EATING DISORDER TREATMENT

A Dissociative Perspective

Mark F. Schwartz D.Sc

Monterey, CA

Harmony Place Monterey

mschwartz@harmonyplacemonterey.com

831 747 1727

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INTRODUCTION

"There is a pressing need to develop more effective treatments for adults with Anorexia Nervosa, because their outcome is poor."

Fairburn, 2005

The Long-Term Course of Severe Anorexia Nervosa

Analysis of Recovery, Relapse, and Outcome Predictors over 10–15 years

Years	Partial	Full
2	10%	0%
5	55%	18%
7	74%	59%
10	84%	73%

Strober, M., Freeman, R., Morrell, W. (1997). The long-term course of severe anorexia nervosa in adolescents: Survival analysis of recovery, relapse, and outcome predictors over 10-15 years in a prospective study. International Journal of Eating Disorders 22,339-360.

How is Recovery Measured?

Recovery is not just the absence of symptoms. It is the presence of a full life, as evidenced by the ability to be human. A truly recovered life will reflect spontaneity, freedom, the ability to breathe, to have wants, needs and desires — knowing that the quest for perfection is an unattainable illusion. It's the ability to embrace the feminine, having close intimate relationships, and it's being aware of the tears in your eyes (whether out of intense or subtle sadness — or out of joy – of from a flicker of utter gratefulness) and then to allow your tears to flow freely. It is a life in which decisions and choices are made more from self and less from a shame- or fear-based prison. It is a life where you fully experience pleasure, joy, and passion and believe and know it is good to desire and enjoy sex.

Eating Disorder and Axis II

Data raises the questions about the extent of which Axis II is adequate for describing clinically meaningful patterns of personality pathology, at least for women with eating disorders. Patients in the high-functioning/perfectionistic cluster generally lacked diagnosable Axis II pathology; indeed, in our study (as in other studies that have isolated at similar cluster), they were defined by the absence of such pathology. These patients are articulate, conscientious and empathic, and they tend to elicit liking in others. Yet, they clearly have personality pathology, *ie., enduring, problematic patterns of thought, feeling, motivation, and behavior*. They are self-critical, perfectionistic, competitive, anxious and guilt-ridden, and these aspects of their personality requires clinical attention.

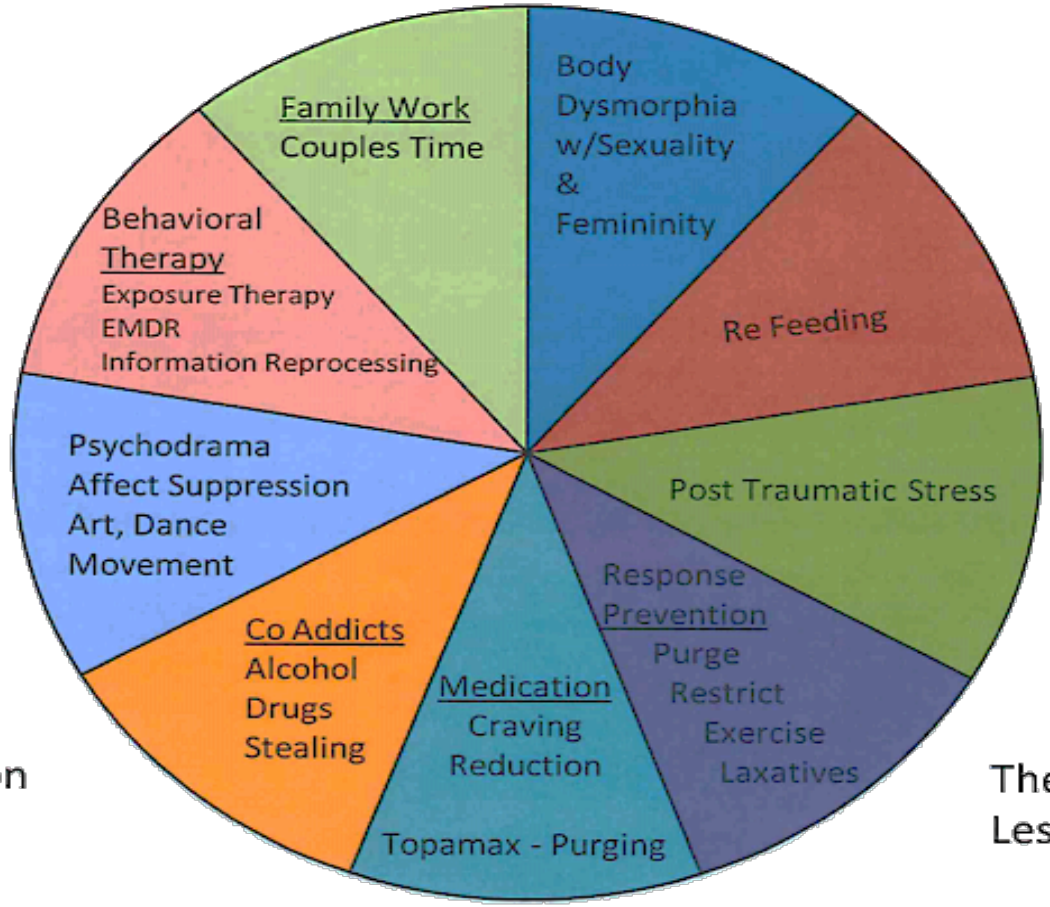
Treatment of ED Premises Philosophically

