexia very well.

When the anorectic patient speaks, she hardly uses her voice, as she has practically nothing to say. Her suffering begs for words. She wishes to express something that is linked to her body’s symptoms, although not articulated in her discourse. Anorexia is a mute symptom that does not make much sense. The real symptom is the aversion to food. “Not eating” is not quite as significant as “eating nothing”. We are dealing with a mute partnership that has been established with “nothing”. The enormous stubbornness and aversion to food can be understood psychoanalytically as a form of a preserving wish, of avoiding being invaded by the “other”. It is a strange and dangerous way of preserving wishes. We are aware that wish is always linked to need. In this manner, the aversion to food may be a way of re-creating a need that was in some way “over-filled” (overwhelmed) by this “other”. (Morais & Drummond, 2002)

In terms of bulimia nervosa, bingeing is seen as an attempt to reunite with the mother, to return to the symbiosis stage which provides safety and comfort (Reich & Cierpka, 1998; Schwartz, 1986; Sugarman & Kurash, 1982). Bingeing symbolises a regression, being cared for, intimacy, and the gratification of instinct. In addition, greed which is a concept introduced by Klein may be relevant to the internal dynamics of bingeing (Caparrotta & Ghaffari, 2006; Hinshelwood, 1994; Mitchell & Black, 1995).

According to Klein, infants are intensely needy creatures. Their existence, both physical and psychological, is hopelessly dependent on the breast (part object of the mother) for nourishment, safety, and pleasure. The breast is experienced as both good

and bad. When the breast provides milk, it is thought of as powerful and plentiful. On the other hand, the breast is also experienced as withholding its wonderful substance, good milk, hoarding it for itself and enjoying its power over the infant, depriving the infant of total control and access to its resource.

As a result, the infant becomes greedy in response to her helplessness at the breast. She is filled with impulses to totally appropriate the breast for her own needs. This is perhaps what goes on in bingeing. The patient becomes greedy and filled with a desire to have it all, as described by a patient in the paper by Freedman and Lavender (2002): “At least I can get everything in that I want.” With greed, the intent is to possess and control, not to destroy. It is not destructive in its intension toward the breast, but deeply resentful of not being in control of the breast’s goodness (milk). Hence, the infant becomes ruthless in her acquisitiveness as evident in the rather frantic nature of bingeing.

On the other hand, as well as providing comfort and satisfying the wish to have it all, bingeing is also tied together with being overpowered, being penetrated, and annihilation. The innate envy of the infant which is destructive in nature also means that the infant would rather destroy the goodness (mother/food) than remain hopelessly dependent on it (Mitchell & Black, 1995). Hence, the client needs to purge to get rid of the poisonous mother. Vomiting is then an attempt to kill and destroy the internalised bad object. While anorexic patients have successfully annihilated the bad internal object, bulimic patients have failed, thus serial killing is required (Lawrence, 2002).

With respect to sexuality and eating disorders, there is plenty of evidence showing that sexual deficits are common among eating disordered patients (e.g., Reich & Cierpka, 1998; Scott, 1987; Zerbe, 1995). As eating disorders usually arise at time of puberty, many authors suggest that there are psychosexual factors in the causation of eating disorders (Scott, 1987). They postulate that eating disorders are a rejection of adult femininity as states by Rampling (1978):

...development of anorexia nervosa represents a regression into psychosexual development as a maladaptive solution to the maturational demands of adolescence, which the patient construes as maleficent and frightening. The libidinous feelings attending sexual maturation along with their potential for consummation in an extrafamilial and heterosexual relationship, are the core issues around which fears evolve.

As mentioned in the last section, there is very little evidence supporting the casual link between eating disorders and sexual development. In other words, rejection

of sexual maturity does not cause an eating disorder. Perhaps, a better explanation of sexual deficits in eating disordered patients is that disordered eating is used as an attempt to cope with many challenges that arise during the time of puberty (Bruch, 1973; Crisp, 1997; Zerbe, 1995). The patient, subjected to conflicts over initiative and independence during adolescence, is unprepared to assume the responsibilities and independence encountered during adolescence after a childhood of obedience and dependence, as emphasised by Crisp (1997) : “Pubertal development is not only sexual in the narrow sense, however. It heralds a spectrum of challenges as large as life itself”. The patient’s reaction to the biological changes of adolescence is therefore to retreat from the demands of adulthood, and an attempt to establish a sense of self-control. Ritvo (1984) describes it in the following:

Her fantasy was that stopping eating was also a way of calling a halt to the bodily changes which her late puberty gave her no time to integrate. No eating was an almost magical way of stopping or undoing bodily changes, employing her body directly as an object or target in an effort to gain mastery over the sexually mature body which felt out of control.

On the one hand, it may seem logical to conclude that the rejection of sexuality has an aetiological link to eating disorders, since maintaining subpubertal weight and body means not being a mature woman. Nonetheless, it is perhaps more plausible that the heightened fear of being out of control during adolescence results in a stronger need to gain control. For the potential anorexic patients with the inability to symbolise, this means controlling the body by not eating. Moreover, sexual intimacy not only heightens the anxiety of being invaded both physically and psychologically, it also requires a capacity for bonding which most eating disordered patients lack (Zerbe, 1995). Thus, it is extremely difficult for eating disordered clients to develop a fulfilled and satisfied romantic relationship. The sexual deficits in eating disordered patients do not automatically signify the rejection of sexuality (Scott, 1987).

The explanation of the roles of food in anorexia nervosa and bulimia nervosa has been elucidated from the psychoanalytic and object relations theories in this chapter. Although the findings shed light on the internal dynamics of eating disordered clients, their subjective experience seems to have been neglected. This perhaps reflects a common pattern in the developmental process of eating disordered patients, neglect of their true self.

Nonetheless, there is evidence suggesting that theoretical contributions from self psychology provide a useful perspective regarding the subjective experience of the

patients (Geist, 1989; de Groot & Rodin 1904). The emphasis on empathy in self psychology allows the therapist another way into the patient's psychic reality, which may enhance the understanding of the illnesses.

Chapter 4: Self psychology perspective on food and the aetiology of eating disorders

In this chapter the roles of food in anorexia nervosa and bulimia nervosa are explained from a self psychology perspective. Self psychology is chosen as a separate chapter for three reasons. First, as mentioned in the last chapter, self psychology provides a subjective view into the patient's world, enabling the therapist to better understand the patient, which may increase the effectiveness of therapy. Second, within the object relations theories, self psychology is the most highly developed theory of the formulation and maintenance of the self (Banai, Mikulincer & Shaver, 2005; Sands, 1989; Summers, 1996). For instance, self psychology has succinctly conceptualised different terms, such as "self", "selfobject", "selfobject needs", and "empathy", to explain the developmental process. Third, self psychology consists of a comprehensive model of clinical practice and therapy (Banai, Mikulincer & Shaver, 2005). The most important aspect of psychotherapy informed by self psychology is the emphasis on empathy and attunement in the practice, which is a different focus from the Freudian psychoanalysis (Bachar, 1998; Bruch, 1982).

For self psychologists, psychological deficits and undeveloped psychic structure are more important than sexual drives or distortions of the self and objects (Goodsitt, 1997). The emphasis is on the cohesive structure of the self. From a self psychology perspective, the self representation of an infant is highly vulnerable and fragile, lacking in cohesiveness and stable boundaries (Banai, Mikulincer & Shaver, 2005; Miller, 1991; Stolorow & Atwood, 1992). Hence, similar to other object relations theories, the child requires the presence of others, mainly the mother, to function as "selfobjects" for maintaining and reinforcing healthy narcissism (Kohut, 1971, 1977; Lichtenberg, 1991).

Selfobject can be described as the subjective aspect of self-sustaining functions performed by the relationship of the self to the objects, who by their presence or activity evoke and maintain the self and the experience of self hood (Bachar, 1998; Kohut, 1971; Lichtenberg, 1991; Wolf, 1998). In other words, selfobject is neither an object nor the self but the functions related to the maintenance, restoration, and transformation of the self-experience. As such, the selfobject relationship refers to an intrapsychic experience and does not describe the interpersonal relationship between the self and other objects (Baker & Baker, 1987; Krueger, 1997).

