The Contributions of Self Psychology to the Treatment of Anorexia and Bulimia

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The major contributions of self psychology to the treatment of anorexia and bulimia include: (a) the unique therapeutic stance of the therapist as a selfobject who tries to empathize with the patient from an experience-near position; (b) the conceptualization of food as fulfilling selfobject needs; and (c) the respect that the theory attributes to the significance of the symptoms for the patient.

SELF-PSYCHOLOGICAL STANCE

The theoretical conceptualizations of self psychology and the ensuing implications for the therapist's stance open up new opportunities for the treatment of anorexia and bulimia.

This article will outline opportunities and dilemmas that ensue from the application of this most modern development in psychoanalytic therapy. Clinical vignettes will illustrate the approach.

The fragility of the anorexic or bulimic patient and her** tendency to ignore her needs, feelings, and interests, necessitate the application of a psychotherapeutic approach that will not impose an interpretation "from without," but rather experience-near "from within" attunement to the patient. Self-psychologically informed therapists, more often than traditional therapists, slip from free-floating attention to the patient into special attention for vicarious introspection into the patient's sense of self. Special attention is given to the patient's experience of the therapist's impact on the patient's sense of self.[1]

According to Wolf,[2] the patient in therapy with a self-psychologically oriented therapist feels that the therapist maintains an attuned stance rather than an adversarial one. The patient experiences the therapist's neutrality as benign, that is, the therapist is affectively on the side of the patient's self

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**Since the vast majority of anorexic and bulimic patients are female, I will refer to the patient in the feminine form.

without necessarily joining the patient in all of his/her judgments. The therapist, according to Kohut,[3] sees him/herself as being simultaneously merged with, and separated from, the patient.

The stance of the self psychologist is sometimes mistakenly thought to be supportive or sympathetic, as if the therapist were supposed to be kind and gratifying, to substitute in the here-and-now for the deprivation that the patient had suffered in early development. Self psychology does not assert that by providing corrective emotional experience in the here-and-now, the deficits can be repaired or filled in. The activity of the therapist that enables the mutative process of the restoration of the self involves the awareness of the therapist of failures in being empathic to the patient's needs. Provided the therapist succeeds in establishing an empathic milieu, these failures will not be harmful. The therapist's ability to analyze them in the transference is what brings about the transmuting internalization: the taking over by the patient of functions of the self that the therapist fulfilled for the patient.

In infancy and childhood, children do need to be mirrored, to be looked upon with joy and basic approval by delighted parental selfobjects. The role of the therapist is to create the proper ambiance for mobilization of the patient's demands for mirroring and the free expression of these demands in the session. The self-psychologically informed therapist meets these needs by acknowledging and attempting to understand the patient's feelings, wishes, thoughts, and behavior from the patient's perspective (vicarious introspection-empathy) before proceeding into the interpretive work. The therapist does not actively soothe or mirror. He understands, acknowledges, justifies, and interprets the patient's yearning for soothing and confirming responses. The therapist does not actively admire or approve of the patient's grandiose experiences, but, knowing their crucial role in normal development, explains to the patient their role in the psychic equilibrium.

Kohut[4] divides the psychotherapeutic work into two phases: the empathic mirroring phase (understanding), and the interpretation phase (explaining). He suggested that there are patients with severe disturbances of the self with whom the whole therapeutic work can be done in the first phase. For eating-disordered patients, staying in this first phase of empathic mirroring is of crucial significance. These patients rarely have been understood and accepted for what they are.[5] Interpretation for these patients can be experienced, especially at the beginning of therapy, as imposing something from without.[6]

The unique therapeutic stance of selfobject bears great significance for

this crucial therapeutic issue of interpretation being experienced from without or within.[7] In order to fully understand this stance, an explanation of self and selfobject is needed.

Self is the center of the individual's psychological universe. It is what we refer to when we say, "I feel" such and such; "I do" such and such. The healthy human self is experienced as a sense of wholeness, aliveness, and vigor, an independent center of initiative over time and through space. This is the essence of one's psychological being.[8]

When individual A refers to another individual B and needs and expects B to fulfill for A an internal need that A cannot fulfill for him/herself, we can, in the language of self psychology, say that A refers to B as a selfobject. A on that occasion expects B to behave as if B were not an independent center of initiative. In other words, the term "selfobject" refers to that dimension of our experience of another person that relates to that person's function of shoring up our self.

The internal needs of the self that we have been referring to are the needs for self-esteem, regulation of emotions, calming, soothing, and a feeling of continuity over time and space. The healthy self can, to a great extent, internally regulate self-esteem and can calm and soothe itself. A healthy self maintains a sense of consistency, cohesiveness and clarity of patterns of experiences and behaviors even if faced with considerable stress. In the course of such healthy functioning of the self, others may serve as selfobjects, but in a mature and limited manner.

Self psychology[9] stresses that even healthy and mature individuals do require that their internal self needs will be met, at least partially, by selfobjects. However, their reliance upon such selfobjects is flexible and mature, i.e., they can endure and even outgrow failures of such selfobjects. The unhealthy self, on the other hand, is dependent, to a great extent, sometimes desperately and totally or archaically, on selfobjects to do what the underdeveloped self cannot do.