1. Different developmental trajectories
2. Symptom has developed as a survival strategy
3. Symptom is logical, rational, and adaptive
4. Symptom remission is dependent on understanding the logical development and allowing for a more optimal solution

SELF-INJURY (David Calof, 1991)

- Self-injury is the container for unmetabolized traumatic stress and underlying unresolved trans-generational trauma and loss.
- Self-injurious, destructive behavior is functional and is always an attempt to protect the client (system).
- Expresses (communicates) underlying dynamics and needs and is "trance logical" ("hurting releases pain")
- Because behavior is dissociated from sensation, affect and knowledge, linkages to specific meaning, function or intent, will typically be unclear.

Eating Disorder



Relapse Prevention
Urge Rehearsal

Then Stepdown with
Less Structure

Psychiatric Comorbidity
Depression, Obsessive Compulsive Disorder, Social & Generalized Anxiety

An Eating Disorder is...

1. A way to provide predictability and therefore comfort…
2. Inability to express internal distress to others…
3. Way to shout for help…
4. Way to get love and attention…
5. Fear of growing up and assuming adulthood…
6. Not having an identity, an anchor…
7. Not having the structural capacities to make it as an adult…
8. Fear or overwhelming terror to be…
9. A manifestation of unresolved trauma…
10. Provides consistency in life transitions…
11. A manifestation of parent's unfinished business…
12. A way of separating from mother and father…
13. Numbing…
14. A way of staying connected to mother to protect her from her own emptiness…
15. A substitute for love…
16. A way to function without feeling…

An Eating Disorder is...

1. A good girl's way to rebellion…
2. A manifestation of cravings due to inner emptiness…
3. A relief for depression…
4. A way of coping with loneliness – a substitute relationship…
5. A solution to internal double binds – I must be, I can't…
6. An escape from requiring perfection…
7. A need to care for a parent and simultaneously to escape…
8. A way to be out of control without appearing so…
9. A susceptibility to influence and needing to please people, while people reject you and are never pleased…
10. An Obsessive-Compulsive Disorder…
11. The manifestation of an insoluble double-bind…
12. Having something that is one's own that no one else can touch…
13. A protection from feeling out of control…
14. A need for fathers' presence…
15. Maintain a child body…
16. A sacrifice of authentic needs and desires in order to seek illusion of ideal…
17. A way to cope with or cover up other horrific intrusive thoughts or memories…
18. An attempt to waste away…
19. An attempt at acquiring perfection…