Only a responsive selfobject environment can provide those experiences of living that facilitate the transformation of the infant's potential into a creative aliveness and realness, a self structure with joyful interests and self affirming initiative (Geist, 1989). A responsive selfobject milieu enables the child to build self-esteem, self-regulation of emotions, find calmness, soothing, and a feeling of continuity over time and space, i.e., a cohesive self (Bachar, 1998; Kohut, 1971; Wolf, 1998).

As the child develops, if she is exposed to an optimal level of frustration, she will gradually learn what she can control and what she has limited or no control over, i.e., "optimal frustration" (Clinton, 2006; Kohut, 1971; Miller, 1991). Within the developmental process the child, because of her developmental omnipotence, becomes aware of her control over her mother's behaviours, resulting in an increase in the child's ability to contain her own emotional states. This process eventually leads to an experience of the self as a regulating agent. The child establishes affects regulation and impulse control, and discovers that emotions can be manipulated and discharged internally as well as through actions. More importantly, the child learns that affects are experienced as something recognisable and sharable. However, expressions of affects by the mother that are mismatched to the infant's internal emotions are likely to result in confusions and unsymbolised internal states which are difficult to regulate (Fonagy, Gergely, Jurist & Target, 2002).

Eating disorders from a self psychology perspective

According to Kohut (1971), the child's capacity to tolerate separation from the mother without some form of psychic decompensation depends on the internalisation of certain mental functions and structures. These important functions are called "selfobject functions".

The selfobject functions are initially provided by the mother who soothes and protects the infant from overloading stimulus. For the infant, the mother provides three types of selfobject function (Banai, Mikulincer & Shaver, 2005; Goodsitt, 1997; Wolf, 1998). First, the mother serves as a mirroring selfobject by valuing and admiring the infant, thereby contributing to a healthy sense of "grandiosity" (Kohut, 1971). Bachar (1998) proposes that for anorexia, the patient's grandiosity is met not by a mirroring human selfobject, but her own notion that she possesses supernatural powers which enable her to avoid food. In other words, the pleasure derived from being in control of

her body fulfils the patient's mirroring needs (needs to be admired for one's qualities and accomplishments). This may be evident in her satisfaction and great triumph related to her ability to lose weight (Goodsitt, 1969).

Second, the mother is an idealised object toward whom the child feels admiration, and with whom she can identify to the point of feeling associated with, or a part of, the mother's highly admirable qualities. Through this kind of identification, the child can develop a secure sense of self and internalise the ability to hold ideals and set high but realistic goals (Banai, Mikulincer & Shaver, 2005). It is suggested that bulimic patients use food to fulfil their idealising selfobject function (Bachar, 1998; Sands, 1989, 1991). Food provides omnipotent power, capable of solving all problems. That is, it supplies soothing, calmness, and comfort. It also regulates painful emotions such as anger, anxiety, depression, and shame (Waters, Hill & Waller, 2001).

Third, and perhaps less relevant to the aetiology of eating disorders, the mother serves a twinship selfobject function to whom the child feels connected, part of, and protected.

Failures in the provision of mirroring, idealising, and validating needs leads to deficits in capacities to maintain self-esteem, cohesion, and self-regulating functions (Bemporad et al., 1992a; Bemporad et al., 1992b; Charone, 1982; de Groot & Rodin, 1994; Dellaverson, 1997; Geist, 1989; Goodsitt, 1997; Gordon, Beresin & Herzog, 1989; Humphrey, 1986; Sands, 1991; Stolorow, 1986; Stolorow & Atwood, 1992; Zerbe, 1993). These disruptions result in painful experiential states in the psyche including; emptiness and numbness, a sense of going through the motions, not feeling alive, not really living, dysphoria, and tension. Ability to think may also be disrupted or disorganised.

Eating disorders are disorders of the self, which developed as a result of severe disturbance in the empathic relationship between the child and the care-giving environment (Goodsitt, 1997; Sands, 1991; Stolorow & Lachmann, 1980). The child's narcissistic needs (needs for self-expression and self-promotion) and the affects that surround them are not empathically responded to, because they somehow threaten the mother's narcissistic equilibrium. Hence, the child copes by several means including disavowing her needs and affects, repressing them, or splitting them off from her total self-structure. The child's developing self thus sustains structural deficits in its capacities for self-cohesion, temporal stability, and self-esteem regulation. As a result, she becomes vulnerable to fragmentation and depletion.

As mentioned in the last chapter, food is chosen in eating disorders because it is the first transitional object, the bridge between the mother and the child (Freud, 1948; Geist, 1989; Krueger, 1997). Not only is food a symbol of everything the mother is or might have been, it is also a real, tangible, and a soothing substance which physiologically and emotionally regulates affect and tension states, hence providing selfobject functions (Krueger, 1989). Alexander (1950) describes the importance of food and eating as follow:

No vital function in early life plays such a central role in the emotional household of the organism as does eating. The child experiences the first relief from physical discomfort during nursing: thus the satisfaction of hunger becomes deeply associated with the feeling of wellbeing and security... For the child, to be fed is equivalent to being loved. In fact, the sense of security associated with satiation is based on this emotional equation. (p. 86)

From a self psychology perspective, eating disordered symptoms are viewed as desperate attempts to restore a sense of being alive, whole, or effective, a reckless effort to free oneself from pain. They represent frantic struggles to supply missing selfobject functions (Bachar, 1998; Brenner, 1983; Caparrotta & Ghaffari, 2006; Goodsitt, 1969, 1997; Miller, 1991; Sands, 1989). By turning to food, the patient tries to avoid the need for human selfobject responsiveness, thus circumventing further shame and disappointment that may damage the self to the point of fragmentation and depletion. Roth (1991) captures the symbolic meaning of food for patients suffering from bulimia nervosa (and to a certain extent, anorexia nervosa) in the following:

Food and love. We begin eating compulsively because of reasons that have to do with the kind and amount of love that is in our lives or that is missing from our lives. If we haven't been loved well, recognised, understood, we arrange ourselves to fit the shape of our situations. We lower our expectations. We stop asking for what we need. We stop showing the places that hurt or need comfort. We stop expecting to be met. And we begin to rely on ourselves and only ourselves to provide sustenance, comfort, and pleasure. We begin to eat. And eat. (p. 20)

Eating disordered patients often lack optimal integration (Miller, 1991; Stolorow & Lachmann, 1980). They are vulnerable to structural decompensation of the self-organisation, and under stress, this decompensation may threaten them with a feeling of loss of self-esteem, identity confusion, and fragmentation or disintegration, i.e., "fear of breakdown" (Geist, 1989; Winnicott, 1974). In essence, the fear of breakdown refers to the fear of emptiness which feels out of control (Krueger, 1997).

For an eating disordered patient, in order to prevent disintegration anxiety, she will organise a controlled emptiness via several means including not eating, frenetic

pace of excruciating exercise, and ruthless binges (Lerner, 1983). These feelings of disintegration are similar in both anorexia nervosa and bulimia nervosa. These methods of using food and body are compulsive in nature, and represent ways to survive, to tolerate and numb the experience of the moment, as illustrated by one of Krueger's bulimic patients (1997): "I feel helpless, worthless, that I can't control how someone responds to me. That's what brings me back to my body to be destructive at least- to binge. It's a substitute for the things I can't get and want. I'm out of control. I take in something to feel better, then I feel more in control."

