PSYCHOANALYTIC TREATMENT OF EATING DISORDERS

Tom Wooldridge, PsyD, ABPP, CEDS-S
Associate Professor, Golden Gate University
Faculty, Psychoanalytic Institute of Northern California
Assistant Clinical Professor, University of California, San Francisco

Agenda…

- What is psychoanalysis?
- Psychoanalytic view of change and symptoms
- Psychoanalytic diagnosis and case formulation
- Treatment teams
- Key psychoanalytic ideas (1,2,3…)
- Q&A

What is psychoanalysis?

- Psychoanalysis is…
  - *a **type of treatment***
  - *a **body of knowledge***
    - obtained from **clinical investigation** and **empirical research** that emphasizes developmental theory and a family of ideas that include personality, intersubjectivity, conflict and defense, repression and dissociation, projection and projective identification, etc.
  - *an **ethos***
    - “The psychoanalytic sensibility involves curiosity and awe, respect for complexity, disciplined empathy, the valuing of subjectivity and affect, appreciation of attachment, and a deep faith in devoted therapeutic collaboration. Although none of us can stand fully outside our own culture, psychoanalytic subcultures have functioned as a kind of alternative sensibility to the consumeristic, technocratic, mobile mass culture that surrounds us in this era of dizzying change” (McWilliams, 2020, p. 99).

McWilliams, N. (2020). The future of psychoanalysis: Preserving Jeremy Safran’s integrative vision. *Psychoanalytic Psychology*, *37*(2), 98.

Psychoanalytic view of change

"The patient is … struggling … against the loss of his world, of the whole range of action and objects that he so laboriously fashioned during his early training. He is fighting, in sum, against the subversion of himself in the only world that he knows. Each object is as much a part of him as is the built-in behavior pattern for transacting with the object. Each action is as much within his nature as the feeling he derives from initiating or contemplating that action. Each rule for behavior is as much part of him as his metabolism, the forward momentum of his life processes … the rules, objects, and self-feeling are fused — taken together they constitute one's 'world'. How is one to relinquish his world unless he first gains a new one? This is the basic problem of personality change" (Becker, 1964, p. 170 — 179).

Becker, E. (1964). The Revolution in Psychiatry: The New Understanding of Man. New York: Free Press.

Psychoanalytic view of symptoms

"To my mind, symptom formation is a means by which patients put on hold the problem of growing up, of coming more fully into being. Individuals for whom symptoms serve this function – which includes all of us to different degrees – are at a loss regarding what it means to take the next steps in growing up, for they have had insufficient experience with a caretaking person engaged with them in ways of being that are more evolved than their own. From this perspective, patients hold firmly to their symptoms, their closed loops of thinking and behaving, because they do not know what else to do" (Ogden, 2020, p. 16).

Ogden, T. H. (2020) Notes on Being and Becoming. Fort Da 26:13-20

Eating disorders - diagnosis

- **Descriptive** diagnoses as opposed to a **structural or psychodynamic** diagnoses
- Patients with the same ED diagnosis do not necessarily share the same underlying psychodynamic structure.
  - *Example: An empirical study used the Shedler-Westen Assessment Protocol (SWAP-200) to assess the personality structure of patients with anorexia nervosa and bulimia nervosa. Three categories of patients emerged: a high-functioning/perfectionistic group, a constricted/overcontrolled group, and an emotionally dysregulated/undercontrolled group.*
  - *As this study suggests, reliance on descriptive diagnosis groups together anorexic patients who are high-functioning and self-critical with those who are highly disturbed, constricted, and avoidant, while also grouping together bulimic patients who are high functioning and self-critical with those who are highly disturbed, impulsive, and emotionally dysregulated (Westen & Hamden-Fischer, 2001).*

Westen, D., & Harnden-Fischer, J. (2001). Personality profiles in eating disorders: rethinking the distinction between axis I and axis II. *American Journal of Psychiatry*, *158*(4), 547-562

Psychoanalytic case formulation

- **Case formulation.** Developed throughout the treatment.
  - Clinicians often focus on intervention before developing an adequate case formulation; this stems from the therapist's anxiety about "being with" the emotional difficulties of the patient and a rush toward symptom resolution.
  - In many cases, this is also mirrored by others in the patient's environment, including other members of the treatment team and the patient's family.
  - An essential task is the therapist's capacity to "be with" the patient's pain and to understand it from the "inside out" *before and while* intervening.

