CHAPTER

12

# Substance-Related Disorders and Eating Disorders

In this chapter I consider two diagnostic categories that involve discrete self-destructive symptoms. Substance abuse is defined by the ingestion of chemicals that may lead to addiction, life-threatening physical problems, and a host of emotional problems. Eating disorders are defined by overeating, voluntary purging, and starvation. Both groups of disorders present a complex problem for psychodynamic clinicians: What is the role of dynamic approaches in disorders that require symptom control as a major thrust of the therapeutic effort? In some quarters, psychodynamic understanding is considered irrelevant to the management of addiction and eating disorders. However, a considerable body of clinical and research literature suggests otherwise.

## Substance-Related Disorders

Because psychodynamic psychiatrists often become frustrated in their efforts to treat alcoholic patients, they may abandon or avoid such efforts. Relapse is common, and interpretations of unconscious motivations often seem to have little impact on the drinking behavior itself. Psychodynamic models of alcoholism are regarded with skepticism both by mental health professionals and by society at large.

Two other models—the moral model and the disease model—receive much greater support (Cooper 1987). The moral model views alcoholic individuals as

bearing complete responsibility for their alcoholism. From this point of view, alcoholic persons are hedonistic individuals interested only in their own pursuit of pleasure, with no regard for the feelings of others. This model has its roots in the fundamentalist religious belief that alcoholism is a sign of moral turpitude. Failings of willpower are closely linked to notions of sin, and punishment through the legal system is often regarded as the appropriate way to deal with alcoholic individuals. Eliminating drinking behavior is a matter of overcoming weak willpower to "pull oneself up by the bootstraps."

The success of Alcoholics Anonymous (AA) has led to the increasing popularity of the disease model of alcoholism. In contrast to the moral model, this paradigm relieves the alcoholic person of responsibility for his or her illness. Just as a diabetic person is not held responsible for diabetes, the alcoholic individual is not held responsible for alcoholism. Alcoholic persons are viewed as having an inherent predisposition to addiction to exogenous substances; psychological factors are irrelevant. Although this model originated as a backlash to moralizing reactions to—and inhumane treatment of—alcoholic persons, it has recently gained support from genetic studies of the offspring of alcoholic individuals. Even when raised apart from their alcoholic parents, these children have an increased risk of developing alcoholism as adults (Goodwin 1979; Schuckit 1985). Twin studies in both male and female twin pairs (Kendler et al. 1992; Prescott and Kendler 1999) suggest that genetic factors play a major role in the development of alcoholism, with similar influence for alcohol abuse and alcohol dependence.

Further support for the disease model has come from Vaillant's (1983) prospective study of male alcoholic patients throughout the course of their adult lives. He found that the eventual development of alcoholism could not be predicted from adverse childhood experiences or even from psychological profiles of these subjects as young adults. The only reliable predictor of adult alcoholism was antisocial behavior. Vaillant concluded that depression, anxiety, and other psychological characteristics often associated with alcoholic persons were *consequences*, rather than causes, of the disorder. Furthermore, psychotherapy and psychological conceptualizations of alcoholism play a minor role in clinical understanding and treatment planning. Vaillant thus decided that enforced abstinence through AA has the greatest likelihood of success.

A shift in focus from alcoholic patients to those who abuse drugs reveals wide usage of the same two models. The moral model is more widely applied to drug abusers than to alcoholic persons, however, largely because of the extensive overlap between crime and drug abuse. Much of the controversy over the appropriate response to the national drug problem involves whether addicted persons are more effectively handled through legalistically oriented punitive approaches or medically oriented therapeutic approaches. Drug abusers have sought to replicate the



success of AA by developing organizations such as Narcotics Anonymous (NA). But the disease model and its associated self-help groups have been less successful with drug abusers, as Vaillant himself (1988) has pointed out, because of apparent fundamental differences between alcoholic persons and polydrug abusers that require differential approaches. In view of these essential differences, the following section will examine the psychodynamic understanding of alcoholic persons and drug abusers in turn.

## Psychodynamic Approaches to Alcoholism

The AA approach to the problem of alcoholism has been highly effective in the treatment of many individuals. Although the AA organization itself promotes the disease model, its methods address psychological needs and facilitate lasting structural personality changes (Mack 1981). Abstinence is achieved in an interpersonal context where alcoholic individuals can experience a caring and concerned community of fellow sufferers. These caring figures can be internalized in the same manner that a psychotherapist is internalized, and they can assist the alcoholic individual with affect management, impulse control, and other ego functions, also as a psychotherapist would. Hence, the psychodynamic model can facilitate an understanding of some of the changes rendered by the AA approach (Mack 1981).

For many alcoholic persons, the psychological changes encouraged by AA and the abstinence associated with commitment to its ideals and regular attendance at the meetings are sufficient treatment. The psychodynamically sensitive clinician, understanding the value of this approach, must have the good judgment to leave well enough alone. Clinical experience has repeatedly demonstrated, however, that AA is not suitable for all patients who suffer from alcoholism. It apparently works best for those who can accept the idea that they have no control over their drinking and thus need to surrender to a "higher power," and for those who are essentially free of other psychiatric disorders.

Most alcoholism experts would agree that alcoholism is a heterogeneous disorder with a multifactorial etiology (Donovan 1986). What works for one patient may not work for another, and all the treatments are surrounded with controversy. A review of treatment studies (McCrady and Langenbucher 1996) suggested that specific treatments appear to have differential effectiveness with different patient groups. No one type of therapy is consistently better than any other type of therapy. In a nationwide project sponsored by the National Institute on Alcohol Abuse and Alcoholism (Project MATCH Research Group 1997), three types of therapy were compared: cognitive-behavioral therapy, 12-step facilitation to prepare subjects for a commitment to AA, and motivational enhancement therapy aimed at

improving readiness and willingness to change drinking habits. Overall, all three treatments had reasonably good results, and none was more successful than any other. Clearly, no treatment is definitive, and clinicians must consider each patient individually, making a careful psychiatric evaluation before developing an individually tailored treatment plan.

Unfortunately, the disease model has promulgated the "de-psychologizing" of alcoholism. The conclusions drawn by Vaillant (1983) are in conflict with those based on other longitudinal studies, which suggest that personality factors may be important to an understanding of vulnerability to alcoholism (Sutker and Allain 1988). Moreover, Vaillant's conclusions are only as valid as his instruments of measurement. Dodes (1988) observed that Vaillant's methods are not capable of identifying a critical feature in alcoholic patients—namely, their disturbance in self-esteem as revealed by an inability to care for themselves.

Perhaps the major difficulty with the treatment approach suggested by Vaillant and other strict adherents to the disease model is that it ignores the heterogeneity of the disorder. Alcoholism is not a monolithic entity. In fact, one might more accurately refer to the "alcoholisms" (Donovan 1986). Numerous studies attest that there is no single "alcoholic personality" that predisposes to alcoholism (Donovan 1986; Nathan 1988; Sutker and Allain 1988). Nonetheless, personality variables and psychological issues are highly relevant in the treatment of many alcoholic patients. A narrow interpretation of the disease model might lead clinicians to ignore how these factors contribute to relapse in the course of the illness.

Although no specific personality traits are connected with alcoholism, psychoanalytic observers have repeatedly noted structural defects, such as ego weakness and difficulty in maintaining self-esteem (Donovan 1986). Both Kohut (1971) and Balint (1979) noted that alcohol serves the function of replacing missing psychological structures and thereby restores some sense of self-regard and inner harmony. Unfortunately, these effects last only as long as the intoxication. Khantzian (1982) also observed that alcoholic patients had problems with self-esteem, the modulation of affect, and the capacity for self-care. Investigators of borderline personality disorder have consistently noted parallels between alcoholic patients and patients with borderline personality disorder (Hartocollis 1982; Kernberg 1975; Knight 1953; Rinsley 1988); in particular, they share such traits as poor anxiety tolerance, poor affective control, and the use of splitting as a predominant defense (see Chapter 15). This linkage of alcoholism with borderline personality disorder has been further substantiated by empirical studies (Nace et al. 1983; Vaglum and Vaglum 1985) that suggest that 30%–39% of alcoholic persons have coexisting borderline pathology. A review of 12 studies of alcoholic patients in whom a specific attempt was made to diagnose personality disorder found that the prevalence of comorbid Axis II conditions varied from 14% to 78% (Gorton and Akhtar



1994). Other common diagnoses accompanying alcoholism are depression (Weissman and Myers 1980) and sociopathy (Schuckit et al. 1970).