The difficult early relationship with the mother is also internalised, and forms a pattern of how the patient relates to others throughout her life. Eating disordered patients often lack the ability to rely on human beings to fulfil their selfobject needs, resulting in reinforcement of food use as a selfobject (Bachar, 1998; Miller, 1991). The following illustrates this dynamic in a bulimic patient:

Trina's experience of love is that it hurts. Love hurts. People lie. People leave. When her husband leaves on a trip, she is not surprised. She knows that people betray you, and she has carefully protected herself from feeling the pain of his (or anyone's) betrayal: She has taken another love, one who will never leave: Food. (Roth, 1991, p. 23)

Self psychology explanation of anorexia nervosa

For the anorexic patient, several authors suggest that her mother is domineering, intrusive, overprotective, and overtly or more subtly discouraging of separation-individuation (e.g., Beresin, Gordon & Herzog, 1989; Bruch, 1973, 1982; Gordon, Beresin & Herzog, 1989; Johnson, 1991a; Minuchin, Rosman & Baker, 1978; O'Kearney, 1996; Steiger, 1989; Sugarman, Quinlan & Devenis, 1981). The mother encourages enmeshment and often responds to the patient according to her own needs rather than those of the patient. The patient adapts to maternal intrusiveness by becoming a compliant "parent pleaser" (Goodsitt, 1969; Johnson, 1991a, p. 186). She attempts to stay alive by tuning into and fitting into the internal states of her mother, a defence against fear of loss, emptiness, and losing omnipotence. She experiences herself as taking in characteristics of the mothers that remain untransmuted. That is, the patient internalises the aspect of the mother that she knows the mother perceives as special, but does not belong to the patient's self. Within this collusive bond, the compliance turns the subordination of the child's self into a narcissistic extension of her mother (Geist, 1989; Goodsitt, 1969). In essence, the patient becomes part of her mother.

This enmeshment results in the patient partially failing to internalise parental selfobject functions. It inhibits the patient from acquiring a firm, independent, cohesive sense of self, and leaves her dependent on the mother for self-regulation. The patient experiences significant difficulties in self-definition and self-regulation as a result of the symbiotic relationship with the overcontrolling mother (Bruch, 1977a; Selvini-Palazzoli, 1974; Swift & Stern, 1982). Essentially, the patient becomes an expert at reading cues from others about how to feel and behave. Given the dependence on external resources, she also learns to accommodate herself freely to others, because she would be lost if the relationship was disrupted (Johnson, 1991a). The following describes the enmeshed relationship between a patient suffering from anorexia nervosa and her mother:

Mother cloned me. I did what she wanted, when she wanted it and it made her so happy and it made me happy. "Oh, isn't she wonderful," said my mother all the time. I'm a victim, but I also got stroked unconditionally. As a teenager my mother told me what to want, what to wear, to wear this bra or that bra. She was very, very intrusive. I felt I couldn't control anything in my life. I confused nurturance and food. I couldn't get angry, because it would be like destroying someone else, like Mother. It felt like she would hate me forever. I got angry through anorexia nervosa. It was my last hope. It's my own body and this was my last ditch effort. (Beresin, Gordon & Herzog, 1989)

The patient's adaptation leaves her sense of self and her capacity for self-regulation intricately tied to or dependent on her mother. She is trapped in a paradoxical situation. On the one hand, she feels the need to rely on the significant other psychologically in order to regulate tensions. However, when this happens she feels engulfed, without identity, and ineffective (Johnson, 1991a; Zerbe, 1993). The self-starvation is an attempt at assertive, independent behaviour (Beresin, Gordon & Herzog, 1989; Bruch, 1973; Goodsitt, 1969; Johnson, 1991a). It is an effort to establish some sense of competency, control, or identity that is independent of, and often in conflict with, significant others. The patient uses her body as a battleground of the separation-individuation war. The self-starvation or control of the body may serve to defend against the threat of maternal intrusiveness. The sense of protection allows the patient to feel strong and safe as described by Krueger (1997):

The attempt of the anorexic patients by saying no to food proffered by their mothers says in effect: "I don't need you or anything you give me. I don't need you or anything you provide- this is where you end and I begin- my body and I are not an extension of you. I am not you and I can control one thing in the world, what comes into my body."

Psychic enmeshment with the mother also results in the anorexic patient's inability to integrate the body self and the psychic self (Goodsitt, 1969, 1997; Thomaе, 1963; Zerbe, 1993). When the integrity of the self becomes unstable, bodily symptoms (hypochondriasis) ensue (Kohut, 1977). The anorexic patient experiences her body as a separate entity from her self. She becomes indifferent to her body needs, failing to take adequate care of her body. Her bodily distortions and delusions are all symptomatic of a lack of cohesiveness and self-organisation (Goodsitt, 1997; Kohut, 1977; Zerbe, 1993). The anorexic patient derives a sense of immediate mastery from the denial of physiological needs, and having absolute control over intake of food. She believes that she does not need anyone or anything, a near-total experience of autonomy from any need whatsoever, reflecting the disavowed selfobject needs (Krueger, 1997). Moreover, having been a narcissistic extension of her mother, thus "depersonalised", she also attempts to feel her "self" through the boundaries of her body by her obsession with the body, constant activity, and vigorous exercises (Goodsitt, 1997; Zerbe, 1993) as illustrated below:

I relish the feeling of my bones pressing against the sheets...My pain is manifested by my body, for then it becomes tangible. My bones, my profile, become constant reminders to me of the control I possess. I feel my bones and feel one with my body, as though I can control it...I want to lose more weight so my body can be mine. It has never been mine, it will never be enough. (de Groot & Rodin, 1994)

The anorexic patient derives their grandiose selfobject function from her body, gaining pleasure from having total control of it (Goodsitt, 1997). She needs to feel that her body is perfect and unchanging. The changing body in adolescence threatens this grandiosity, thereby threatens the patient's fragile psychic equilibrium, resulting in the hatred of her body. The patient feels ashamed and embarrassed by her body to such an extent that she delusionally believes she can starve it to death and yet has the psyche survive (Sacksteder, 1989).

Self psychology explanation of bulimia nervosa

Mothers of bulimic patients have been described as passive, rejecting, and disengaged. Whilst they are not blatantly neglectful, the under-involvement appears to be emotional unavailability (Johnson & Connors, 1987; Johnson, 1991a; Steiger, 1989; Strober & Humphrey, 1987; Tereno, Soares, Martins, Celani & Sampaio, 2008). The quality of the caretaking could be characterized as form without substance. Although

the primary needs are fulfilled, there is no warmth in the holding experience or any attunement that facilitates the capacity for self soothing.

The emotional unavailability results in the child's lack of a secure base from which she can individuate. Under these circumstances, the child may become tentative and even more dependent. The child's strong reliance, particularly through the rapprochement phase, further strains the mother's limited resources and may provoke increased rejection of the child's needs to be soothed and comforted. Since soothing is unavailable from the mother, the child will begin to find other means of self-regulating outside the mother-child relationship. As mentioned earlier, food is likely to be adopted by the child as a self-regulatory tool, because of its powerful symbolic associations. The function that food serves can be conceptualised as being similar to that of a transitional object. That is, it provides soothing ability while remains under the patients' total control (Bachar, 1998; Sands, 1991).

Despite the emotional unavailability of the mother, the bulimic patient often has enough ego resources to compensate for the deficit (Johnson, 1991a). She prematurely takes responsibility for her own and often other's self-regulation. Although the patient can adapt superficially, her self-cohesion is inadequately developed to accommodate her infantile needs, such as self-soothe when feeling angry, frightened, or anxious. She still relies on other selfobject (food) to provide these selfobject functions. The patient uses a binge to relieve distress, and feels more intact, sated, and more in control afterward. The temporary illusions of fullness, completeness, and affirmation are created during a bingeing episode.