Psychoanalytic case formulation

- **Case formulation.** Developed throughout the treatment.
  - Case formulation suggests how can we form a relationship with this person that will forward their development.
  - Depending on the treatment context (i.e., long-term outpatient psychotherapy, partial hospitalization, inpatient, etc.) that relationship will take different forms.
  - There is plenty of room for multiple forms of intervention, including third-wave treatments (CBT, DBT, etc.), family therapy and FBT, psychopharmacology, nutritional counseling, etc. **It is essential that the therapist establish a treatment team.** We will discuss the idea of treatment teams shortly.

Theoretical influences

- **Object relations theory** is concerned with how the patient's early relational experiences have been internalized as psychological structure that continues to organize and give meaning to her experiences in the present.
- **Relational psychoanalysis** builds upon diverse, inherited theoretical ideas, including object relations, and ideas about gender, culture, the therapist's subjectivity, and trauma/dissociation.
  - **The self-state paradigm** suggests that even in health, the self is dissociatively structured by relational trauma, with different self-states more-or-less cordoned off from other self-states.

Treatment teams

- Psychoanalytic psychotherapists may be an important member of the treatment team because there is a strong pull toward symptom-focused treatment, which risks neglecting the patient's underlying emotional pain and how this manifests across numerous dimensions of the patient's personality and functioning in the world.
- Patients with eating disorders often rely on dissociation, cordoning off parts of the self that come to reside in disconnected mind and body states.
- In a similar way, Novack (2021) points out, different dissociative self-states may emerge within different therapeutic dyads across the treatment team. The psychoanalytic psychotherapist may play an important role in helping the patient to access, engage, and link dissociated self-states as they emerge in this way.

Novack, D. (2021). "It Takes a Village": Concurrent Eating Disorder Treatment and the Multiperson Field. *Psychoanalytic Dialogues*, *31*(2), 181-196.

Idea #1: Symbolic function

- Symbolic function refers to the capacity to connect bodily excitations (i.e., emotions) with representations of those emotions (i.e., images and words).
- The four registers of emotion are **somatic, motoric, imaginal, and verbal.**
- In the **somatic register**, emotion is expressed viscerally through internal bodily sensations.
  - *In an infant, emotion is first experienced as bodily excitation (e.g., pain, tension, or nausea).*
  - *The body remains our emotional backdrop, the place in which experience we cannot know with our minds continues to make its mark.*
- The **motoric register** refers to the behavior and action of the muscular body, including positive and negative manifestations (i.e., twitches and pacing and but also silences, stillness).
  - *The infant squirms, wiggles, cries, and smiles — all enactments of a felt somatic state.*