These studies are cited not to convince readers that all alcoholic persons suffer from coexisting psychiatric disorders or preexisting intrapsychic deficits, but rather to highlight the obvious fact that addiction to alcohol occurs in a *person*. An individual may develop alcoholism as the final common pathway of a complex interaction between structural deficits, genetic predisposition, familial influences, cultural contributions, and other assorted environmental variables. A thorough psychodynamic evaluation of the patient will consider the alcoholism and all its contributing factors in the context of the total person. Whether depression, for example, is a cause or a consequence of alcoholism, or a completely separate disease state, is of more interest to researchers than to clinicians. When alcoholic individuals sober up and look back at the wreckage caused by their alcoholic existence, they are commonly faced with a good deal of depression. This depression stems from the painful recognition that they have hurt others (frequently those most important to them). They must also mourn the things (e.g., relationships, possessions) that they have lost or destroyed as the result of their addictive behavior. Although antidepressant medication may alleviate the depression, psychotherapy can assist in the process of working through these painful issues. Also, assessment and treatment of suicide risk must be part of the overall planning in the treatment of alcoholic patients. Twenty-five percent of all suicides occur in alcoholic individuals, and an alcoholic person's likelihood of suicide is between 60 and 120 times higher than that of a person who is not psychiatrically ill (Murphy and Wetzel 1990). When depression and alcoholism are found together, they appear to have a synergistic or additive effect that results in a disproportionately high level of acute suicidality (Cornelius et al. 1995; Pages et al. 1997).

Another implication of the observation that alcoholism occurs in an individual is that each person will prefer and accept different treatment options. Dodes (1988) noted: "Some patients are able to use only psychotherapy, others can use only AA, and there are those who will best be treated with a combination of the two. Accurate prescription of treatment requires individual clinical judgment" (pp. 283–284). Many alcoholic individuals find AA unworkable either because of their embarrassment at having to speak in front of a group or because of their philosophical opposition to the notion of a "higher power." Although Vaillant (1981) has declared psychotherapy to be wasteful in the treatment of alcoholism, some patients are able to maintain sobriety with psychotherapy alone (Dodes 1984; Khantzian 1985a). An unfortunate "straw man" stereotype often applied to the dynamic psychotherapy of alcoholic patients is that the therapist uncovers unconscious motivations for drinking while ignoring the patient's actual drinking behavior. The fact that psychotherapy can be misused by some patients and by some

therapists does not mean, however, that it should be written off as a treatment (Dodes 1988).

Patients involved in AA are often in psychotherapy as well. In one study, more than 90% of the abstinent alcoholic patients in AA who sought psychotherapy found it helpful (Brown 1985). Psychotherapy and AA often work synergistically. Dodes (1988) observed that alcoholic patients may develop, in self psychological terms, an idealizing or mirror transference to the AA organization. They view it as a caring, idealized figure in their life that sustains and supports them. This transference may be split off from the psychotherapeutic transference, and the psychotherapist is wise to delay analyzing it. Eventually, the selfobject functions of AA can be internalized enough to improve self-care and heighten self-esteem. After some degree of internalization, psychotherapists can shift the therapy from a supportive to a more expressive emphasis.

Other researchers have argued that abstinence is not an absolute requirement for effective psychotherapy (Dodes 1984; Pattison 1976). If a therapist demands abstinence, some patients will refuse treatment altogether. In fact, it is naive to expect total abstinence in the course of long-term psychotherapy. Very few alcoholic individuals are unambivalent about giving up their symptomatic drinking; any lack of motivation should be viewed as a symptom rather than as a contraindication for psychotherapy (Cooper 1987). However, if patients continue to drink heavily, with no capacity for or interest in exploring their reasons for drinking, they may be unable to use the psychotherapeutic process and may instead require hospitalization to be effectively treated.

Group psychotherapy is also commonly used in both inpatient and outpatient treatment of alcoholism. In a randomized controlled trial of psychodynamic group therapy and cognitive-behavioral therapy for alcohol-dependent patients (Sandahl et al. 1998), patients in both treatment groups improved with 15 weekly 90-minute group sessions. Most of the patients in the psychodynamic group therapy were able to maintain a more positive drinking pattern during the 15-month follow-up period, in contrast to the patients in cognitive-behavioral treatment, who appeared to relapse over time.

Other therapists (e.g., Khantzian 1986) have cautioned against a confrontational approach. Because of the difficulty that many alcoholic patients have in regulating affects such as anxiety, depression, and anger, confrontation in a group setting can be counterproductive or even harmful. Cooper (1987) shared Khantzian's view that confrontation should be used judiciously. He believed that the therapist should empathize with the alcoholic individual's defensive need to avoid painful affect. Cooper advocated inpatient groups that focus on the here and now but are less confrontational. He reported a 55% abstinence rate with patients in such groups, compared with 16% for patients in an inpatient group program



without group psychotherapy. Those patients who remained in group therapy for at least 25 hours also demonstrated greater compliance with other aspects of the program.

## Psychodynamic Approaches to Drug Abuse

Although the disease model is popular in many drug rehabilitation programs, psychodynamic approaches are more widely accepted and valued in the treatment of drug abusers than in the treatment of alcoholic persons. Vaillant (1988), for example, noted that polydrug abusers, in contrast to alcoholic individuals, are more likely to have had unstable childhoods, more likely to use drugs as "self-medication" for psychiatric symptoms, and more likely to benefit from psychotherapeutic efforts to address their underlying symptomatology and character pathology.

A considerable body of research literature supports the association of personality disorder and depression with the development of drug addiction (Blatt et al. 1984a; Kandel et al. 1978; Paton et al. 1977; Treece 1984; Treece and Khantzian 1986). These studies suggested that whereas initiation to marijuana use may be related to peer pressure in adolescence, use of and eventual addiction to hard drugs are not. One study found impaired relationships with parents and depression to be highly significant predictors of eventual abuse of illicit drugs, whereas sociodemographic variables were not (Kandel et al. 1978). Another study of high school students who became involved in heavy drug use identified depression as the most potent predictor of all personality variables (Paton et al. 1977). Treece (1984) concluded that the key factor differentiating the chronic drug-addicted person from the controlled or casual abuser is the presence in the former of a severe personality disorder. Gorton and Akhtar (1994) conducted a review of 24 studies to examine the interrelationship between drug abuse and personality disorder. Comorbidity was found to range between 18% and 100%.

Compared with alcoholic persons, drug abusers are much more likely to have significant coexisting psychiatric disorders. In a large epidemiological study involving interviews with 20,291 persons (Regier et al. 1990), drug abusers had a 53% rate of comorbidity, compared with only 37% for alcoholic individuals. Studies of narcotic-addicted individuals have found other psychiatric diagnoses in as many as 80%–93% (Khantzian and Treece 1985; Rounsaville et al. 1982). The comorbidity rate is also high among cocaine abusers. As many as 73% of those seeking treatment meet lifetime criteria for another psychiatric disorder, with anxiety disorders, antisocial personality disorder, and attention deficit disorder ordinarily preceding the onset of the cocaine abuse, and affective disorders and alcohol

abuse usually following the onset of the cocaine abuse (Rounsaville et al. 1991). The investigators pointed out that a uniform approach to the treatment of substance abusers is inadequate because those with personality disorders require different treatment approaches. Substance abusers with personality disorders are more depressed, more impulsive, more isolated, and generally less satisfied with their lives than are substance abusers without such disorders.