However, substance cannot adequately fulfil the missing selfobject functions, and what goes in must come out (Bachar, 1998; Levin, 1991). Roth (1991) illustrates what goes on in a bingeing episode in the following:

So you get in the car and begin driving to your favourite store, but as you come to a stoplight, you realize that something is wrong. Something is gnawing at you. You can't put it into words, but as you sit there, it grows more and more oppressive until you feel you'll suffocate under the weight of it. You're having a hard time breathing, the anxiety is rising and you want it to stop. All you care about is having it stop, and you begin thinking about the éclairs in the bakery next to the clothes store. Suddenly you are relieved. Something will take this feeling away. You don't have to come apart. You will not suffocate. With the determination of a samurai, you steer the car to the parking lot, click click click go your shoes on the pavement. You look at the man with tortoiseshell glasses who is passing on your left but you don't really see him, you don't see anything, your mind is a laser beam of intent. You want food. Then you are standing in front of the glass case, hearing yourself order not one but four éclairs, five

cookies, and a marzipan cake. You mutter something about having a party as you pay for your relief and leave. Click click click on the pavement, the sound of car door opening, the thud of its slamming shut and finally, finally you are alone with your blessed relief. Quickly, frantically and without tasting them, you inhale two éclairs, at a more leisurely pace, you eat a third. Your stomach is getting full; you can feel the whipped cream sloshing against your ribs, can feel you pants getting tighter. Oh shit. You've blown it. You've fucking blown it. You were doing so well, sixteen days of eating dry toast and skinless chicken and you blew it in one afternoon. (p. 103)

After a binge, the patient often experiences a distended and physically painful stomach, which gives her a “bad” feeling both physically and psychologically. This is worsened by the sense that it is something she has created, both by the action of bingeing, and by the choice of “bad” food. This “bad” feeling, usually comprises anger, guilt, and shame, leads to purging, which is an immediate and active way of solving the problem. Purging provides the actual release from physical discomfort, which also results in psychological calm. By purging, the “bad” feeling is also symbolically eliminated providing a sense of calmness, regulating the immediate tension state (Krueger, 1997).

Disordered eating, as with other selfobject functions, becomes a component part of the self, necessary in order to maintain the integrity of vital functions. Food, then represents a concretised selfobject that is more tangible, reliable and predictable than disappointing and dissatisfying human selfobjects (Krueger, 1997): “It’s better to eat than to care about someone because food doesn’t leave and moms do. Food doesn’t hit and grandmothers do” (Roth, 1991, p. 22). That is, food becomes the replacement for love and care: “If Trina could not get her grandmother’s love, she would steal her food” (Roth, 1991, p. 22)

Unfortunately, the eating disordered patient attempting to self-supply the missing selfobject only gets halfway (Geist, 1989; Roth, 1991; Sands, 1991). The problem with a restrictive selfobject system organised around food is that its satisfactions, while seductively powerful, are only momentary (Dellaverson, 1997). No psychic structure is built, and the defect in the self remains (Kohut, 1977). Stable regulators can only be developed through transmuting internalisation (the internalisation of self-regulation functions that are fulfilled via mirroring, opportunities for idealisation, and twinship. The child gradually acquires the ability to perform these functions autonomously through nurturing and responsive selfobject milieu; Banai, Mikulincer & Shaver, 2005). It is only when attainment of a stable, cohesive self occurs

that the patient can process an external stimulus, be it food or information, and maintain a sense of wholeness and integrity (Goodsitt, 1997).

In summary, inadequate attunement and faulty mirroring in the early relationship with the caregiver (usually mother), results in the child's inability to build a cohesive self. Food, which is associated with the mother and her care, is used to supply the missing selfobject functions. For the anorexic patient, self-starvation provides a sense of control, an adaptive effort to defend against self-regulatory deficits resulting from maternal over-involvement. For the bulimic patient, chaotic eating behaviour is a desperate defence against emptiness resulting from maternal under-involvement. Without a nurturing care giving environment transmuting internalisation does not occur, thus no cohesive self is built, leaving the eating disordered patient to continue using food as a selfobject.

Although self psychology provides a subjective viewpoint into the patient's world, it ignores the gender differences in the developmental process. Thus, the fact that many more women than men develop eating disorders has been dismissed. Nonetheless, the self psychology perspective described in this chapter provides sufficient information to answer the hypothesis outlined in the introduction.

Chapter 5: Treatment implications for anorexia nervosa and bulimia nervosa

The roles of food in anorexia nervosa and bulimia nervosa have been described from a psychoanalytic stance, an object relations viewpoint, and a self psychology perspective in the previous two chapters. Essentially, massive failures in the early developmental process result in the patient's archaic self. Food, representing the mother's love and care, is used to provide many selfobject functions necessary for maintaining self cohesion.

Having explained why food is chosen, treatment implications based on the functions of food are explained in this chapter. First, the current research regarding treatment for anorexia nervosa and bulimia nervosa is described. It is followed by recommendations for psychotherapy, in which the importance of employing an empathic stance is highlighted. The rationales for treatment recommendations based largely on a self psychological perspective are given. Finally, the psychotherapeutic process for working with patients suffering from anorexia nervosa and bulimia nervosa is explained.

Current research on treatment of patients with anorexia nervosa and bulimia nervosa

Anorexia nervosa and bulimia nervosa are most prevalent in young women from Western societies between the age of 14 and 24 years (Hay, 2004). Eating disordered patients are known to be resistant to therapy, and take several years for recuperation (Goodsitt, 1969; Herzog, Franko & Brotman, 1989). More than half of the patients do not recover and are at risk of developing a chronic disease, and a portion of anorexic patients die from the medical complications of starvation or suicide (Hay, 2004; Herzog, Hamburg & Brotman, 1987; Steinhausen, 2002; Zerbe, 1992) Research evidence suggests that eating disorders are multi-faceted in both aetiological and maintaining factors (Garner, Garfinkel & Bemis, 1982; Steiger, 1989; Strober, 1997). Many etiologic aspects including biological, social, and psychological factors have been proposed, but none have been uniformly accepted (Dickstein, 1985; Garner, Garfinkel & Bemis, 1982; Orbach, 1978; Sands, 2003). There is also a lack of a consensus on the effective treatment of eating disordered patients (Dickstein, 1985; Herzog, Keller, Strober, Yeh & Pai, 1992). However, there is evidence supporting a multidimensional

treatment approach (Dickstein, 1985; Goodsitt, 1969; Hay, 2004; Herzog, Franko & Brotman, 1989; Steiger, 1989; Strober, 1997; Zerbe, 1992, 1993) The multidimensional approach often includes medical monitoring, individual psychotherapy, behavioural therapy, psychopharmacological therapy, family therapy, group therapy, and dietetic input.

Despite the lack of a clear-cut effective treatment approach, the first priority of treatment is a thorough medical evaluation and the establishment of a medical management regime. This is because eating disordered patients maybe in extreme physical danger, particularly those with anorexia nervosa (Dickstein, 1985; Hay, 2004; Reich & Cierpka, 1998). Medically at-risk and severely under-nourished patients will not be able to make use of any psychological input provided by the therapists as described by Garfinkel (1985): “Cognitively, they (eating disordered patients) display poor concentration and indecisiveness. Their moods are characterised by irritability, anxiety, and lability. Sleep may become fragmented. Social withdrawal and a narrowing of interests are common. Libido decreases. Gastric emptying is markedly reduced.” Starvation may result in a self-perpetuating process where the patient experiences these starvation effects as being out of control, hence, increases her dieting to enhance her sense of personal control and worth. Hospitalisation may be appropriate (Becker, Grinspoon, Klibanski & Herzog, 1999).

In terms of psychological treatments, Herzog, Hamburg, and Brothman (1987) suggest that psychotherapy maybe the most commonly prescribed treatment for anorexia nervosa and bulimia nervosa in the United States. However, there is little evidence to support its effectiveness. Few outcome studies which test the effectiveness of psychotherapy as treatment for eating disorders have been done, and are often seriously flawed by a lack of control or randomisation (Hay, 2004; Herzog, Hamburg & Brotman, 1987; Norman, Herzog & Chauncy, 1986).