Eating Disorder as a Disorder of Attachment and Intimacy

TWO YEARS — Part 2

The mother of the anxiously attached children, by contrast, seemed unwilling or unable to maintain an appropriate distance. Some became intrusive and made it impossible for the child to have his own experience. "They couldn't tolerate the child having any frustration," Albersheim says. "They would just get in there and almost solve the problem for him, because it was too painful for them to watch the child struggle. But if children don't get to struggle a little bit – and be able to see that either they can accomplish it or that they need a little help, and to be able to figure that out on their own. If that's interfered with, it's a real loss for the child."

Karen, R. (1994). Becoming Attached. New York: Warner Books

Stern's Work — Part 1

Mollys mother was controlling in a different way. She constantly told Molly how to play with toys ("Shake it up and down – don't toll it on the floor"), and in effect, rode rough-shod over Molly's natural rhythms of interest and excitement. Her exertion of power over the baby was such that Stern and his colleagues often experienced a tightening knot of rag in their stomachs as they watched the tapes. Molly's solution was compliance: "Instead of actively avoiding or opposing these intuitions," Stern wrote, "she became on of those enigmatic gazers into space. She could stare through you, her eyes focused somewhere at infinity and her facial expressions opaque enough to be just uninterpretable and, at the same time.. By and large, do what she was invited or told to do. Watching her over the months was like watching her self-regulation of excitement slip away."