These research findings have played a key role in the development of sophisticated psychodynamic formulations of substance abuse problems. The early psychoanalytic interpretation of all substance abuse as a regression to the oral stage of psychosexual development has been replaced by an understanding of most drug abuse as *defensive* and *adaptive* rather than regressive (Khantzian 1985b, 1986, 1997; Wurmser 1974). Drug use may actually reverse regressive states by reinforcing defective ego defenses against powerful affects such as rage, shame, and depression. The early psychoanalytic formulations often depicted persons with drug addictions as pleasure-seeking hedonists bent on self-destruction. Contemporary psychoanalytic investigators understand addictive behavior more as a reflection of a deficit in self-care than as a self-destructive impulse (Khantzian 1997). This impairment in self-care results from early developmental disturbances that lead to an inadequate internalization of parental figures, leaving the addicted person without the capacity for self-protection. Hence, the majority of chronic drug-addicted individuals exhibit a fundamental impairment in judgment about the dangers of drug abuse.

Equally important in the pathogenesis of drug addiction is the impaired regulatory function in affect and impulse control and in maintenance of self-esteem (Treece and Khantzian 1986). These deficits create corresponding problems in object relations. Heavy polydrug use has been related directly to the addicted person's incapacity for tolerating and regulating interpersonal closeness (Nicholson and Treece 1981; Treece 1984). Contributing to these relationship problems are the narcissistic vulnerability inherent in interpersonal risks and the inability to modulate the affects associated with closeness. Dodes (1990) noted that addicted individuals tend to feel powerless as a reflection of a specific narcissistic impairment. Their addictive behavior wards off a sense of powerlessness or helplessness by controlling and regulating their affective states. Narcissistic rage and humiliation impel them to use drugs as a way of reestablishing a sense of power. The ingestion of a drug can thus be viewed as a desperate attempt to compensate for deficits in ego functioning, low self-esteem, and related interpersonal problems.

Many drug-addicted patients knowingly perpetuate their pain and suffering by continuing to use drugs. Khantzian (1997) regarded this pain-perpetuating aspect of substance abuse as a manifestation of a repetition compulsion of early trauma. In some cases, the repetitive infliction of pain on oneself represents an attempt to work out traumatic states that cannot be remembered. These states exist as presymbolic and unconscious configurations. Thus, the motive for the drug use can be viewed as control of suffering rather than relief from it.



The notion that drug-addicted individuals are medicating themselves leads directly to another observation of contemporary psychodynamic investigators—namely, that specific substances are chosen for specific psychological and pharmacological effects according to each abuser's needs. The most painful affect is likely to be what determines the choice of drug. Khantzian (1997) noted that cocaine appears to relieve distress associated with depression, hyperactivity, and hypomania, while narcotics apparently tone down feelings of rage.

An in-depth study of narcotic-addicted individuals led Blatt et al. (1984a, 1984b) to conclude that heroin addiction is multiply determined by 1) the need to contain aggression, 2) a yearning for gratification of longings for a symbiotic relationship with a maternal figure, and 3) a desire to alleviate depressive affects. Although the research data indicate that a small subgroup of individuals with narcotic addictions also suffers from antisocial personality disorder (Rounsaville et al. 1982), Blatt et al. identified a larger group of severely neurotic opiate-addicted persons, which may represent the majority. These individuals struggle with feelings of worthlessness, guilt, self-criticism, and shame. Their depression appears to intensify when they attempt to become close to others, so they withdraw into isolated "bliss" brought on by heroin or other narcotics, which has both regressive and defensive dimensions. The depressive core of the opiate-addicted individual was further substantiated by a comparison study (Blatt et al. 1984a, 1984b), which found persons with opiate addictions to be significantly more depressed than polydrug abusers. This study also identified self-criticism as a main component of their depression.

The finding of Blatt and his colleagues of a high correlation between superego-ridden, self-critical, depression-prone personality features and opiate addiction has received support from Wurmser's (1974, 1987a, 1987b) psychoanalytic work with addicted patients. He argued that those addicted individuals amenable to psychoanalytic therapy do not suffer from underdeveloped superegos, like antisocial persons with addictions, but rather from an excessively harsh conscience. The intoxicating substance is sought as an escape from a tormenting superego. Many drug abusers employ the defense of splitting to disavow a drug-abusing self-representation that alternates with a non-drug-abusing self-representation. These individuals often feel as if someone else has taken over for a brief period. Wurmser identified success as a prominent trigger for an episode of drug abuse. Positive feelings associated with successful achievement seem to produce an altered state of consciousness characterized by feelings of guilt and shame. Impulsive drug use is seen as the solution to these painful affects. Recurring crises of this kind are char-

acterized by an overbearing conscience that becomes so intolerable that temporary defiance seems the only means of relief.

Although early studies with narcotic-addicted patients suggested that psychotherapy materially contributes to the recovery of addicted persons, much of this research was subsequently discounted because of methodological problems. More recently, a number of reports from the Veterans Administration–Penn Study (Woody et al. 1983, 1984, 1985, 1986, 1987, 1995) have persuasively demonstrated with rigorous methodology that adding psychotherapy to the overall treatment plan of narcotic-addicted patients produces clear benefits. Narcotic-addicted patients in a methadone maintenance program were randomly assigned to one of three treatment conditions: 1) drug counseling alone with paraprofessionals, 2) expressive-supportive psychotherapy plus drug counseling, or 3) cognitive-behavioral psychotherapy plus counseling. Of 110 patients who completed the full treatment program, those receiving psychotherapy improved considerably more than those who received counseling alone. Expressive-supportive psychotherapy based on dynamic principles resulted in greater improvement in psychiatric symptoms and more success in finding and holding a job than did cognitive-behavioral psychotherapy (Woody et al. 1983). Those patients who were depressed showed the most improvement, followed by patients who had opiate dependency but no other psychiatric disorder. Those with antisocial personality disorder alone did not benefit from psychotherapy (Woody et al. 1985). Patients with antisocial personality disorder improved only when depression was also a symptom.

When the researchers divided the 110 psychotherapy patients into groups according to the severity of their psychiatric symptoms, they noted that patients in the low-severity group made equal progress with counseling or with psychotherapy, while patients with a medium degree of severity had better outcomes with treatment plans combining both of these approaches (although some improved just with counseling). However, the group with extremely severe psychiatric symptoms achieved little progress with counseling alone, but made considerable progress when psychotherapy was added: at 7-month follow-up, those patients in the group who received psychotherapy used both illicit and prescribed drugs far less often than did those who did not receive psychotherapy. These changes were sustained at 12-month follow-up (Woody et al. 1987), even though the subjects were no longer in psychotherapy (the duration of psychotherapeutic treatment was 6 months).

The investigators (Woody et al. 1986) drew several conclusions about the psychotherapy of patients with opiate addictions: 1) Both expressive-supportive and cognitive-behavioral psychotherapy can help those narcotic-addicted persons who can become engaged in and will regularly attend such a treatment program. 2) Patients with significant psychiatric disturbances are the best candidates for psychotherapy and will benefit from it the most. 3) The psychotherapist must be integrated into the overall treatment program and must collaborate with other staff members in the treatment. The researchers believed that there were clear benefits to locating the psychotherapy sessions in the same facility as the rest of the methadone maintenance program. Psychotherapy that is fragmented from the rest of the treatment is unlikely to succeed.



Woody et al. (1995) conducted a partial replication study involving psychiatrically symptomatic opiate-dependent patients receiving methadone maintenance treatment. Patients were randomly assigned to 24 weeks of counseling or to counseling plus supportive-expressive psychotherapy. Follow-ups were conducted at 1 month and 6 months after treatment ended. Patients receiving supportive-expressive therapy had fewer cocaine-positive urine samples and required lower doses of methadone. Although both groups made significant gains in 1 month, by 6-month follow-up, many of the gains made by the drug counseling patients had begun to deteriorate. On the other hand, most of the gains made by the supportive-expressive therapy patients remained or were still evident. All significant differences favored the supportive-expressive psychotherapy group.