On the other hand, a study by Herzog, Keller, Strober, Yeh, and Pai (1992) shows that although there is no consensus regarding the treatment of either anorexia nervosa or bulimia nervosa, a de facto agreement indicating the use of “talking therapy” was endorsed unanimously. In addition, there is plenty of evidence suggesting that cognitive-behavioural therapy appears to be the most effective treatment for bulimia nervosa (Fairburn, Jones, Peveler, Carr & et al., 1991; Fairburn, Jones, Peveler, Hope & et al., 1993; Fairburn, Norman, Welch, O'Connor & et al., 1995; Herzog et al., 1999; Wilson, Fairburn, Agras, Walsh & Kraemer, 2002). This may be due to the reason

mentioned above, the effectiveness of psychotherapy is difficult to measure, and the available evidence of its usefulness lacks reliability and validity. Psychopharmacological therapy is also proven effective in reducing binge-purge frequencies and scores on depression inventories (Hay, 2004; Walsh et al., 2000; Zerbe, 1992).

Despite a lack of evidence illustrating the effectiveness of psychotherapy for eating disordered patients, the review of eating disorders literature indicates a heavy use of long-term psychodynamic psychotherapy for the majority of these patients (Bachar, Latzer, Kreitler & Berry, 1999; Bruch, 1970, 1973, 1977b, 1982; Herzog, Hamburg & Brotman, 1987; Johnson, 1991b). Hilde Bruch is perhaps the most influential author in the modern psychotherapeutic practice with eating disorders (Bachar, 1998; Garfinkel, 1985; Swift, 1991). She profoundly influenced treatment approaches and provided a new theoretical understanding of eating disorders. Prior to Bruch, anorexia nervosa was generally understood to be some form of conversion hysteria in which the refusal to eat symbolically expressed a repudiation of sexuality (Caparrotta & Ghaffari, 2006; Masserman, 1941).

Based on her extensive work with eating disordered patients, Bruch concluded that the two models of psychoanalytic development that existed in her time, the psychosexual and the object relations models, were not appropriate for treatment of eating disorders (Goodsitt, 1997; Swift, 1991). The psychosexual or drive conflict theorists postulate that pathological symptoms derive from internal conflicts between the id, ego, and superego. They believe interpretations and insight are the cure. Object relations models suggest that symptoms stem from deficiencies and/or distortions of the self and object representations. Similar to the drive conflict model, interpretation of these distorted psychic representations is deemed to be the treatment of choice.

Bruch, in contrast, viewed anorexic symptomatology as a defence against the underlying sense of powerlessness and ineffectiveness associated with major deficits in the developmental process, resulting from a massive failure of the mother to respond appropriately to the child (Bruch, 1973, 1982; Caparrotta & Ghaffari, 2006; Swift, 1991). Her greatest contribution is perhaps the promotion of “fact finding, noninterpretive approach” (Bruch, 1973, p. 336). In this stance, the therapist should listen closely to discern the patient’s story, treat the patient as a true collaborator, and should not act from a superior position.

Bruch's view closely resembles Kohut's self psychology (Bachar, 1998). Other authors also support the use of an empathic stance in treatment for patients with deficits in self-regulation (Goodsitt, 1997; Lichtenberg, 1981). For instance, Goodsitt (1997) argues that the psychotherapy based on intrapsychic conflict works best for neurotic patients with well-structured psyche, whilst patients with deficits in psychic structure (e.g., eating disordered patients) benefit more from regulatory based therapy.

In addition, since the majority of anorexic patients have the experience of being invaded and intruded upon, it is likely that the therapist's interpretations will be taken as imposition. The therapist who gives interpretation from an "experience distant" position is likely to be felt by the patient as an acting recapitulation of early trauma, in which the patient was told how to feel and think (Barth, 1991; Garfinkel, 1985; Miller, 1991; Swift, 1991; Zerbe, 1993).

Using empathy and self psychology based therapy does not mean ignoring interpretation or transference. It simply indicates that interpretation is the secondary process (Goldberg, 1978; Lichtenberg, 1981). That is, rather than interpreting the distorted self and object representations or internal conflicts, the therapeutic experience such as the patient's wish for soothing and mirroring, a reflection of selfobject transference, becomes the material for interpretation. Accordingly, the treatment approach described in this chapter is based largely on self psychology. Beresin, Gordon, and Herzog (1989) encapsulate the treatment process as follow:

Generally, the movement toward health entails forming a therapeutic relationship in which the anorexic can identify and express feeling, experience the empathic, nonjudgmental understanding of another person, separate from a pathological family system, resolve hostile dependent attachment to parents, assuage primitive guilt, and engage in the trials of adolescent psychosexual development to enter adulthood with the beginning of a firm, cohesive sense of self.

Treatment implications for anorexia nervosa

The goal of therapy during the beginning phase is the establishment of a therapeutic alliance (Beresin, Gordon & Herzog, 1989; Goodsitt, 1983). For an anorexic patient, her vehement denial of a need for human selfobject makes it more difficult for her to form a developmental or selfobject transference (Bachar, 1998; Bruch, 1963; Goodsitt, 1969, 1997; Sands, 2003). That is, the transference that the therapist is "experienced as a longed-for other" is absent. The patient tends to remain aloof from the

therapist, and refrains from investing herself in treatment for a long period of time (Swift & Stern, 1982). The lack of therapeutic alliance may worsen because a profound sense of emptiness, resulting from the difficulties introjecting a good maternal object, creates a deadness in the therapeutic interaction (Goodsitt, 1969; Winston, 2009). The selfobject transference is to the food or eating activity, instead of the therapist. The therapist is often left with unsymbolised countertransference of helplessness, physical starvation, and deprivation of any basis of valid identification (Freedman & Lavender, 2002).

In order to develop a therapeutic connection, the disavowal of illness must be addressed, and treatment resistance dealt with immediately (Goodsitt, 1997). Psychoeducation or shallow interpretation regarding the functions of the eating disorders is appropriate. The patient must first understand her selfobject transference to food or the eating process (Barth, 1988, 1991; Sands, 1991, 2003). In other words, the job of the therapist is to successfully redefine anorexia as a problem for the patient (Swift, 1991). The eating pattern, although self-defeating and self-destructive, needs to be considered with respect (Bachar, 1998; Ornstein, 2000). While the anorexic behaviour may be maladaptive to an outside observer, and may indeed cause the individual pain, it is also a highly successful method for protecting a damaged self in a frightening world. The patient must come to understand how her eating pattern is her attempt to restore and maintain her self-cohesion, and that her deepest relational longings have been split off into a separate self state (Barth, 1988, 1991).

The primary transference themes of the anorexic patient revolve around ambivalence regarding attachments and fears of depletion in both the patient's self and other should separation occur. The patient feels the need to rely on the significant other (therapist) psychologically in order to regulate tensions, but when this happens the patient often feels engulfed, without identity, and ineffective. Transferentially, the vertical split in the patient is always accompanied by a similar split in the therapist (Goldberg, 1999; Johnson, 1991a; Sands, 2003). Countertransferentially, the therapist alternately becomes overconcerned and overactive, then oblivious and neglectful, in response to the patient's ominous physical condition. The shift between needing and not needing states is the clue into the patient's experience. The therapist's task is to hold the extremities of the patient's experience, and any tendency to provide solutions quickly and actively should be carefully avoided (Johnson, 1991a).

Initially, the split in the psyche is often evident in the patient's contradictory behaviour through her regular engagement in therapy and the continuation of weight loss (Goodsitt, 1969; Swift, 1991). In addressing this issue, several authors suggest employing a "benign neglect" stance initially if the patient is medically stable, albeit the below average body weight (Goodsitt, 1969; Johnson, 1991a; Swift, 1991). This is because being too forward would be experienced as intrusive by the patient, but being too permissive may also be felt as abandonment. On the other hand, the therapist may need to take more control over the patient's food intake if the patient becomes medically unsafe.