Karen, R. (1994). Becoming Attached. New York: Warner Books

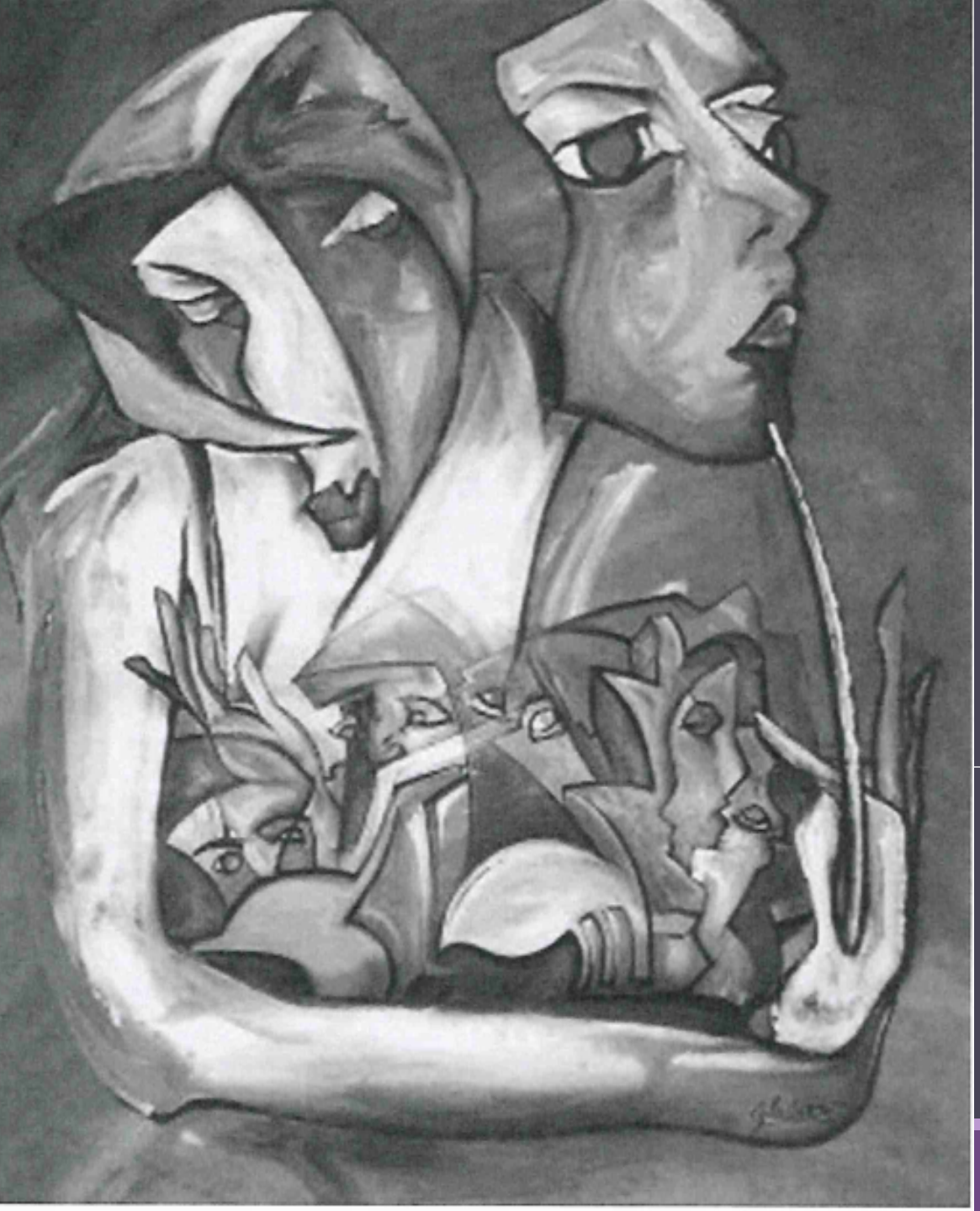
STERN'S WORK – Part 2

Such manipulative misattunements take many forms and are, Stern argued, the likely origin of later lying, evasions, and secrets. The child, and later the adult, comes to feel that if people are allowed access to his true inner experience, they will be able to manipulate it, distort it, or undo it. Only by freezing them out can he keep his inner experience unspoiled.

- Karen, R. (1994). Becoming Attached. New York: Warner Books

Constant misattunement, neglect and abuse at the hands of family members cause the child to split off experiences, relegating them to inaccessible parts of self. The person's sense of self becomes corroded with inner badness and is hidden.

This leads to an attempt to present a socially acceptable persona with compulsive efforts for achievement and an idealized body.



DISSOCIATION

Case reports of dissociative symptoms and high levels of ‘hypnotizability’ in patients with eating disorders led Demitrack et. Al (1990) to investigate dissociation levels in anorexic as well as bulimic subjects. They found that both groups produced substantially higher overall DES scores compared with a group of age-and-sex-matched control subjects.

DISSOCIATION and FOOD

Food is not simply a symptom to be gotten rid of, but rather holds dissociated parts of the patient's self and relational history. Food is the most significant relationship in an eating disorder individual's life. The symptoms have lost connection to the problems, and vulnerabilities that stimulated their onset and have taken on a life of their own. They are now ingrained habits with their own rhythms and expression – *ie. valued friend/secret companion.* This lessons anxiety, becomes a strict task-master or abusive tyrant that punishes transgressions. The Therapist cultivates curiosity, finding and connecting parts of the patient that have been disconnected so long.

REPETITION

Repetition of trauma is less a compulsion to repeat what is unresolved and more a need to make sense out of disparate elements of experience using the only means available, when thinking and feelings are blocked by dissociative process

DISSOCIATION

- Early dyadic processes lead to a “primary breakdown” or lack of integration of a coherent sense of self*, ie. Unintegrated internal working models.*

- Disorganized Attachment is the initial step in the developmental trajectory that leaves an individual vulnerable to developing dissociation in response to trauma.

Liotta, 2000

PATHOLOGICAL DISSOCIATION

Four characteristics distinguish pathological from normative dissociation: Only in pathological dissociation do we encounter loss of executive control, change in self-representation, amnestic barriers, and loss of ownership over behavior.

Kluft, 1993

Denying the client's subjective experience of split-off-parts or selves, some therapists insist there is one true self and any other presentation of the client is untrue. This insistence is counter-transferential and prevents empathetic connection with the client, and thus blocks therapeutic action.