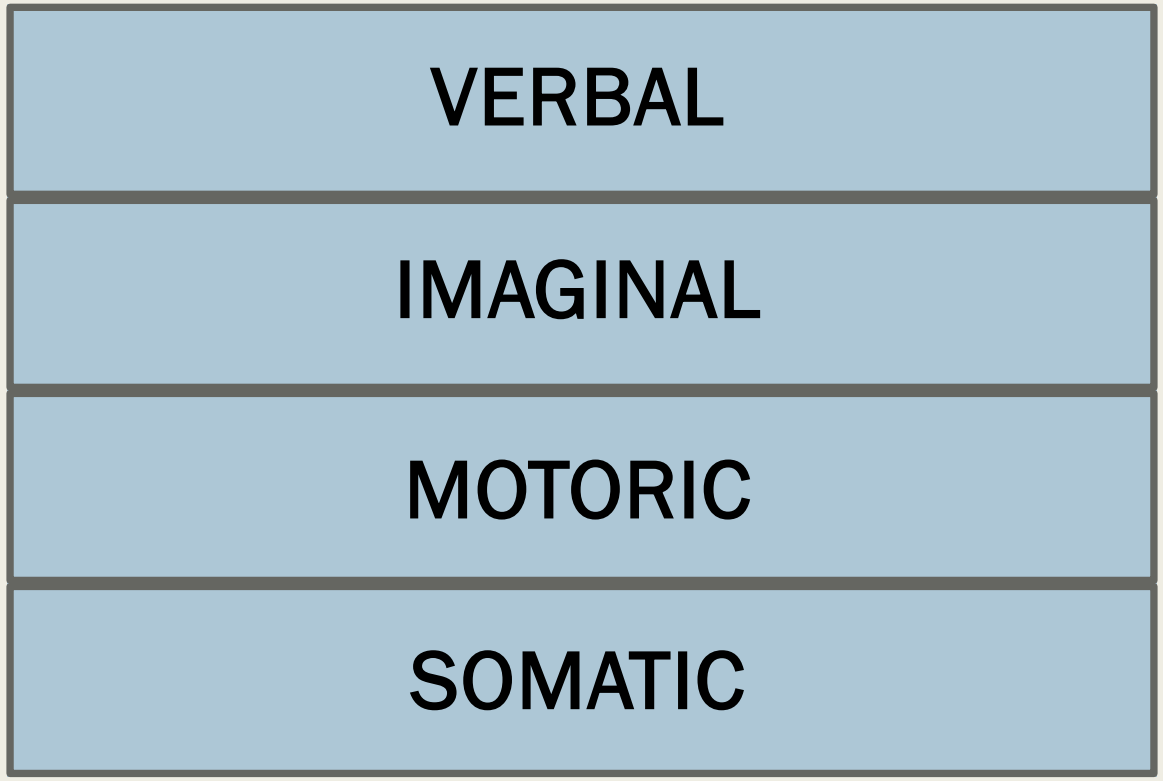
Lecours S, Bouchard M-A (1997). Dimensions of mentalisation: Outlining levels of psychic transformation. *Int. J. Psycho-Anal.* 78:855-75. [⟶]

Idea #1: Symbolic function

- The **imaginal** involves mental imagery: mental pictures and scenes as representations of underlying bodily states.
  - *Images expressed in dreams, fantasies, and metaphors.*
  - *It is the first register that moves from experience of a thing-in-itself to a representation of that thing.*
- The **verbal** involves the manifestation of emotion in language, in words and stories, explanations and insights.
  - *Allows us to link past and present, to hold up an experience and to examine it from different angles, to put our emotions "on pause," and to bridge, even if only partially, the gaps that separate us as individuals (Quatman, 2015).*

Quatman, T. (2015). Essential psychodynamic psychotherapy: An acquired art. New York: Routledge.