Stern's opposing currents technique may be useful when addressing the patient's oscillating states (Stern, 1991, 1992). In addressing his patient's conflict over her wish to stay in a relationship with her boyfriend, and the threat this poses to her private anorexic rituals, Stern uses his simultaneous countertransference reactions of: a combination of awe and repulsion at what is clearly the patient's capacity to cold-heartedly eliminate someone she loves from her life; and a parental-protective wish for her to stay open to the relationship rather than isolate herself completely. He further states that the reactions induce a strong inclination to "side" with the seemingly healthier part of the patient's two currents, her wish to stay in the relationship. However, instead of yielding to this temptation, he gains a greater appreciation of the patient's conflicting states. On the one hand, her wish to stay in the relationship is motivated by a healthy developmental drive toward heterosexual intimacy. In contrast, the patient's desire to preserve her private anorexic world is an adaptation to unmanageable early deprivations, and currently essential as a selfobject. Stern's intervention is to pose both of the opposing currents back to the patient: "On the one hand you obviously care about Andrew and want to be able to have a relationship with a man. But your feelings of wanting to get rid of him are quite strong and it might be that you have to act on these for now in order to preserve your private space." As a result, the patient seems relieved, as if she had been given a "permission" to leave her boyfriend if that is what she wants to do. In this instance, the intervention works because: (1) it provides a safe holding environment (a safe, secure place, free from threat, wherein habitual maladaptive ways of coping could be held in abeyance and new methods tried out; Winnicott, 1965) ; (2) it makes use of a specific kind of non-transference interpretation that helps the patient integrate dissociated affects and

motivational strivings (i.e., the vertical split), and resolves basic developmental conflicts.

Honouring the defence (disordered eating) also shows the therapist's empathic stance (Barth, 1988; Kohut, 1977). The therapist's attempt to understand the patient's experience from the patient's point of view will lead to the patient's ability for self-empathy (Bachar, 1998). Part of the therapeutic work involves the patient's identification with the therapist's empathic stance. This process leads to the subsequent development of empathy for the patient's own feelings, and needs. Self empathy is necessary before the feelings can be integrated into the individual's overall sense of self (Barth, 1991).

Since faulty attunement results in the patient's lack of symbolisation, there is a developmental arrest in the integration of the body self and the psychological self (Freedman & Lavender, 2002; Sands, 1989, 1991; Sugarman, 1991). There is a split in the patient's psyche, and the patient's deepest needs and affects are sequestered in her body. As the body does not have language, the archaic needs are enacted. In addition, the patient often experiences her body as somehow foreign and almost extraneous to the rest of her self experience. She is strangely indifferent to the needs of her body and to the damage inflicted by the eating disordered behaviours. As a result, the body must also be part of therapy. That is, the body (e.g., "big butt") and the patient's concrete attitude (e.g., obsession with food, weight loss, calorie counting) cannot be ignored. These aspects need to be encouraged because the patient is often cut off from all anxiety, depression, or other feelings about anything else in her life, it is difficult to engage her at this abstract level (Miller, 1991).

Miller (1991) suggests that this may be done by asking the patient to keep a diary of her exact food intake, thoughts and feelings that accompany the eating, and any other activity that may arise. The journal entries then become the focus of therapy sessions, which allows the patient's experience to be vivified (Charles, 2006). The treatment focus is not on the disordered eating, the body, or the "concrete attitude", but on the subjective meaning underneath (Sands, 1991). For example, the patient's "big butt" and imperfect body represent her sense of self as imperfect, and not needing food represents not needing anything from anyone. Focusing on the patient's experience provides the patient with a reparative occurrence of learning her self-worth. In other words, the therapist's empathy and attention to the patient's life conveys the message

that the patient deserves to enjoy the services of a human selfobject, and that the patient deserves to be a self and not just a selfobject for others (Bachar, 1998).

Because faulty attunement results in alexithymia and emptiness, the patient usually does not possess the ability to recognise or express her emotions in words. The therapist can help her by teaching her a new language of feeling states (Charles, 2006; Clinton, 2006; Zerbe, 1993). The aim is to make these inner states more recognisable and communicable. This maybe done by providing psychoeducation about the nature, range, description, and intensity of various feelings via using the feeling wheel (see Appendix B). Empathic attunement provided by the therapist also helps the patient sort out and name all feelings as they occur.

The empathic contact made with the patient and her intricate workings of the eating disordered system allows the patient to begin to transfer her early longing from the eating activity to the therapist, leading to a development of selfobject transference (Bachar, 1998; Barth, 1988, 1991; Bruch, 1970; Sands, 1991, 2003). The role of the therapist is a new selfobject whose chief function is to facilitate the re-emergence of the dissociated true self (Stern, 1992). The patient, in the back and forth communicative process, senses the therapist's helpful and empathic response, risks bringing increasingly vulnerable and painful aspects of the true self into the therapeutic relationship, where arrested developmental processes can safely be reengaged (Banai, Mikulincer & Shaver, 2005; Kohut, 1971, 1977; Winnicott, 1971, 1974; Wolf, 1998). Sands (2003) describes this healing process in the following:

Little by little, over the first year of treatment, Bonnie's emotional longings began to appear. She began to be able to put into words what she had previously only been able to put into her body. She let herself depend on me more as she depended on her eating disorder less. She acknowledged, following my vacation, that she had "missed coming to therapy." She reported "saving things up" to bring to me. At the same time, she began to feel rage at her father's abandoning her to remarry, and along with the rage came feelings of being entitled to get more from him: "I was first," she declared one day, "I should come first in getting things." She spoke, pointedly but still carefully, to her mother about the horrors of her childhood and allowed her mother to apologize to her. During one session, she wondered "what would I be doing if I weren't spending so much time thinking about how terrible my body is?" When I asked her what she thought she would be doing, she replied immediately, "wanting things," then went on to talk excitedly about several jobs she was interested in pursuing.

Treatment implications for bulimia nervosa

Similar to the treatment for anorexia nervosa explained earlier, the initial phase of treatment for bulimia nervosa involves building a therapeutic alliance, since without this, the patient will be gone before treatment starts (Goodsitt, 1997). Secondly, it is also important for the therapist to adopt the empathic, non-judgemental, non-interpretative stance until the selfobject transference with the therapist is established (Barth, 1988, 1991; Sands, 1991, 2003). The importance of viewing the bulimic symptoms as an adaptive effort to organise the self and/or maintain self cohesion is also paramount as emphasised by Barth (1988):

Only if the therapist can accept that the patient must resist in order to protect the integrity of a fragile and vulnerable self can the patient eventually enter into the therapeutic alliance and make use of the therapist as a selfobject...Patricia could not ally herself with me enough to explore her feelings with me until she repeatedly experienced my noncritical acceptance of her need to withdraw from me.

Sands (1991) proposes that because the archaic selfobject needs of the bulimic patient have been split off, it is experienced subjectively as a “bulimic self” (p. 37). According to Sands, it is important to use an empathic stance to approach the patient’s bulimic self. She, like Barth (1988, 1991), emphasises the therapist’s empathic stance as the key intervention in treatment:

The crucial turning point in case after case has come when the patient realized that I could empathize with even appreciate her bulimic self...a patient will invariably present her bulimic self in the worst possible light to see whether the therapist will reject it as other important figures have denied her true needs and feelings. (p. 43)

In addition to using the empathic stance, it is important to determine: exact definitions of the symptoms; behaviours; experience related with the disordered eating; eating habits; the patient’s acceptance or rejection of certain parts of her body; and the effects a loss or gain in weight have on her body image and self-esteem (Fairburn, 1997; Reich & Cierpka, 1998). When this information is gathered, the next and more important step is establishing the affective conditions and conflicts associated with the bulimic symptoms (Barth, 1988) This process is essential not only because it includes the body into treatment, but the bulimic patient often experiences alexithymia and emotional dysregulation resulting in her inability to recognise any triggers for the bulimic symptoms (Berthoz, Perdereau, Godart, Corcos & Haviland, 2007; Gilboa-Schechtman, Avnon, Zubery & Jeczmierny, 2006). Working on differentiation of

perception supports the observational ego and the working alliance, as it requires the patient's participation (Reich & Cierpka, 1998).