Saakvitne, K. (1995). Therapists responses to dissociative clients: Countertransference and vicarious traumatization. In L. Choen, J. Berzoff & M. Elin, (Eds.), Dissociative Identity Disorder, Northvale, NJ: Jason Aronson, Inc.

Consensus Proposed Criteria for Development

- Self and Relational Dysregulation. The child exhibits impaired normative developmental competencies in their sense of personal identity and involvement in relationships, including at least three of the following:

1. Intense preoccupation with safety of the caregiver or other loved ones (including precocious caregiving) or difficulty tolerating reunion with them after separation.
2. Persistent negative sense of self, including self-loathing, helplessness, worthlessness, ineffectiveness or defectiveness.
3. Extreme and persistent distrust, defiance or lack of reciprocal behavior in close relationships with adults and peers.
4. Reactive physical or verbal aggression towards peers, caregivers, or other adults.
5. Inappropriate (excessive or promiscuous) attempts to get intimate contact (including but not limited to sexual or physical intimacy) or excessive reliance on peers or adults for safety and reassurance.
6. Impaired capacity to regulate empathic arousal as evidenced by lack of empathy for, or intolerance of, expressions of distress of others, or excessive responsiveness to the distress of others.

The National Child Traumatic Stress Network (NCTSN)

Therapy: Self Integration

If ego states are split off, projected, rejected, indulged or otherwise unassimilated, they become black holes that absorb fear and create the defensive posture of the isolated self – unable to make satisfying contact with one's self or other. When split-off ego states are made conscious — accepted and tolerated or integrated, the self can be at one, and compassion be released.

Therapy involves helping the client reclaim parts of self that were sacrificed to gain safety.

In therapy, we create a context and relationships where pain, anger and difficulty can be safely acknowledged while maintain a connection.

RECOVERY PART

- Capable
- Creative
- Compassionate
- Self Love!
- Connected
- Clear
- Courage
- Curiosity
- Tolerant
- Acceptance
- Strength
- Confidence
- Trust

Critical Part

- Comparing myself to unrealistic/impossible standards.
- I criticize for criticizing myself
- You can't recover!
- I'm dead
- Failure
- You're worthless
- You'll always be rejected
- Be thin again
- My dreams will never come true
- Disgusting
- Stupid
- No success
- Disappointment
- Be perfect
- Therapy is not working
- You'll never be happy
- You're a failure
- I hate myself!
- Insecure
- Why did you give in?
- Comparing
- Bottled up
- I want to kill myself!
- I always quit
- Unworthy
- Don't exist
- No help! No support!
- I can't recover
- Suffer!
- Self is never accessible and never will be!
- You're pathetic
- FAT!
- YOU WILL NEVER RECOVER!
- Hurt
- Nobody cares
- Unappreciative
- I hate myself!
- Depression
- Pesticides
- Errors
- You'll never go to college
- Why?
- Too judgmental
- Intoxicated
- You will never recover!
- You should of...
- Will I...
- Too hard for you to handle!
- Toxic
- I'm hopeless
- You're not capable
- Why did you trust?
- You're a piece of shit
- Mistakes
- Don't let anybody in
- Never accept yourself
- Be miserable.
- INSANE
- You'll never travel the world.
- You'll always have ED
- TOO HARD!
- Helpless
- Fuck me and everyone else!
- UGLY
- Exposed
- No progression
- Empty
- How dare you let go of your restrictive side!
- Incapable
- Don't motivate
- Nothing pays off
- I have to live up to certain standards
- Mentally ill
- Get it right!
- Pointless
- Additives
- Pessimistic
- I don't care
- Uncontrollable
- Kill yourself!
- Inadequate
- Nothing's working
- End your life
- You're going to become obese
- SHAME
- Criticism
- Don't upset people
- Humiliation
- Vulnerable
- I have no capacity of succeeding in the future!
- I can never change
- Pollution!
- Too difficult
- Fake and unreal
- Ostracized
- No risks
- Poison!
- You'll always be lonely
- Liar!
- Prison
- Lazy
- You'll never have sex
- Graduate? No!
- Why bother?
- Suffer!
- PAIN
- Preservatives!
- Feel worse
- Push away
- Artificial
- Everything and everyone will reject you
- Artificial
- Nothing pays off
- Sink!
- There's no way out
- Isolate
- Anger