This comprehensive treatment approach is also highly cost-effective (Gabbard et al. 1997). McLellan et al. (1993) found that adding psychotherapy to standard methadone maintenance treatment led to greater earning power, less welfare income, and strikingly lower hospitalization rates for patients.

Psychotherapy with drug abusers is a treatment approach that indirectly addresses the addiction by focusing on the associated psychopathology. Most clinicians believe that abstinence from the abused substance is a prerequisite to adequate treatment through psychotherapeutic technique of the underlying disturbances—anxiety, depression, personality disorder, self-esteem problems, or ego deficits. The exception would be a drug substitution program such as methadone maintenance. Once abstinence is achieved, the addicted person often feels despair at having given up something more than a drug—a valued part of the self (Treece and Khantzian 1986). Both therapist and patient realize that abstinence alone does not automatically lead to changes in other areas of life. As abstinent persons with addictions struggle with their longing for the drug and their grief over its loss, the therapist must address their tenaciously defended belief that drug use is an adaptive solution to life's problems. The therapist must identify the underlying problems of modulating affects, of regulating self-esteem, and of relating to others, so as to help the addicted person discover alternative answers to those problems. A study of 240 methadone maintenance patients with the self-report Bell Object Relations Reality Testing Inventory found that these patients exhibited specific impairments in object relations (Rutherford et al. 1996). Scores were poorest for those with Axis II disorders in association with the addiction.

One difficulty that psychotherapists will most likely encounter is the alexithymia common in many addicted patients (Krystal 1982–1983). In other words, most of these patients are unable to recognize and identify their internal feeling states. A good deal of education may have to occur during the early phases of therapy, with the therapist explaining how the experience of unpleasant feelings initially leads to drug abuse. These patients must be helped to contain and tolerate their affects so that they can substitute words describing their inner states for actions such as the ingestion of a drug. The therapist can assist patients in this regard by identifying feelings that occur during the therapy hour.

An individual psychotherapy process is much more likely to be successful in the context of a comprehensive program. Khantzian (1986) suggested the concept of the primary care therapist—an individual who facilitates the addicted patient's involvement with all treatment modalities. The therapist analyzes the patient's resistance to accepting other forms of treatment, such as NA or group therapy, but also provides a holding environment for dealing with the strong affects mobilized in the treatment process. The primary care therapist must also participate in treatment decisions involving other modalities. In this model, the emphasis is more supportive than expressive at the beginning of treatment, and the therapist's role is similar to that of a hospital doctor working with an inpatient.

Treece and Khantzian (1986) identified four essential components of a treatment program for mastery of drug dependence: 1) a substitute for the dependency on chemicals (e.g., NA, an alternative system of beliefs, or a benign dependency on a person or religious institution); 2) adequate treatment for other psychiatric disorders, including appropriate psychotropic medication and psychotherapy; 3) enforced abstinence (e.g., drug antagonists, urine surveillance, probation, drug substitutes such as methadone, external support systems) during a psychological maturational process; and 4) promotion of growth and structural personality change through psychotherapy.

Wurmser (1987b) also advocated a multi-pronged approach, but with more expressive psychotherapy. Because he conceptualized an overbearing superego as central to the pathogenesis of compulsive drug use, he cautioned therapists to avoid being punitive or critical with their patients and to refrain from "preaching" to them about drug abuse. A more appropriate role for therapists, in Wurmser's view, is to attempt to understand the superego pressures on the patient, much as in working with a severely neurotic patient. He also believed that therapists should devote their time to looking at underlying issues rather than just focusing on the drug abuse, which can be taken up by other members of the treatment team.

Although no major controlled studies of dynamic group psychotherapy with addicted patients share the methodological sophistication of the Veterans Administration–Penn Study on individual psychotherapy, group psychotherapy has become a component of many programs because of the clinical impression that it is helpful to many patients. Because group psychotherapy is rarely the only treatment modality used in these programs, it is difficult to determine whether any specific therapeutic aspects of group therapy are not also present in other modalities. However, practically speaking, many addicted persons are helped by talking with others who have had the same problem. Also, because denial is a prominent defense in all substance abusers, a group setting of peers facilitates a powerful confrontation of denial and compels addicted individuals to accept the seriousness of their substance abuse. The same caveats about the negative effects of overly aggressive confrontation that were mentioned in the section on group psychotherapy of alcoholic patients also apply to group psychotherapy of addicted persons. Effective groups provide as much support as they do confrontation. Inpatient programs often rely more on groups for the practical reason that enforcing attendance is easier with inpatients than with outpatients (Woody et al. 1986). A commonly encountered resistance to groups in both inpatient and outpatient facilities is that many members may have committed crimes and are therefore reluctant to open up in groups for fear that confidentiality will be breached.



In summary, the indications for expressive-supportive psychotherapy can be conceptualized as the following: 1) serious psychopathology other than drug abuse; 2) engagement in an overall treatment program that includes NA or another support group, enforced abstinence, possibly a drug substitute such as methadone, and appropriate psychotropic medication; 3) no diagnosis of antisocial personality disorder (unless depression is also present) (treatment considerations with antisocial personality disorder are discussed in detail in Chapter 17); and 4) sufficient motivation to keep session appointments and become engaged in the process. The indications for an expressive or supportive emphasis after the process is well launched are largely determined by the same factors that determine the emphasis in any other psychotherapeutic process (see Table 4–1 in Chapter 4).

## Eating Disorders

Anorexia nervosa and bulimia nervosa appear to be disorders of our time. The electronic media bombard the public with images of slender women who "have it all." In many areas of Western culture, food is in abundance, a precondition for binge eating behavior. Individuals affected by these disorders tend to be Caucasian, educated, female, economically advantaged, and ensconced in Western cultures (Johnson et al. 1989). Anorexia nervosa is virtually unknown in countries where thinness is not considered a virtue (Powers 1984). Media images of females,

moreover, suggest that external appearance is far more important than internal identity. Although intrapsychic and biological factors should not be minimized in the etiology and pathogenesis of eating disorders, those factors clearly interface with a particular sociocultural period in Western civilization to produce a syndrome that reflects the culture. Anorexia nervosa has more than doubled in incidence since the 1960s, while the prevalence of bulimia nervosa has been found to be approximately 1% in adolescent and young adult females (Fairburn and Beglin 1990). These disturbing figures indicate that the disorder may be an increasingly common solution to a variety of intrapsychic, familial, and environmental stressors.

## Anorexia Nervosa

The label *anorexia nervosa* can be misleading, since the first word of the phrase implies that loss of appetite is the central problem. The diagnostic hallmark of anorexia nervosa is actually a fanatical pursuit of thinness related to an overwhelming fear of becoming fat. An arbitrary cutoff of less than 85% of minimal normal body weight for age and height is often used to make the diagnosis. Amenorrhea is a prominent feature of anorexia nervosa in females. Although 5%–10% of cases are male, their clinical features and psychodynamics are remarkably similar to those of females.

**Psychodynamic understanding.** For the last few decades, the seminal contributions of Hilde Bruch (1973, 1978, 1982, 1987) have served as a beacon in the darkness for clinicians treating anorexic patients. She observed that the preoccupation with food and weight is a relatively late occurrence emblematic of a more fundamental disturbance in self-concept. Most patients with anorexia nervosa have a thoroughgoing conviction that they are utterly powerless and ineffective. The illness often occurs in "good girls" who have spent their life trying to please their parents, only to suddenly become stubborn and negativistic in adolescence. The body is often experienced as separate from the self, as though it belongs to the parents. These patients lack any sense of autonomy to the point that they do not even feel in control of their bodily functions. The premorbid defensive posture of being a perfect little girl ordinarily defends against a profound underlying feeling of worthlessness. Anorexia nervosa develops as "an attempt at self-cure, to develop through discipline over the body a sense of selfhood and interpersonal effectiveness. Anorexics transform their anxiety and psychological problems through manipulation of food intake and size" (Bruch 1987, p. 211).