Similar to the treatment of anorexia nervosa, Herzog, Franko, and Brothman (1989) and Reich and Cierpka (1998) draw attention to the use of food diaries in treatment of bulimia nervosa. The patient is asked to record the events, thoughts, and feelings that occur before and after an episode of bingeing and purging. The entries are then discussed and the diaries returned to the patient weekly. The authors state that the use of food diaries is beneficial in several ways. First, food diaries serve as transitional objects offering the patient some control when the therapist is not available. Second, the diaries gradually direct the patient's ego attitude toward affects, increasing self-awareness, and setting the stage for further exploration of psychodynamic issues. Third, they encourage working alliance and the patient's active participation. Herzog, Franko, and Brothman (1989) found that of the eight cognitive-behavioural groups they conducted, the lowest dropout rate occurred in the group in which food diaries were commented on and returned to the patients each week.

Initially, it may be necessary to approach the self-destructive behaviour (self-starvation, and bingeing and purging) from a behavioural and cognitive level as the patient is unable to engage in the deeper psychological state (Johnson, 1991a; Reich & Cierpka, 1998). It may also be useful for both the anorexic and bulimic patients to learn symptom management techniques such as stress management, relaxation, and mindfulness to reduce their dependence on the disordered eating (Barth, 1988; Bays, 2009; Dennis & Sansone, 1991; Proulx, 2008). This in no way means the therapist should abandon the empathic stance. The therapeutic work may begin on the surface, and then continue into the deeper level as illustrated by Goodsitt (1997):

We identified a pattern: Bingeing and purging occurred when Ellen ignored a self-state of tiredness or a longing to drop her responsibilities, curl up in bed, and read a book. She had a guilt-ridden fantasy of spending money on a tan at a tanning spa. She revealed to me that the secretive bingeing and purging were the only activities for which she allowed herself time and space in her busy day. I affirmed the importance of identifying her self's needs and tending to them, and the heavy price she paid for ignoring these needs. It was her birthright to have a self. Tending to her self's needs was as vital as providing food and water for her body. As long as she ignored or negated herself, she would need to be bulimic. We explored here longings, fantasies, wishes, and needs as legitimate expressions of her self. Thus the focus was not just on what had gone wrong in the past, but also on identifying her unfulfilled longings and on providing validating understanding and affirming legitimization of her selfobject needs.

Clearly, it was healing and integrating for Ellen to reveal to me the worst aspects of herself or her most secret desires and to find I was still on her side. (p. 216)

Transferentially, the primary themes with the bulimic patient revolve around attachment issues (Johnson, 1991a). The patient is very cautious about involvement resulting from the premature separation in response to the under-involvement care-giving environment. The conflict is around wish for love and care, and fear of losing the self in order to get the needed love and care, and overwhelming others (Reich & Cierpka, 1998). In line with the treatment of the anorexic patient, the therapist's task here is to create a holding environment that allows the patient to initially experience a regressive dependency that evolves into mature interdependency.

From a self psychology perspective, the process of empathic rapture and healing leads to transmuting internalisation and change (Kohut, 1971, 1977, 1984). Hence, it is crucial that the therapist does not willingly accept the role of the ideal "good" mother who attempts to be all giving and all good (Charles, 2006; Zerbe, 1993). Not only is this stance unrealistic, it may never be believed as it has not been the internal experience of the patient. In other words, whilst the patient must feel the therapist's empathy, she must also know that the therapist is fallible. This may simply mean saying "I am not perfect and can't tell you what to do", whilst being aware of not rescuing the patient but encouraging her to choose her own way.

However, it is only after empathic failures that healing occurs (Barth, 1988; Kohut, 1984). The patient will frequently test the therapist via the disordered eating pattern and several forms of acting out behaviours, and the therapist is likely to fail the test by, for instance, making interpretation based on the therapist's (countertransferential) wish to change the patient (Zerbe, 1993) as explained by Barth (1988):

When things began to deteriorate between herself and this man, I made a comment in an attempt to help her maintain the relationship. I realized later that this was out of my countertransferential need, not out of response to her needs. I was concerned that she was about to sabotage the best relationship she had ever been in, and I was eager to make an interpretation which would keep her from repeating destructive patterns of relating to men. As a result of the work we did following the empathic rapture which my remark caused, Patricia and I understood that my implicit expectations of changing her (not uncommon for therapists) paradoxically interfered with her ability to change. It was not my attempt to change her which would, in the end, help Patricia to grow, but instead my acceptance of who she was and my recognition of why she was that way which would foster her development.

As empathic failures and reparative experiences occur, transmuting internalisation takes place. The patient's archaic selfobject needs are transformed into more mature selfobject relatedness, as manifested in a cohesive self that is capable of maintaining self-esteem, resulting in the patient's less dependence on the disordered eating as a way to preserve wholeness and autonomy (Banai, Mikulincer & Shaver, 2005; Barth, 1988; Kohut, 1984).

To conclude, treatment of patients with eating disorders is often difficult and painstakingly long due to the factors explored in the last two chapters, but most importantly the patient's denial for human selfobject including the therapist. Hilde Bruch, a seminal contributor to the practice of psychotherapy with anorexic and bulimic patients, proposed a nonjudgmental, non-interpretive psychotherapeutic stance, similar to a self psychology's use of empathy. Several authors support Bruch's viewpoint for many reasons. First, the eating disordered patients are unable to make use of interpretations because of alexithymia and the lack of self-awareness. Second, interpretation provided by the therapist from a superior position is likely to reinforce the patients' past experience of being invaded and/or neglected. Last, interpretation from an "experience distant" position does not foster therapeutic alliance.

In addition to using the empathic stance, the patient's symptoms, including food use and the body, must be taken into consideration. Cognitive and behavioural techniques such as using diaries and mindfulness are appropriate methods in order to promote the patient's involvement in the therapeutic process, increasing both her self-awareness and collaboration. Transference and countertransference are interpreted in the secondary process, in order for the patient's selfobject transference to be understood and moved from food to the therapist. Finally, within the safe and secure place therapy provides, the patient is able to examine her maladaptive behaviours and try out new ways of living, enabling her to make positive changes in the wider world.

Chapter 6: Discussion and conclusion

Discussion

Very little has been written specifically about why food is chosen and the roles of food in eating disorders, which may reflect an underestimation of the significance of food, especially its symbolic associations, in the aetiology and treatment of this group of illnesses. Without an awareness of the representation of food for these clients, however, it becomes difficult for anyone, let alone the clinicians, to be empathic with the eating disordered clients. This may be mainly because of the destructive nature of the illnesses and the seemingly simple solution—normal eating.

The findings from this dissertation support the hypothesis that there is a connection between disturbances in the early relationship with the caregiver and distortions in eating pattern.

Based on the literature reviewed for this study, the research question, why food?, seems to remain inadequately answered. The only explanation appears to lie in the patient's inability to symbolise. That is, not being adequately cared for means the patient has not learned to operate in an abstract level. Symbolic equation remains, and for her, mother and food are the same. Further research to explore this area may shed more light on why food is chosen.

This dissertation concludes with an explanation that fits well with the self psychology model. Unlike other theories, self psychology seems to provide a more comprehensive explanation. Not only does it describe the link between deficits in the early relationship and disordered eating, it also explains the patient's continuous dependence on food use (to maintain self cohesion).

Self psychology proposes that deficits in the early relationship result in many developmental arrests, leading to an archaic self structure. Food, because of its symbolic associations with the mother, is used to provide the selfobject functions required to maintain self cohesion, e.g., self soothing, and self regulation.

In addition, self psychology has developed a method of working with the deficits of the self. It argues that recovery from these illnesses will only occur when self cohesion is achieved without the use of food. It places an emphasis on the empathic stance, which enables the therapist to "be" with the client so that the client's selfobject needs can be transferred from food and its use to the therapist. The attachment to the

therapist, in turn, fosters the development of a cohesive self through transmuting internalisation, eventually reducing the client's dependence on food. Therefore, the findings from this study suggest that a treatment approach based on self psychology should be considered. A self psychology based treatment approach, rather than distant interpretation, appears to be more appropriate for illnesses with aetiology relating to trauma or deficits including eating disorders.

Although treatment of eating disordered patients based on self psychology has been described as effective, more empirical evidence is required to provide support of its usefulness. Thus, my recommendation is that further outcome studies of self psychology based treatment are required.