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KOHUT

Self-cohesion requires the presence of others (self-objects). The relationship between the person and the other is the "source" and the transitional object allows for symbolic representation.

The need for the experience of self-objects is never ending.

A weak self is therefore the result of faulty self-object experiences.

Structural Deficits

There is good reason to believe that large segments of the population lack may critical capacities, such as self-observing abilities, necessary for mental health, and that even patients who have them, have them only in part. These capacities which can be called “structural capacities” (Greenspan, 1989) have to do with critical abilities such as self-regulation, relating, presymbolic-affective communicating, representing and differentializing experience, representing internal experiences and self observation.

From Greenspan, S. (1997). Developmentally Based Psychotherapy, Madison: International Universities Press, Inc.

Eating Disorder as a Trauma-Bond

Every deep desire, every powerful emotion, gives a trail into the unconscious. Usually there is only one-way traffic: outbound, toward the world of sensation and action. But we can follow the trail to its source by going against the current. With this desire to go against desire, to buck the demands of biological conditioning, the journey of self-realization beings in earnest.

Meditation in Action
Eknath Easwaran

Re-Framing the Meaning of Symptoms

- Start with the assumption that every symptom is a valuable piece of data!
- Use psychoeducational material to make educated guesses about the meaning of symptoms, as a symptom-memory or a valiant attempt to cope.
- Ask her "How would this ____ have helped you to survive in an unsafe world?" "Helped you feel less overwhelmed? Less helpless? More hopeful?"
- Look for what the symptom is still trying to accomplish: *i.e.*, chronic suicidal feelings might offer comfort or a "bail-out plan;" cutting might help modulate arousal; social avoidance could be an attempt to avoid "danger."
- Once it is clear what the symptom is trying to accomplish, then the therapist and the patient can look for other ways to accomplish the same goal in a context that describes the patient as an ingenious and resourceful survivor, rather than as a damaged victim.

Failed Protectors

Where the ‘part’ got the idea that it had to coerce and shame her into dieting, working, being nice? Perhaps a parent monitoring and scorning, or a ‘part’ like a single parent... These are inner censors and tyrants that control us, keep our noses to the grindstone, and will not risk any behavior that brings us the slightest embarrassment.

Compassionate Witnessing

This occurs when the Self of the client is able to witness the stories of parts from a compassionate position. Ask the client to identify an activated part (usually associated with extreme behaviors, thought or feelings). Ask the client where in the body the ‘part’ is, (position of Self), this indicates that another ‘part’ is blended with the Self. Ask the blended part to please step aside and let the Self work with the ‘activated part’. (This may include asking more than one ‘part’ to step aside).

RECOVERY

“Faith is taking the first step even when you don’t see the whole staircase.”

— Martin Luther King, Jr.

Eating Disorder Takes Away…

- ✓Ability to be human (stay out of your body!)
- ✓Voice
- ✓Ability to be in your body
- ✓Breathe
- ✓Pleasure
- ✓Joy
- ✓Spontaneity
- ✓Allowance to have needs, wants, and desires
- ✓Passion and vibrancy
- ✓Balance
- ✓Intimacy with self and others…
- ✓Resulting in the loss of self, loss of the soul and spirit

Writing | Journaling

1. Your worst eating-disorder day
2. Using a journal entry or intense situation, follow the thoughts and map out the feelings and triggering event

It Is About the Food!

- ✓ Deconstructing the meaning of food
- ✓ Write, in detail, a description of your addictive behaviors
- ✓ Have a meal with your client
- ✓ Explore ways of allowing self to taste, enjoy, desire food.