Idea #1: Symbolic function



Idea #1: Symbolic function

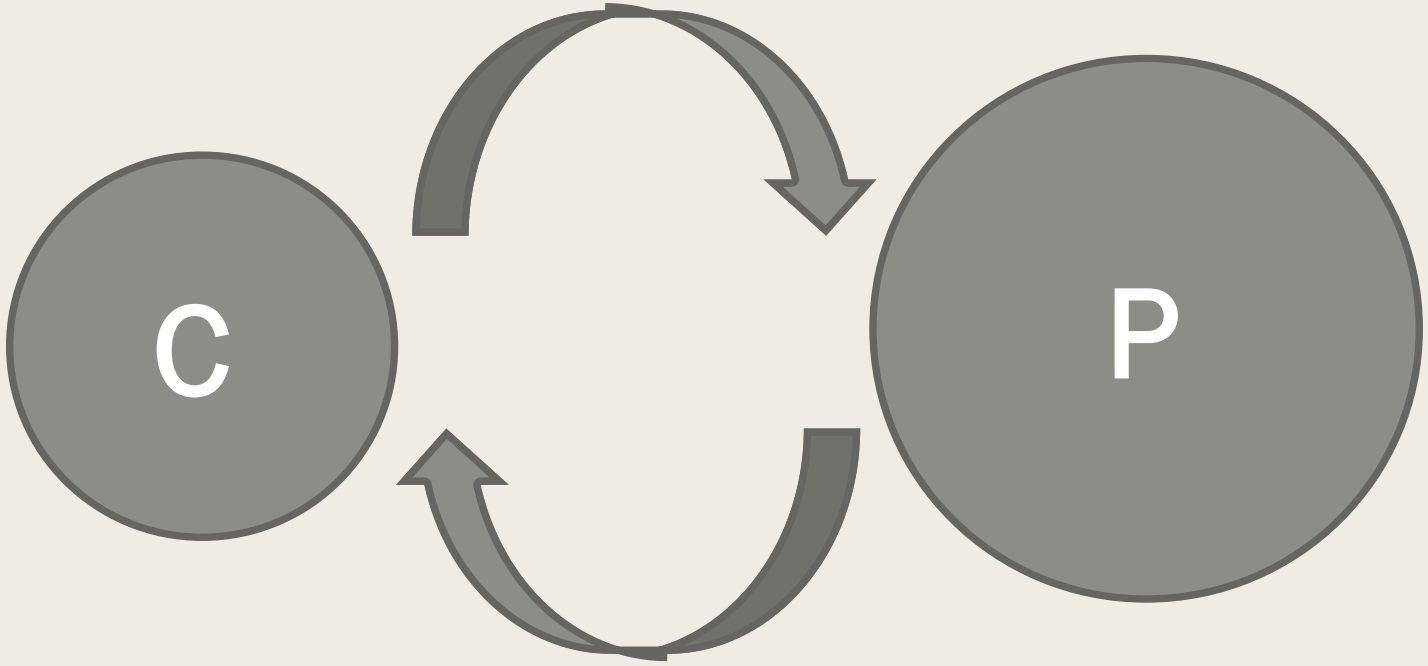
- **Alexithymia** comes from the Greek (a = lack, lexis = word, thymus = emotion) and refers to a cluster of features including difficulty identifying and describing subjective feelings, a circumscribed fantasy life, and an externally oriented thinking style
- In a range of populations, including post-traumatic states (Krystal, 1968), drug dependence (Krystal & Raskin, 1970), eating disorders (Bruch, 1971, 1973, 1978), and panic disorder (Nemiah, 1984).
  - *Emotion that cannot be put into words and images may generate bodily symptoms secondary to unregulated activation of bodily systems (Taylor & Bagby, 2013).*

Idea #1: Symbolic function

- Empirical research has established that alexithymia co-occurs with eating disorders of all subtypes (Westwood et al., 2017) and with symptomatology that does not rise to the level of an eating disorder diagnosis (e.g., Ridout et al., 2010; De Berardis et al., 2007).
- Whereas some studies have reported no significant differences in alexithymia across eating disorder diagnoses, others have suggested individuals with anorexia nervosa experience higher levels (Nowakowski, McFarlane, & Cassin, 2013).
- Alexithymia appears to **decrease significantly post-treatment** with all eating disorders (ibid).