Clearly, this necessarily limited exploration into food and its connections with anorexia nervosa and bulimia nervosa has neglected areas of the literature that warrants further research. As mentioned briefly in chapter 4, further investigation into gender differences in the development of eating disorders is needed. Whilst there are indications that gender differences and social roles may play major parts in the aetiology of eating disorders (e.g., Lawrence, 2002; Sands, 2003; Steiner-Adair, 1986), integration between these factors and the roles of food described in this dissertation may provide a more effective treatment approach for eating disordered patients.

This study is also limited by the inclusion of only literature written in English. Research studies written in other languages would be useful in a larger research project. The research included in this dissertation was restricted to anorexia nervosa and bulimia nervosa. The functions of food may be different in other types of eating disorders such as binge eating disorder, and obesity. Treatment implications may also be different as a result.

In terms of subjects for future research, it may be useful to explore the functions of food in cultures different from those in the western world. Since eating disorders are less common in these cultures, the functions and meanings of food may vary (Katzman & Lee, 1997; Ma, 2007; Viernes et al., 2007). For instance, as suggested in the introduction, food is closely tied with health and happiness in the Chinese culture, thus, having a slightly overweight child is preferable whilst a slim child may indicate poor parenting (Ma, 2007). Obtaining further understanding of how these meanings may play a part in the development of eating disorders can have positive treatment implications.

Moreover, examining the role of the father in the developmental process would be valuable. The mother is generally considered to be the main caregiver and the

primary source from which developmental arrests arise. However, research evidence clearly indicates the father's place in the development of his daughter's eating disorder, and deeper understanding of his role may be of benefit (Benninghoven, Tetsch, Kunzendorf & Jantschek, 2007; Jones, Leung & Harris, 2006; Mountford, Corstorphine, Tomlinson & Waller, 2007).

Conclusion

Literature reviewed in this dissertation suggests that eating disorders are a consequence of major failures in the early developmental process. Eating disorders and the roles of food are described from three major psychoanalytic theories namely: psychoanalytic or drive conflict theory; object relations theories; and self psychology theory.

Within the drive conflict model, eating disordered symptomatology is viewed as a conflict around sexuality, especially pregnancy wishes and fears. From the object relations theories standpoint and self psychology perspective, eating disorders are a result of major failures in the early developmental process. Inadequate mirroring, faulty attunement, and lack of empathy in the care-giving environment give rise to many development arrests, most importantly, the inability to maintain self cohesion.

Given the significance of its symbolic meaning, food is used to provide the essential selfobject functions in the maintenance of self cohesion. The therapist's job is to help the patient transfer her selfobject needs from food to a more appropriate selfobject, the therapist. Only when this happens, can the patient let go of her eating disorder.

This dissertation has deepened my understanding of eating disordered clients, and given me insight into their world. It has dramatically transformed my practice, my comprehension of my clients, and my countertransference. Greater understanding and awareness has meant that as a therapist, I am now able to feel more empathic towards my clients with eating disordered rather than harbouring a continual feeling of frustration at what seemed to be infinitesimally slow progress. In addition, this dissertation has increased my passion for working with this client group. It is my hope that this study will be beneficial in helping clinicians working with eating disordered clients to develop a more effective therapeutic practice.

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Appendix A: Diagnostic criteria for anorexia nervosa and bulimia nervosa

Diagnostic criteria for 307.1 Anorexia Nervosa

- A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less 85% of that expected).
- B. Intense fear of gaining weight or becoming fat, even though underweight.
- C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
- D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstruation cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

Specific type

Restricting Type: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

Binge-Eating/ Purging Type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

(American Psychiatric Association, 2000, p. 589)

Diagnostic criteria for 307.51 Bulimia Nervosa

- A. Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
 - (1) eating, in a discrete period of time (e.g., within any 2 hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
 - (2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)
- B. Recurrent in appropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
- C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for 3 months.
- D. Self-evaluation is unduly influenced by body shape and weight.
- E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

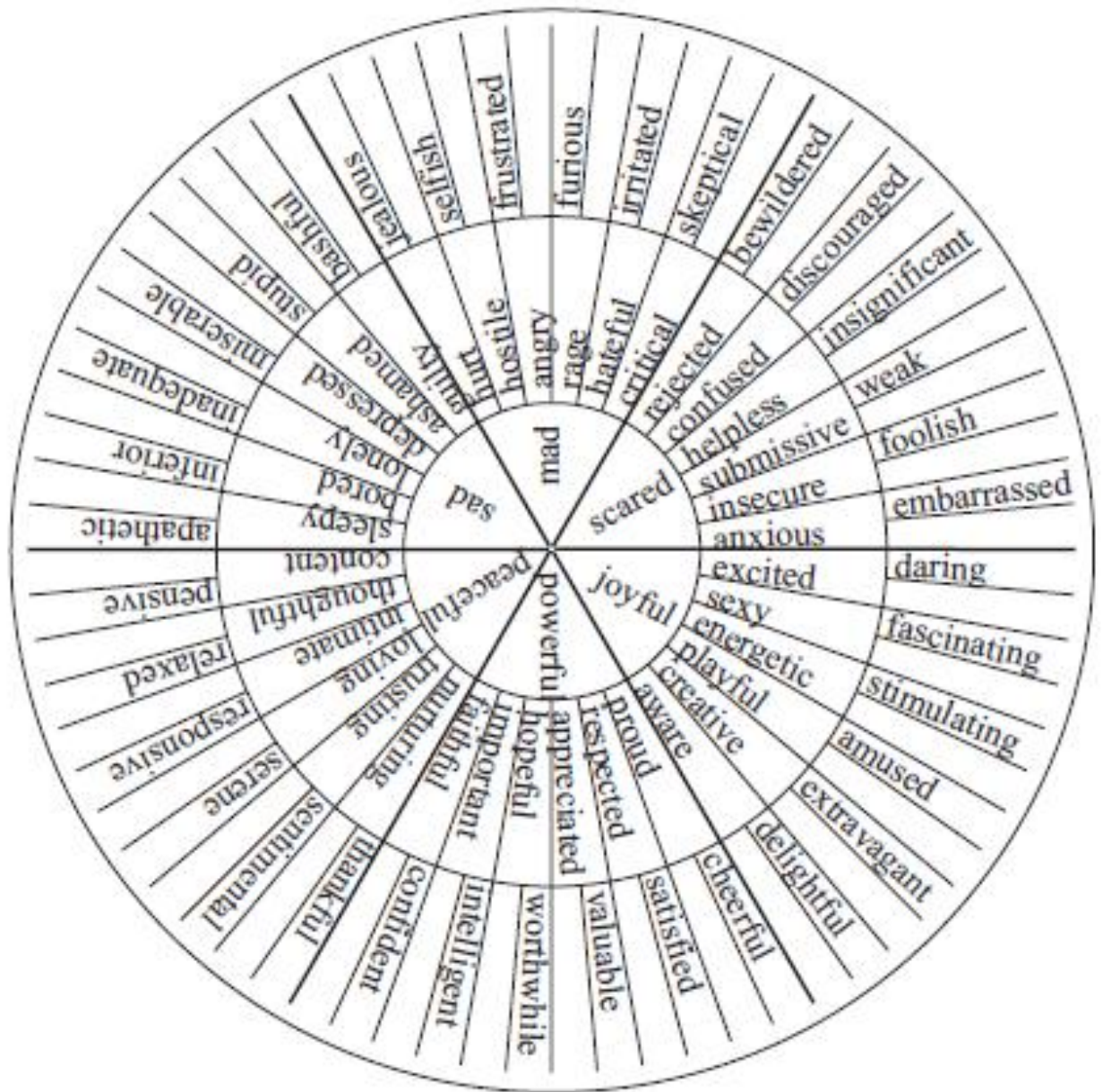
Specific type:

Purging Type: during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas

Nonpurging Type: during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviours, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas

(American Psychiatric Association, 2000, p. 594)

Appendix B: The feeling wheel



(Willcox, 1982)