WRITING ASSIGNMENTS

- Dialogue with “fat”
- Have family members write why they believe client has an eating disorder
- Letters: to ED, to the body, from the body
- How does the way you relate to food resemble how you relate to people?
- Have the eating disorder write and introduce itself: likes, dislikes, values, fears, hopes, and goals
- What will your life look like in 5 years…?
- What did you learn in your family about food, body size, femininity, and feelings?

Eating Disorder Patients Experience of Recovery

- Realistic appraisal of medical dangers
- Improvement in the care of self (e.g. eating habits, use of leisure time)
- New ways to self-soothe, self-regulate
- Ability to access social support from family, friends, and fellow patients
- Enhanced problem-solving skills
- Improved capacity to invest in and work on interpersonal relationships
- Gradual relinquishment of ED identity and eating disorder thoughts (*e.g. "this food will make me fat," "I'll feel better after I eat this package of cookies, etc.*)

Eating Disorder Patients Experience of Recover

- Ability to take responsibility for self and eschew victim mentality
- Establishment of a sense of “true self,” “real me,” or “knowing who I am.”
- Capacity to formulate goals, tolerate setbacks, yet maintain positive motivation to get better
- Reclamation of the sense of one's personal power
- Decrease emphasis on perfectionism
- Firmer Interpersonal boundaries; enhanced capacities to set appropriate boundaries
- Cultivation of sense of purpose, of meaning in life

Earned Secure Attachment and Eating Disorders

She just gets. . . mad at me, sometimes mean to me, a little bit, but um, not in a real bad way, and then it blows over. But it could get difficult she was kinda bad sometimes..uh, difficult to be, for her, to...for me also to be around her. . . . . .

And finally, your last word was happy. Uh, does a particular memory or incident come to mind there with respect to your relationship being happy?

Yeah, uh, she loves cooking, and when she had a chance to cook, that made her very happy and, and I was very happy because she was happy at those same times. She isn't really a good cook, I mean, the food was actually not all that good but it was wonderful to be cooked for and to be cared for in that way, I think, the way she cared for me back then. Uhm, let me see, I don't know, it's, you know how everybody has little idiosyncrasy things *(sure)*, well, uhm, she likes to go out and do things *(Uh huh)*. Just a couple of months ago, there was a, some people came into {{Place 2}}, *(Uh huh)* and uh, they have to go and do this sort of thing. But she is, uh, --I don't know, every time like, a Mother's Day comes around, or a birthday or something, I do something, or make a little present and send it to her, and, she, I mean I'm not always able to be there anymore when she gets it but she will just light up, and-- *(Uh huh)* I like to think how her face will light up. Just a really happy person...

Well, that's good, thank you. Uh, do you have another memory where you felt your relationship was happy?

A specific time. . . . . {9 secs} yeah, I had been crying a lot--um, I was mad about something. . . {3 sec}. Uhm, she had maybe left the room too early for me, or something? *(Um-hm)* And she came back--and--stayed there for maybe 2 hours, and it was a very happy feeling.

4, 5. My next questions would have been about your father in the same way, but I am wondering if you in fact have any memories of him?

. . . . . {10 sec}. Uh, no. He died when I was tiny.

M x loving

Can't score for M loving M happy when cooking but no direct connection to Lucinda.

(M loving)

} X relevance. Asked about past, answers in present.