Idea #2: Reverie and containment

- How does a child develop symbolic function?
  - *Within the context of a container-contained relationship (Bion)*
  - *We need the mind of an other (i.e., their reverie) to give meaning to our emotional experience (first experienced as bodily sensation) and to eventually develop the (always limited) capacity to do this on our own*



Idea #3: Object relations

- **Object relations theory:** how early relational experiences have been **internalized as psychological structure** that continues to organize and give meaning to her experiences in the present.
- It is the underlying psychological structure – not just the eating disorder symptoms that manifest from it – that are the focus
- The eating disorder is constituted by dynamics that are woven throughout the patient's personality.
- **Traumatic themes** allows us to think about patterns of early relational experience that have shaped psychological structure.
  - *Traumatic themes are chronic patterns of frustrating and depriving childhood experience at the hands of caretakers.*

Traumatic Theme #1: Object Hunger

- Early disappointment in the object(s) derails the development of an internalized representation — a key component of psychological structure.
  - *Because the child experiences recurrent, disappointed need for connection with an important other, he is unable to internalize that other and to provide, to some degree, for himself what that other might have provided for him.*
- The term *object hunger* has been widely used in the literature (Blos, 1967; Kohut, 1968; Ritvo, 1971; Chessick, 1985; Boris, 1984; Yarock, 1993).
- Object hunger is a **desperately felt need** for contact with another person who can serve as a substitute for missing segments of one's own psychic structure. This other is loved **not** as separate, whole person but, rather, is **fervently needed** to make up for what is missing internally.
- This yearning often has a desperate quality that may be conscious or, in contrast, vehemently defended against.

Traumatic Theme #1: Object Hunger

- **Anorexia nervosa**: Many years of clinical reports, in addition to more recent empirical investigations, indicate a disturbed relationship with the mother, a distant and uninvolved relationship with the father, and a distorted sense of self.
  - *In one empirical study, patients were found to experience disrupted maternal relationships, to have a defensively overdeveloped, yet highly self-critical, sense of self, and to struggle with intense but well-defended feelings of neediness.*
  - *Behind the rejection of food and nurturance lies a powerful longing for the care and attention of the mother — in other words, object hunger (Bers et al., 2013).*
- A central task is not only to address the self-destructive symptom of self-starvation but also the dependency needs **defended against** by a refusal to accept nurturance.
- We might hypothesize that patients with **bulimia nervosa** deny their dependency through food restriction but that this denial breaks down in a “rush of object hunger” (Yarock, 1993, p. 9). Within moments, disgust and guilt lead to an undoing of that object hunger, manifest as subsequent vomiting.

Traumatic Theme #1: Object Hunger

- Eating disorders commonly manifest in adolescence.
- Adolescence is a period in which object hunger is exacerbated.
  - *Adolescence is a second individuation process (Blos, 1967): a phase in which the processes of separation-individuation are expanded.*
  - *Whereas toddlers in separation-individuation gain emotional supplies from reunion with mother, adolescents seek supplies from peers, including through the expression of their emerging sexuality.*
  - *Adolescents are notable for seeking out experiences of heightened affect, whether of excitement and elation or pain and anguish*
  - *These may be manifestations of object hunger, intensified because of the concurrent lessening of parental ties as they establish a greater sense of autonomy and personal identity.*

Traumatic Theme #1: Object Hunger

- With genital sexuality gaining prominence, adolescents are confronted with dependence upon external objects for gratification of these needs (Ritvo, 1971).
- There is a large body of literature examining the relationship between sexuality and eating disorders (Wiederman, 1996).
  - *Anorexic symptoms are associated with decreased sexual activity and bulimic symptoms with increased sexual activity (Eddy et al., 2004). The anorexic is defended against her object hunger whereas the bulimic's defenses against that hunger break down, both in purges and in increased sexual expression.*
  - *The relationship of each to their sexuality, a genital manifestation of object hunger, follows the same pattern as their eating disturbances.*
- The exacerbation of object hunger and the emergence of new modes of its expression places great demand on these patients and may contribute, at least in part, to the emergence of disordered eating in adolescence.

Traumatic Theme #2: Breakdowns in Containment

- Disruptions between children and their parents can take different forms.
  - *Attachment theory provides one perspective: how does the child make use of the caregiver as a secure base and safe haven?*
  - *Bion's theory of containment provides another, complementary lens.*
- A child needs a caregiver who can receive a child's communications of emotions that, due to her relative lack of emotional development, cannot be represented by the child in images or words and thought about alone (Bion, 1962).
  - *Remember, reverie facilitates the development of symbolic function.*
- Without the caregiver's assistance, the child cannot "make sense" of what she is feeling. When all goes well, the caregiver receives these communications, attempts to make sense of them, and communicates this understanding back to the child, perhaps in words but just as often through her way of behaving with him.