Bruch traced the developmental origins of anorexia nervosa back to a disturbed relationship between the infant and its mother. Specifically, the mother appears to parent the child according to her own needs rather than those of the child. When the child-initiated cues do not receive confirming and validating responses, the child cannot develop a healthy sense of self. Instead, the child experiences herself simply as an extension of her mother, not as a center of autonomy in her own right. This understanding is in keeping with early psychoanalytic formulations about the pathogenesis of psychosomatic disorders in children in which an "appersonation" of the child was noted (Sperling 1944). The child is not perceived as a separate individual, but rather as the "right arm" of the mother.



Bruch, then, understood the behavior of the anorexic patient as a frantic effort to gain admiration and validation as a unique and special person with extraordinary attributes. More recently, Bruch (1987) suggested that the clinical picture may be changing somewhat because it is more and more difficult for the anorexic patient to feel unique, given the increasing prevalence of the disorder and the media attention on eating disorders of all kinds. The illness has now become imbued with a sense of competition to be the thinnest or the most unique.

Family therapists, such as Selvini Palazzoli (1978) and Minuchin (Minuchin et al. 1978), have confirmed and elaborated some of the dynamic concepts of Bruch. Minuchin and his colleagues described a pattern of enmeshment in the families of anorexic patients, where there is a general absence of generational and personal boundaries. Each family member is overinvolved in the life of every other family member to the extent that no one feels a sense of separate identity apart from the family matrix. Selvini Palazzoli (1978) also noted that patients with anorexia nervosa have been unable to psychologically separate from their mothers, which results in a failure to achieve any stable sense of their own bodies. The body is thus often perceived as if it were inhabited by a bad maternal introject, and starvation may be an attempt to stop the growth of this hostile, intrusive internal object. Williams (1997) similarly stressed that the parents of an anorexic patient tend to project their anxiety onto their child rather than contain it. These projections may be experienced as inimical foreign bodies within the child. To protect herself from the unmetabolized experiences and fantasies projected onto her by her parents, the young girl may develop a "no entry" system of defenses, concretized by not eating.

The extreme defensive posture of anorexia nervosa suggests that a powerful underlying impulse warrants such a strategy. Indeed, Boris (1984b) noted that intense greed forms the core of anorexia nervosa. Oral desires are so unacceptable, however, that they must be dealt with projectively. Through projective identification, the greedy, demanding self-representation is transferred to the parents. In response to the patient's refusal to eat, the parents become obsessed with whether or not the patient is eating; they become the ones who have desires. In a formulation influenced by Kleinian thinking, Boris conceptualized anorexia nervosa as an in-

ability to receive good things from others because of an inordinate desire to possess. Any act of receiving food or love confronts these patients squarely with the fact that they cannot possess what they desire. Their solution is to not receive anything from anyone. Envy and greed are often closely linked in the unconscious. The patient envies the mother's good possessions—love, compassion, nurturance—but to receive them simply increases the envy. Renouncing them supports the unconscious fantasy of spoiling what is envied, not unlike the fox in Aesop's fable who concluded that the grapes he couldn't reach were sour. The patient conveys the following message: "There is nothing good available for me to possess, so I will simply renounce all my desires." Such renunciation makes the anorexic patient the object of the desire of others and, in her fantasy, the object of their envy and admiration, because they are "impressed" by her self-control. Food symbolizes their positive qualities that she desires in herself; being enslaved by hunger is preferable to desiring to possess the maternal figure.

Most developmental formulations of the origins of anorexia nervosa focus on the mother-daughter dyad. Bemporad and Ratey (1985), however, observed a characteristic pattern of paternal involvement with anorexic daughters. The typical father was superficially caring and supportive but emotionally abandoning of his daughter whenever she truly needed him. In addition, many fathers of anorexic patients seek emotional nurturance from—rather than give it to—their daughters. Both parents often are experiencing serious disappointment in their marriage, leading each parent to seek emotional sustenance from the daughter.

In self psychological terms, the daughter may be treated as a selfobject that provides mirroring and validating functions for each parent but is denied her own sense of self. The child, in turn, cannot rely on human beings to meet her selfobject needs. The anorexic child seriously doubts that parents or any other significant figures in her life will even temporarily give up their own interests and needs to attend to her needs for soothing, affirmation, and mirroring (Bachar et al. 1999). The child may escalate the starvation and restriction in a desperate attempt to force her parents to pay attention to her suffering and recognize her need for help.

To summarize our psychodynamic understanding of anorexia nervosa, the overt behavior of self-starvation is a multiply determined symptom. It is 1) a desperate attempt to be special and unique, 2) an attack on the false sense of self fostered by parental expectations, 3) an assertion of a nascent true self, 4) an attack on a hostile maternal introject viewed as equivalent to the body, 5) a defense against greed and desire, 6) an effort to make others—rather than the patient—feel greedy and helpless, 7) a defensive attempt to prevent unmetabolized projections from the parents from entering the patient, and 8) an escalating cry for help to shake the parents out of their self-absorption and make them aware of the child's suffering.

These psychodynamic factors are also accompanied by certain characteristic



cognitive features. These features include misperception of one's own body image, all-or-nothing thinking, magical thinking, and obsessive-compulsive thoughts and rituals. The presence of obsessive-compulsive symptoms has led some researchers to wonder whether obsessive-compulsive personality disorder coexists with anorexia nervosa. This assumption is confounded by the notorious unreliability of personality disorder diagnoses in the presence of starvation (Kaplan and Woodside 1987; Powers 1984). Many symptoms, including obsessive-compulsive behavior, appear secondary to starvation. Also, premorbid personality characteristics are accentuated in states of nutritional deficiency. The fear of being fat has itself been shown to moderate when the patient begins to eat and gain weight (Garfinkel and Garner 1982).

**Treatment approaches.** Clinicians who treat patients who have anorexia nervosa are in consensus that the treatment goals must not be focused narrowly on weight gain (Boris 1984a, 1984b; Bruch 1973, 1978, 1982, 1987; Chessick 1985; Dare 1995; Hsu 1986; Hughes 1997; Powers 1984). A "two-track" approach, advocated by Garner et al. (1986), includes a first step of restoration of eating for weight gain. Once this step is accomplished, the second step of psychotherapeutic intervention can begin. Anorexic patients show much greater improvement when provided with a mixture of family therapy and dynamic individual therapy than when they are simply managed with educational measures designed to control weight (Dare 1995; Hall and Crisp 1983). Long-term, individual expressive-supportive psychotherapy is the cornerstone of the treatment. Unless the patient's underlying disturbance of the self and the associated distortions of internal object relations are addressed, the patient will follow a course of repeated relapse and revolving-door hospital admissions (Bruch 1982). For those patients living at home, family therapy may be a valuable adjunct to individual therapy. Although some patients appear to benefit from group psychotherapy (Lieb and Thompson 1984; Polivy 1981), the limited data suggest that those who benefit most do not have associated personality disorders (Maher 1984).

Hospitalization may also be a beneficial adjunct to individual psychotherapy. Although no indications for inpatient treatment are universally agreed on, a weight loss of 30% of normal body weight is a good rule of thumb to use in determining whether inpatient treatment is necessary (Garfinkel and Garner 1982). Approximately 80% of all anorexic patients will gain weight with hospital treatment (Hsu 1986), provided that the hospital staff can create a specific milieu. As described in Chapter 6, the hospital staff must be wary of the patient's unconscious efforts to reenact the family struggle in the hospital milieu. They must convey an interest in helping the patient restore weight without becoming excessively concerned about it and without making demands similar to those the patient's parents

would make. The patient can be helped to cope with the fear of losing control by arranging an eating plan of frequent but small meals with a member of the nursing staff who is available to discuss the patient's anxiety about eating. Weight gains should be reported to the patient with concomitant positive reinforcements. Any surreptitious vomiting or purging should be confronted and controlled with structural measures such as locking the bathroom door. Members of the treatment staff may need to reassure the patient that they will not allow too much weight gain, thus helping the patient develop a sense of trust in them.