... #8:3.5 Corrected. Note S does not complete sentence with "its natural ending here (uh, difficult to be around her") but runs away to difficult for M.

~~~ ! Minor oscillation?

} Somewhat hallowed sense of past.

1, # 3: 5 ...

... # 3:7.5. No referent, nothing like an etc.

X relevance. Moved to M being happy in the present

? How can S know this

Note: "Happy" describes M chiefly, and M being happy makes S happy. S then moves completely into present.

(+ good illustration)

} but ends up with vague, childlike voice.

... #7:5? Unusual speech for adult in this context.
~~~

EXPERIENCE SCALES (1-9)

1. LOVING —
   - Memories of special and tender concern and soothing when ill
   - Memories of having done something bad, expecting to be punished, parent's caring and forgiven
   - Memories of having done something perceived bad by teachers, etc. and supported by parents
   - Memories of childhood fears and being comforted
2. UNLOVING –

(3) Instrumental attention

(5) Present occasionally

(7) Good-enough parenting

WHAT IS LOVE?

TURN CHILD TO OBJECT

EXPERIENCE SCALES (1-9)

REJECTION —

- Turning back on child's dependence, affection, attention, need and attachment
- Speaker avoids discussing relationship with parent on emotional terms
- Speaker reports rejection of siblings
- Speaker recalls favorite towards siblings
- Speaker describes being “spoiled rotten” by parent
- Speaker described self as favorite and others rejected
- Fear parent would leave
- Overtures to parent rejected

(3) Mildly rejecting of attachment, aloof, “differentially showing me love”

(5) Child seldom given encouragement

(7) Parent mad when child sick misses' graduation

(9) Wishes child was not born

WHAT TO LOOK FOR
iN AN INTERVIEW

EXPERIENCE SCALES (1-9)

INVOLVING | ROLE REVERSAL

- Making it clear that the child's presence is necessary for maintenance of own sense of self or well being
- (1) Parent looking to child for parenting
- (5) Parent is looking to child as substitute spouse
- (7) Parent depends on child's attention for safety
- Taking care of children seems a bit too much
- Parent confused or helpless; parent not a real adult
- Parent complains children are too much
- Parent afraid to stand-up to another person
- Child advises parent on how to behave as a parent
- Parent over-protective
- Parent martyr, guilt-inducing "child not loving enough" for parent
- Childis focused on pleasing parent
- Child felt guilty for bad grade, etc. "hurting" parent
- Child says, "I was my mother's" whole life
- Child remembers desire to protect parent
- Parent treats child a sa friend or spouse

SO IMPORTANT FOR INTERVIEW

EXPERIENCE SCALES (1-9)

NEGLECTING

- Parent inattentive and preoccupied, uninvolved or inaccessible
  - (Distinguish neglect from rejection: “He never had time for us” would be neglect)
  - (Distinguish neglect from role-reversal: “Parent was ill” can be neglect)
- Parent preoccupied with work, family, household
- Parent unable to spend time, because kids are too much for them
- Child remembers crying at night
- Parent always busy thinking of someone else
- Parent always with friends, at bar, etc.

EXPERIENCE SCALES (1-9)

PRESSURED TO ACHIEVE DURING CHILDHOOD

- Status or position overemphasized
- Over-concern with school performance with an emphasis on how it looks “regarding the family”
- High ratings when parents withdraw affection, when child fails to perform
- Child very anxious regarding report card
- Parent “pushed” child to care for self, and parent unloving
- Early excessive excellence stressed
- Child pushed to do adults work when young

Deconstructing Attachment

IMPLICATIONS OF PSYCHOTHERAPY

1. Idealization
2. Dismissing derogation
3. Lack of memory
4. Response appears abstract and remote from memories or feeling
5. Regard self as strong, independent, normal
6. Little articulation of hurt, distress, or needing
7. Endorsement of negative aspects of parent's behavior
8. Minimizing or downplaying negative experiences
9. Positive wrap-up
10. No negative effects
11. Made me more independent

Therapist Job with Attachment Trauma

1. Transformation of the self through relationship
2. Provide a secure base for exploitation, development, and change
3. Provide attunement in helping the client tolerate, modulate, and communicate difficult feelings
4. Affect-regulating interactions for accessing disavowed or dissociated experiences, strengthening narrative competence
5. Deconstruct the attachment patterns of the past to construct new ones in the present

See David Wallin, Attachment in Psychotherapy, Guilford Press, 2007)