Traumatic Theme #2: Breakdowns in Containment

- This process can break down in several ways.
  - *The child experiences the parent as impermeable: unable or unwilling to communicate and to help the child to make sense of experience. This leads to what Bion called **nameless dread**.*
- Williams (1997) describes another : when parents need to divest themselves of their own pain, which cannot not be managed within their own minds, and use the child as a **receptacle** for it.
  - *The child experiences this as a type of **foreign body** inserted into her mind, which serves as a receptacle.*

Traumatic Theme #2: Breakdowns in Containment

- For patients with anorexia nervosa, this form of breakdown may lead to the development of a **no-entry system of defense, which is a rejection of input both at the concrete level of food but also at the emotional level.**
  - *Lawrence (2001): the mother is experienced as dangerously intrusive and is concretely equated with food.*
  - *Zerbe (1993): the refusal of food is "an autonomous statement, par excellence: 'I don't need you. I don't need anything. I don't even need food to survive. I am totally independent'" (p. 95).*
  - *The patient cannot think about how food is experienced like the mother; rather, it feels that the food is intrusive because it* ***is*** *the mother.*

- Patients with anorexia tend to form transferences shaped by the fear of intrusion, leading them to avoidantly approach the analytic relationship.
- Clinicians report feeling relationally deprived by the anorexic patient, in the same way that the patient deprives herself.

Traumatic Theme #2: Breakdowns in Containment

- Williams' description of her patient with bulimia nervosa, Daniel, as follows:

"Describing his bulimia, Daniel conveyed a vivid perception of being full of inimical foreign bodies. When I started seeing him he was bingeing and vomiting up to six times a day. He was tormented by concrete bodily feelings, of being 'all dirty inside'. Blocked sinuses and nose contributed to his perception. He said he felt 'greasy', 'full of soot', 'disgusting'. Vomiting gave him very temporary relief.

He binged on anything he could find or buy with his limited pocket money allowance. He bought mostly loaves of white bread which, he said, was 'like blotting paper'. It soaked up 'all the nasties' that could then be got rid of by vomiting. After being sick, he felt temporarily 'clean inside'. His mind became clear and for a few hours he could apply himself to his studies. Then 'the buzz', as he called it, would start again. When 'the buzz' started, Daniel was unable to concentrate. … He described 'the buzz' as 'thoughts racing through his mind at 150 miles per hour'. It became clear that they were not thoughts he could think or talk about, but something more akin to flying debris." (p. 930)."

- Daniel's felt himself to be 'all dirty inside,' a concrete experience of having been the receptacle for his mother's anxiety. This led him to expel, through vomiting, those toxic foreign bodies — soaked up by the 'blotting paper' of white bread — which left him, temporarily, feeling 'clean inside.' Before long, however, the cycle starts again.

Idea #3: Self-States and Dissociation

- Some contemporary thinkers regard in the relational school regard the self not as a supraordinate and comprehensive structure, stable and consistent over time, but as decentralized and composed of relatively discrete psychic structures — “selves” — that, in a good enough developmental situation, attain an “illusion” of coherence and continuity (Bromberg, 1998).
- Each self-state comprises ways of thinking, feeling, and acting — different ways of being in different contexts. In a sense, each self-state is its own personality system, an assemblage of affective and cognitive processes that make up “versions” of us (Hill, 2015).
- In optimal development, the self-state system is integrated. Various self-states are compatible with one another and we shift fluidly between them, retaining a feeling of relative coherence and unity among different versions of ourselves (Hill, 2015).