If individual and family therapy were being conducted prior to admission, these should continue during hospitalization. If the patient's hospitalization is her first treatment contact, however, these adjunctive therapies should be implemented as part of the hospital treatment. Antidepressant medication is helpful with patients who meet the criteria for major depression. (Milder forms of depression improve with weight gain.) Brief hospitalizations are rarely curative, nor are treatment programs that demand a normal average weight and then ignore the intense anxiety aroused by such a demand (Bruch 1982). At least 50% of the patients who successfully control their anorexia nervosa with inpatient treatment will relapse within a year (Hsu 1980). For the 20% who do not respond to brief hospitalization, extended hospitalization is indicated.

Individual expressive-supportive psychotherapy often takes several years of painstaking work because of the formidable resistance posed by the anorexic patient. Four guiding principles of technique are useful (Table 12–1).

1. *Avoid excessive investment in trying to change the eating behavior.* As Boris (1984b) observed, "What we call their symptoms they call their salvation" (p. 315). The patient views anorexia nervosa as the solution to an internal problem. Psychotherapists who immediately define it as a problem that must be changed reduce their chances of forming a viable therapeutic alliance. The behavior associated with anorexia nervosa elicits demands and expectations for change from the patient's parents. Through projective identification, the therapist is likely to experience powerful pressure to identify with the patient's projected internal objects that are associated with the parents. Instead of acting on that pressure and becoming a parental figure, the therapist must try to understand the patient's internal world. One form of this reenactment is the equation of eating with talking. Just as the patient provokes her parents by refusing to eat, she will attempt to provoke the therapist by refusing to talk (Mintz 1988). At the beginning of the therapy, it may thus be helpful to clarify that the primary goal of the treatment is to understand the patient's underlying emotional disturbance rather than the problem of not eating (Bruch 1982; Chessick 1985). Although Boris (1984a) advocated complete avoidance of psychotherapeutic focus on eating, Bruch (1982) suggested that psychotherapy is not feasible unless the patient weighs in the neighborhood of 95 pounds. She explains to her patients that their capacity for thinking and communicating will improve if they can get their weight at least to that level.

**TABLE 12–1.** Technical guidelines in the psychotherapy of anorexic patients

| |
|---|
| Avoid excessive investment in trying to change the eating behavior. |
| Avoid interpretations early in the therapy. |
| Carefully monitor countertransference. |
| Examine cognitive distortions. |



2. *Avoid interpretations early in the therapy.* Interpretations of unconscious wishes or fears will be experienced by the anorexic patient as a repetition of her life story. *Someone else* is telling her what she really feels, while her conscious experience is minimized and invalidated. Rather, the therapist's task should be to validate and empathize with the patient's internal experience (Bruch 1987; Chessick 1985). The therapist should take an active interest in what the patient thinks and feels, conveying the message that the patient is an autonomous person entitled to her own ideas about her illness. Of major importance is helping the patient define her own feeling states. The actions and decisions stemming from these feelings must be legitimized and respected. The therapist can help the patient explore various options but should refrain from telling her what to do (Chessick 1985). This empathic, ego-building, supportive approach in the early phases of therapy will facilitate introjection of the therapist as a benign object. Bruch (1987) suggested emphasizing the positive and conceptualizing the therapy as an experience in which patients will discover their positive qualities. She acknowledged that her approach has many similarities to Kohut's (1984) self psychological approach. Chessick (1985) shared this view that insight into unconscious conflict is unlikely to be curative with these patients. Although slightly more optimistic about the use of interpretations, Boris (1984a) recommended withholding interpretations until the patient finds herself. Even then, he advocated talking "to the air" instead of directly to the patient, thereby providing some distance in the relationship and respecting her boundaries. Such interpretations should be delivered as hypotheses, as though talking to an imaginary colleague rather than as making a definitive pronouncement directly to the patient.
3. *Carefully monitor countertransference.* Anorexic patients commonly believe that their parents want them to gain weight so that other people won't view the parents as failures (Powers 1984). The therapist is likely to become anxious about similar matters. Therapists who work within the framework of a com-

prehensive treatment team, in particular, may begin to feel that others are negatively judging their work if their patients fail to gain weight. This countertransference concern may lead the therapist to fall into the trap of identifying with the patient's parents. The ideal situation for individual psychotherapy is for another treater to monitor weight gain, leaving the therapist free to explore the patient's underlying psychological issues. When hospitalization is required for weight control, the admitting psychiatrist can manage food intake while the psychotherapist continues the psychotherapeutic work in the hospital. In this setting, the psychotherapist can work productively with the team.

Hughes (1997) has beautifully described some of the typical countertransference dilemmas confronted in the treatment of patients with anorexia nervosa. Just as the patient keeps the parents involved in trying to help but always failing, she also engages the therapist in that role. Frequently, the patient presents herself as wanting to cooperate with treatment but then sabotages the therapist's help. With anorexia patients, the therapeutic alliance is typically much more tenuous than it appears, and the therapist must cope with the frustration of feeling duped by the patient. To handle the countertransference, it is useful to remember that the patient understands progress as equivalent to separation from family and growing up, both of which are highly threatening. Anxiety is stirred up in the therapist by the patient's flirtation with death, which is made all the more frustrating because of the patient's frequent denial of suicidal wishes. Just as families may get exhausted and angry and even develop unconscious murderous wishes toward the anorexic patient, the therapist may also experience despair, murderous rage, and a sense that no one else fully appreciates the lethality of the patient. This unfolding transference-countertransference drama is the core of the illness as manifested in the therapeutic relationship and thus provides enormously valuable information for the therapist that can ultimately be shared and understood with the patient.

4. *Examine cognitive distortions.* Misperceptions of body size and illogical cognitive beliefs should be explored with the patient nonjudgmentally (Powers 1984). The therapist thus serves as an auxiliary ego to help the patient sharpen her powers of observation and her critical thinking (Chessick 1985). Clearly, the psychotherapist must assume an educative role with these patients, helping them understand the effects of starvation on cognition. However, the therapist must seek to educate while making no demand for change. Alternatively, the therapist can simply explore the consequences of the patient's choices.

These technical guidelines, while useful, are not to be taken as a "cookbook" formula for the psychotherapy of anorexic patients. Therapists must be flexible, persistent, and stable in the face of the patient's tendency to "wait out" the therapy process until she can once again be left alone. Body image distortions, which often approach delusional proportions, may be particularly refractory to educational and therapeutic efforts. Therapists must be wary of countertransference despair and frustration that might lead them to attempt to force the patient to "see things as they really are."



Although patients with anorexia nervosa may seem highly treatment resistant in the short run, many of them ultimately improve. In one long-term follow-up study (Sullivan et al. 1998), only 10% of patients followed up a mean of 12 years after initial referral still met criteria for anorexia nervosa. However, many still struggled with some of the features of the illness, including perfectionism and a relatively low body weight. On the other hand, in a review of 300 patients in four different series, Hsu (1991) calculated that about 1 in 7, or 14% of the patients, had subsequently died from suicide or complications of the illness. In a 5-year follow-up comparison of family therapy and individual supportive therapy (Eisler et al. 1997), both treatments produced significant improvements. Patients with early onset and a short history of anorexia nervosa appeared to do better with family therapy, whereas those with late onset appeared to do better with individual supportive therapy. Psychoanalytic psychotherapy also appears to be as effective as supportive therapy (Dare 1995). In a randomized controlled study comparing self psychological therapy with cognitive orientation treatment, five of six anorexia nervosa patients treated with self psychological therapy remitted, while neither of the two patients treated with cognitive orientation therapy remitted. In a different study (Robin et al. 1995), anorexic patients ages 12–19 years were treated with either family therapy or individual ego treatment. After a year of therapy, all patients from both groups were menstruating, and 82% from family therapy and 50% from the ego treatment met the dual criteria of target weight and menstruation.