Idea #3: Self-States and Dissociation

- **Relational trauma***:* exposure to chronic misattunement and prolonged states of dysregulation in the context of the early attachment relationship.
  - *This leads to self-states becoming more or less dissociated and are activated involuntarily and automatically.*
- In contrast to the “complex” or “developmental” trauma described by Herman (1997) and van der Kolk (2005), which focuses on sexual, physical, and verbal abuse and neglect within the attachment relationship, relational trauma points to less obvious, and often invisible, trauma within the attachment relationship.
- In the face of relational trauma, self-states may become more or less dissociated and, given the resulting impaired capacity for affect regulation, dissociation likely becomes a chronic pattern of defense.
- Hill (2015) proposes that dissociated self-states share three characteristics: automaticity, compartmentalization, and altered states of consciousness.

Idea #3: Self-States and Dissociation

- Empirical evidence that dissociation is prominent in patients with eating disorders.
- Association between binge eating disorder and childhood maltreatment (Amianto et al., 2018; Imperatori et al., 2016; Allison et al., 2007; Grilo & Masheb, 2001).
  - *#1 -- 83% of BED patients reported some form of childhood maltreatment, with 59% reporting emotional abuse, 36% physical abuse, and 30% sexual abuse, 69% emotional neglect, and 49% physical neglect. Emotional abuse was significantly associated with greater body dissatisfaction, higher depression, and lower self-esteem in both men and women (Grilo & Masheb, 2001).*
- There is also evidence of dissociation in other eating disorders.
  - *Subliminal threat cues increased state dissociation (particularly levels of derealization) in bulimic women but had no effect on the nonclinical group, supporting the idea that bulimic women are more vulnerable to dissociation in response to specific threats (i.e.., state dissociation) (Hallings-Pott et al., 2005).*
  - *#3 – Difficulties with affect regulation and dissociation: significant mediators between childhood traumas and eating psychopathology (Moulton et al., 2015).*

Idea #3: Self-States and Dissociation

From a psychoanalytic point of view, Bromberg (2001) suggests that eating disorders develop as the result of a prolonged necessity in infancy to control trauma and affect dysregulation, leading to a mental structure that has been shaped by dissociative dynamics and an impaired faith in human relatedness. Eating disordered symptoms represent the “repackaging” of unlinked states of mind into symptomatic thoughts, feelings, and behaviors — dissociated self-states. These dissociative defenses inevitably manifest in the transference as well, representing the patient’s attempt to “stay enough in relationship with the human environment to survive the present while, at the same time, keeping the needs for more intimate relatedness sequestered but alive” (Sands, 1994, p. 149).

Idea #3: Self-States and Dissociation

- the “hungry self,” a self-state prominent in many patients with binge eating disorder
- When the “hungry self” – a combination of need and rage that stems from emotional, physical, or sexual abuse and neglect – emerges in a binge episode, the patient’s thinking and perception is dissociatively narrowed. She becomes absorbed in the movements and sensations – not the meaning – of eating and is unable to evaluate that eating against norms such as what might constitute an appropriately sized meal or a healthy selection of food to eat (Tibon & Rothschild, 2009).

Resources

- Petrucelli, J. (Ed.). (2014). Body-states: Interpersonal and relational perspectives on the treatment of eating disorders. New York, NY: Routledge.
- Kullman, A. (2018). *Hunger for Connection: Finding Meaning in Eating Disorders*. Routledge.
- Wooldridge, T. (in press). *Eating Disorders (New Introductions to Contemporary Psychoanalysis).* New York: Routledge.
- Wooldridge, T. (Ed.) (2018). *Psychoanalytic treatment of eating disorders: When words fail and bodies speak. (Relational Perspectives Book Series).* New York: Routledge.
- Petrucelli, J., & Stuart, C. (Eds.). (2001). *Hungers and compulsions: The psychodynamic treatment of eating disorders and addictions*. Jason Aronson.
- Williams, G. (1997). Reflections on some dynamics of eating disorders: “No entry” defenses and foreign bodies. *International Journal of Psychoanalysis*, 78(5), 927–941.