## Bulimia Nervosa

Patients with bulimia nervosa are generally distinguished from those with anorexia nervosa on the basis of relatively normal weight and the presence of binge eating and purging. Emaciated patients who are also binge eating and purging are often classified as anorexics, bulimic subgroup (Hsu 1986). This diagnostic classification reflects how the concept of anorexia nervosa has become blurred by the cultural fascination with bulimia (Bruch 1987). In Bruch's view, the two syndromes have little in common—the rigid self-discipline and harsh conscience of the anorexic patient contrast sharply with the impulse-ridden, irresponsible, and undisciplined behavior of the bulimic person. The condensed term *bulimarexia* is thus a "semantic atrocity" (Bruch 1987) in that it mistakenly implies similarity.

Bruch's view, however, is not supported by accumulating data that suggest considerable linkage between the two disorders (Garner et al. 1986). At least 40%–50% of all anorexic patients also have bulimia (Garfinkel et al. 1980; Hall et al. 1984; Hsu et al. 1979). Long-term follow-up data suggest that over a long period of time, anorexia nervosa may give way to bulimia nervosa, but that the reverse pattern is much rarer (Hsu 1991). In light of these findings, DSM-IV (American Psychiatric Association 1994) subtypes anorexia nervosa according to the presence or absence of bulimic symptoms and precludes the diagnosis of bulimia nervosa in the presence of anorexia nervosa when the bulimia occurs only during episodes of anorexia nervosa.

Part of the reason for the blurring of diagnostic boundaries between anorexic and bulimic behavior is that the clinical picture can be so varied. Concurrent psychiatric disorders are common (Yager 1984), and over half of all bulimic patients may suffer from associated personality disorders (Johnson et al. 1989). As Yager (1984) eloquently observed,

> Bulimia is not a disease. Nor is it a simple habit. Bulimia is heterogeneous and, like pneumonia, it may result from a variety of causes. I have found it useful to conceptualize bulimia as a habit or behavioral pattern embedded in a personality, in turn embedded in a biology, and all this embedded in a culture in which bulimia seems to be developing at an increasing rate. (p. 63)

**Psychodynamic understanding.** When considering the psychodynamics of bulimia, therapists must keep in mind this heterogeneity. The various contributors to our dynamic understanding of bulimia are likely to be analogous to the proverbial blind men reporting their perceptions of an elephant based on their particular vantage points. As always, dynamic understanding must be individualized. A clinical picture of bulimia may be observed in patients with vastly different character structures, ranging from psychotic through borderline to neurotic (Wilson 1983). Anorexia and bulimia are essentially opposite sides of the same coin (Mintz 1988). Whereas the anorexic patient is characterized by both greater ego strength and greater superego control, the bulimic patient may suffer from a generalized inability to delay impulse discharge, based on a weakened ego and a lax superego. Binge eating and purging are not usually isolated impulse problems; rather, they typically coexist with impulsive, self-destructive sexual relationships and with polydrug abuse.

Some empirical evidence suggests which psychodynamic factors might be at work in patients with bulimia nervosa. In a multivariate genetic analysis, Kendler et al. (1995) found that family and environmental factors play key roles in the development of the disorder. In a community-based case-control study involving



102 subjects with bulimia nervosa and 204 healthy control subjects (Fairburn et al. 1997), parental problems, sexual or physical abuse, and negative self-evaluation were all associated with the development of the illness. The investigators suggested that negative self-evaluation might encourage dieting by distorting the girls' views of their appearance. These empirical findings are supported by observations stemming from psychoanalytic treatment. Reich and Cierpka (1998) found disturbances in the emotional dialogue between the bulimic patients and their parents and a consistent pattern of conflict between contradictory parts of the self that was undoubtedly influenced by conflicting identifications with parents. These authors also suggested that many bulimic patients experience a lack of respect for boundaries and a tactless intrusion into their privacy, which would apply to both sexual abuse and psychological abuse. Reich and Cierpka noted that these patients frequently used defenses involving reversal of affects and turning passive to active, and they also experienced contradictory superego demands.

Those authors who have studied the developmental origins of bulimia have identified extensive difficulty with separation both in the parents and in the individual patient. A common theme in the developmental history of bulimic patients is the absence of a transitional object, such as a pacifier or blanket, to help the child separate psychologically from her mother (Goodsitt 1983). This developmental struggle to separate may be played out instead by using the body itself as a transitional object (Sugarman and Kurash 1982), with the ingestion of food representing a wish for symbiotic merger with the mother and the expulsion of food an effort at separation from her. Like the mothers of anorexic patients, the parents of children who grow up to be bulimic often relate to their children as extensions of themselves (Humphrey and Stern 1988; Strober and Humphrey 1987). These children are used as selfobjects to validate the self of the parent. Each member of the family depends on all the other members to maintain a sense of cohesion. Although this pattern characterizes the families of anorexic patients, a particular mode of managing unacceptable "bad" qualities is predominant in bulimic families. The bulimic family system apparently involves a strong need for everyone to see themselves as "all good." Unacceptable qualities in the parents are often projected onto the bulimic child, who becomes the repository of all "badness." By unconsciously identifying with these projections, she becomes the carrier of all the family's greed and impulsivity. The resulting homeostatic balance keeps the focus on the "sick" child rather than on conflicts within or between the parents.

The psychodynamic observations about difficulties with separation in bulimic patients have been confirmed by empirical research (Patton 1992). A group of 40 patients with eating disorders was compared with a control group of 40 women with normal eating patterns to see how they would respond to subliminal or supraliminal stimuli. Each group was shown an abandonment or a control stimu-

lus at exposure durations that was either subliminal or supraliminal. Following exposure to an abandonment stimulus, the group with eating disorders ate significantly more crackers than did subjects in the control group. The investigators concluded that binge eating was indeed a defense against an unconscious fear of abandonment.

In many instances, then, bulimic patients concretize the object relations mechanisms of introjection and projection. Ingestion and expulsion of food may directly reflect the introjection and projection of aggressive, or "bad," introjects. In many cases, this splitting process is further concretized by the patient. She may regard protein as "good" food, which is therefore retained rather than purged, and carbohydrates or junk food as "bad" food, which is consumed in huge quantities, only to be regurgitated. On the surface, this strategy of managing aggression may be compelling—the expulsion of badness in the form of vomit leaves the patient feeling good. However, the residual feeling of "goodness" is unstable because it is based on splitting, denial, and projection of aggression rather than on integration of the bad with the good.

**Treatment considerations.** The most important single principle in the treatment of bulimia is individualization of the treatment plan. Concurrent psychiatric disorders, such as depression, personality disorders, and drug abuse, should be addressed as part of comprehensive treatment planning. "Assembly line treatment programs" (Yager 1984) that treat all bulimic patients alike will only help a fraction of them because of a failure to recognize and appreciate the inherent heterogeneity of the bulimic population. About one-third of all bulimic patients represent a relatively healthy subgroup who will respond well to a time-limited approach involving brief cognitive-behavioral therapy and a psychoeducational program (Johnson and Connors 1987; Johnson et al. 1989). Support groups such as Overeaters Anonymous (OA) may also sustain this subgroup of patients without further treatment.

Follow-up studies suggest that the temporal stability of bulimic symptoms may be a problem for many patients (Joiner et al. 1997). In a review of 88 studies conducting follow-up assessments with bulimic subjects, Keel and Mitchell (1997) found that approximately 50% of women had fully recovered from the disorder 5–10 years after presentation. However, 20% continued to meet full criteria for bulimia nervosa, and approximately 30% had relapsed into bulimic symptoms. In a follow-up of 173 women more than 10 years following presentation, the same investigators (Keel et al. 1999) reported that nearly 70% of their sample were either in full or partial remission, but 30% continued to engage in recurrent binge eating or purging behaviors.

Although dynamic approaches may not be indicated or necessary for all patients, they still may benefit the majority. Among nonresponders, as many as



two-thirds may have borderline personality disorder (Johnson et al. 1989), while others may have other personality disorders or significant depression. These patients usually require long-term, expressive-supportive psychotherapy and often need psychopharmacological intervention as well. Many patients also frankly resent a behavioral approach to their bulimic symptoms (Yager 1984). Focusing on the patient's overt behavior while neglecting her internal world may recapitulate the patient's experience of growing up with parents who are more concerned about surface than substance. Yager (1984) suggested that as many as 50% of all bulimic patients are dissatisfied with behavior modification techniques. Some patients will even experience the task of writing a daily diary about their eating habits as demeaning, because they may view their eating problems as symptomatic of more fundamental disturbances. Treatment that does not match the patient's interests and belief system is doomed to failure (Yager 1984).

Bulimia nervosa can be life-threatening. Patients have been known to alter their electrolyte balance sufficiently to precipitate cardiac arrest. Blood chemistry monitoring should therefore be part of the outpatient management of these patients, with hospitalization as a backup strategy. Since many bulimic patients also suffer from borderline personality disorder or major affective disorders, hospitalization may be required in the face of a suicide attempt or severe self-mutilation. The hospital treatment must follow an individualized comprehensive treatment plan, in addition to the task of gaining symptom control through locking bathrooms, implementing a normal meal schedule, providing psychoeducational assistance from a dietitian, and encouraging the keeping of a diary. Hospitalization often provides the therapist with an opportunity to better understand the patient's internal object relations; thus, it facilitates more sophisticated diagnostic understanding and more precise treatment planning:

> Ms. W was a 19-year-old college student with a mixture of bulimic and anorexic symptoms. She was hospitalized after "firing" her psychotherapist and completely losing control of her binge eating and purging. Her parents, who were quite exasperated with her behavior, brought her to the hospital because they felt hopeless about ever getting her to eat properly. During the first week of hospitalization, Ms. W informed her hospital doctor that she planned to remain aloof and distant because she did not want to get attached to a doctor again only to be disappointed. Regular meals and group meetings were immediately implemented, but the patient refused to go to meals or to attend the group. She insisted that she was capable of dieting only by eating when and what she wanted. She pointed out to her doctor that her weight was remaining constant, so there was no need for concern.
>
> The nursing staff became increasingly irritated with Ms. W for her utter lack of cooperation. The more stubborn and resistant the patient became, the more the staff insisted that she follow the structure of the hospital program. In one staff meeting,

the hospital doctor observed that the patient had succeeded in recapitulating her family situation. By asserting that she should have control over her diet, she provoked others into attempting to take control of her eating. She could then feel victimized by the controlling forces around her, just as she felt victimized by her parents.

Ms. W's doctor met with her and pointed out to Ms. W that she was attempting to provoke the hospital staff into a reenactment of her family situation. She asked the patient to reflect on what she might gain from this reenactment. Ms. W responded by indicating to her doctor that she was not interested in talking. Three days later, she told her doctor that she had been hoarding medications and sharp objects in a locked drawer in her hospital room so that she might attempt suicide. She said that she had decided to tell her doctor because she really did not want to die. She also indicated that it was terribly difficult for her to communicate feelings to her doctor because she believed that she would become uncontrollably dependent and would lose any sense of her own self. She was certain that dependency on her doctor would lead to her being exploited and mistreated according to the doctor's needs rather than her own treatment needs.

This information helped the hospital staff understand Ms. W's resistance to the treatment structure. By refusing to cooperate, this patient was attempting to establish a sense of self independent of the demands and expectations of others. Cooperation with the nursing staff and collaboration with her hospital doctor carried the risk that she would become a mere extension of others, as she had in her family. Once this underlying anxiety surfaced, the staff members allowed Ms. W to have more say in her eating program. With a member of the nursing staff, she was able to collaborate on and then follow a program that was acceptable to both of them.

Just when Ms. W seemed to be improving, however, her hospital doctor received a call at home on Christmas morning as her family was opening presents. A hospital nurse was calling to inform her that Ms. W had smuggled in and then taken a large number of laxatives and had been having diarrhea all morning. The nurse was worried that Ms. W might require emergency medical treatment, so Ms. W's doctor felt compelled to go to the hospital to see the patient. Two days later, when Ms. W was medically stable, her doctor confronted her about the transference hostility involved in her purging, then suggested that perhaps Ms. W had wished to spoil her doctor's Christmas morning. Although the patient blandly denied any such possibility, her doctor had to suppress intense anger at Ms. W for the timing of her acting-out. It gradually dawned on the doctor that the act of purging had enabled the patient to expel her own aggression. As a result, she could not relate to the doctor's interpretation of her act as hostile; the doctor unconsciously served as a container of the patient's projected anger.

Although this case illustrates a more refractory patient with borderline personality disorder as part of the clinical picture, the transference/countertransference struggles are not atypical of what individual therapists commonly encounter with



bulimic patients. Therapists may find themselves repeatedly provoked into accepting the "badness" the patient is attempting to expel. They may also feel "vomited on" when the patient repeatedly spits back at them all their therapeutic efforts. The recapitulation of the family pattern in hospital treatment or in individual psychotherapy helps the clinician understand the patient's role within the family system. Because bulimia is so often part of a homeostatic balance in the family, family therapy or family intervention in association with individual therapy is frequently needed. By ignoring the family system, the therapist runs the risk that the patient's improvement will be terribly threatening to other family members. Defensive reactions to this threat may include an insidious undermining of the bulimic patient's treatment or the development of a serious dysfunction in another family member. The family's need for the bulimic patient's illness must be respected, and the parents must feel "held" and validated so that they will not sabotage the treatment (Humphrey and Stern 1988).

Because of their intense ambivalence and their concern about upsetting the family equilibrium, many bulimic patients will try to avoid intensive psychodynamic therapy. They may consider themselves to be defective, and psychotherapeutic exploration involves a risk that this defectiveness will be exposed (Reich and Cierpka 1998). Introducing an eating diary and pointing out the association between certain eating patterns and emotional states may be an extremely effective way to build a therapeutic alliance with the patient. One of the common countertransference difficulties encountered is the desire to cure the patient quickly, which leads the therapist to begin "overfeeding" the patient by introducing too many interpretive interventions too soon. As Reich and Cierpka (1998) cautioned, interpretations and confrontations may be handled in a bulimic way by greedily consuming but not properly digesting them. A self psychologically based empathic approach in which interpretation is postponed appears to help many bulimic patients. In a randomized controlled study of self psychological therapy versus cognitive orientation treatment, 4 of the 8 bulimic patients treated with the former intervention remitted, while only 2 of 10 treated with the cognitive orientation treatment did so (Bachar et al. 1999).

Dynamic group psychotherapy may also be a useful adjunctive treatment. A growing empirical literature testifies to the efficacy of group psychotherapy for patients with bulimia nervosa (Harper-Giuffre et al. 1992; Liedtke et al. 1991; Mitchell et al. 1990). In a review of 18 different reports of this modality with bulimic patients in an outpatient setting, Oesterheld et al. (1987) found reason for guarded optimism. The consensus was that group psychotherapy effectively reduced bulimic symptoms by an average of 70%. However, these figures appear inflated because most studies excluded dropouts from their calculations. Dropout rates tended to be high even though most groups had excluded patients with borderline

personality disorder and other severe character pathology. Long-term follow-up data were also lacking. The group therapists appeared to agree, much as did the individual therapists, that a stable remission requires both insight and symptom control.

In summary, the indication for a dynamic approach to bulimia nervosa is a lack of response to time-limited psychoeducational and cognitive-behavioral methods. Family interventions in the form of support, education, and possibly family therapy are also generally necessary. Some form of symptom control is required in conjunction with the other approaches. Brief hospitalization, support groups such as OA, and group psychotherapy can all assist the patient with symptom control. Some individual psychotherapists also consider symptom control as part of the treatment process. A substantial subset of bulimic patients with associated severe character pathology, suicidal tendencies, and propensities toward life-threatening electrolyte disturbances will require psychotherapy in the context of long-term hospitalization. These patients defy the most diligent efforts of treaters to structure their lives. They seem bent on a self-destructive course that may indeed be fatal without extended hospital treatment.

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