The emergence of the self in childhood depends upon appropriate selfobject experiences. The therapist, in treating patients' disorders of the self according to self psychology, renews the growth of the self by serving as a selfobject to the patient. He emphasizes more and stays longer in the first stage of therapy, the phase of empathic understanding, than the traditional therapists (as suggested by Kohut[9]), before proceeding onto the explaining phase (the phase of interpretation). The therapist acknowledges the patient from the patient's unique perspective and by interpreting "from within" rather than "from without,"[7] evokes in the patient the selfobject experiences and renews the growth of the self. An essential element in this process

is the therapist's awareness of potential retraumatization in the transference caused by the therapist's empathy failures. The therapist conveys to the patient his/her special awareness of his own repeated potential failures by interpreting them to the patient.

Barth[5] described how eating-disordered patients lacked much of that feeling of being understood. She described how they lacked experiences of someone making an active effort to understand their perspective. She vividly describes sessions with eating-disordered patients in which, whenever the patient felt that the perspective of the therapist was different from hers, she felt criticized and diminished. When therapy progresses, patient and therapist learn to identify where the therapist deviates from the patient's perspective. Patients in advanced stages of therapy can talk about their hurt feelings rather than trying to restore a sense of cohesion through bingeing and vomiting.[5]

ANOREXIA AND BULIMIA AS DISORDERS OF THE SELF

Self psychology views eating disorders as disorders of the self. The core of this conceptualization of the disorder and its cure is that bulimic and anorexic patients cannot rely on human beings to fulfill their selfobject needs. Rather, those patients resort to food to fulfill these needs.[5,10–12]

Kohut[9] initially described two main selfobject needs: (a) mirroring selfobject needs and (b) idealizing selfobject needs.

The *anorexic* patient derives her satisfaction for selfobject needs through food, mainly through *mirroring* selfobject experiences. Her need for grandiosity is met not by admiration or approval from her fellow human beings, but rather from her own notion that she possesses supernatural powers which enable her to avoid food. Everyone who meets anorexic patients becomes acquainted with their feeling of great triumph that comes with every pound they lose. The elimination or the ignoring of this substance, "food," fulfills mirroring selfobject needs.

The *bulimic* patient derives satisfaction of her selfobject needs through food, mainly through *idealizing* selfobject experiences.[5,12] Food is experienced by her as an omnipotent power: it supplies soothing, calmness, and comfort and regulates painful emotions like anger, depression or shame and guilt.[5,12–14] Since food and the ceremonies around it are experienced as the main source for fulfilling selfobject needs, it is defended by her with much the same intensity that other people will adhere to a human selfobject.

Goodsitt[11] identifies in the anorexic patient an extreme manifestation of her inability to refer to human beings in order to fulfill her selfobject needs: she wishes to behave as if she were a selfless human being. In order to

insure her selflessness, she sticks to the position of fulfilling selfobject needs for others, primarily her parents. Clinging to this position of her being a selfobject to others serves as a barrier that keeps other people from being a selfobject for her. Her selflessness is expressed by her ignoring even her basic needs, such as nutrition and occupying space in the world. The typical observations of many parents of anorexics are, "She was our best child. She was obedient and never thought of herself and always was conscientious and aware of the needs of other family members." These observations ensue from the basic position of the anorexic as a selfless human being who devotes herself to the fulfillment of other's selfobject needs. The anorexic patient's great feeling of triumph upon losing more and more weight actually signifies that she is looking for ways to gratify her grandiose needs, and, hence, nourish herself; but the content that stands behind the triumphant feeling is again towards selflessness. This is because she is saying in effect, "I can be admired by my success in relinquishing myself."

Self psychology[10,12] assumes that eating disorders originate, like other disturbances of the self, from chronic disturbances in empathy emanating from the caretakers of the growing child. The uniqueness of eating disorders is that at some crucial point in her development the eating-disordered child, whose crucial narcissistic needs were not being met empathically, invents a new restorative system in which disordered eating patterns are used instead of human beings in order to meet selfobject needs. The child relies on this system because previous attempts to gain selfobject-sustaining responses from caregivers were disappointing and frustrating. Geist[10] maintains that the underdevelopment of the self is expressed as a central malignant feeling of emptiness. As a defense against this emptiness, according to Geist,[10] the eating-disordered patient organizes some control over the fear of emptiness through her symptoms. She controls the feeling of emptiness by ruthless, compulsive eating, or by creating "controlled emptiness" by vomiting or avoiding food.

In Geist's opinion,[10] eating is the most closely related activity to filling up or emptying and, therefore, food can become a reliable selfobject for the eating-disordered patient in dealing symbolically with this feeling of emptiness. Over this selfobject she has complete control.

Sands[12] adds another element to explain why food and eating behavior can serve as an attractive substitute for a human selfobject. Food is the first medium through which soothing and comforting experiences were transferred from parental figures.

Ulman and Paul[15] suggest that, as the bulimic patient does not think

that she deserves "indulgence," her vomiting is an attempt to magically undo this overindulgence, the binge.

Disturbed eating behavior affords the anorexic or bulimic patient some kind of autonomy over reliance on human selfobjects. It provides some defense against total fragmentation and disintegration. But as Levin[16] simply puts it in his self-psychological treatment of alcoholics, substance cannot fulfill adequately the missing functions of the self. Substance that is taken in must, of course, go out. Stable regulators can be built up only through transmuting internalization of self, selfobject relationships.

The aim of therapy is to reestablish in the eating-disordered patient confidence in the capacity of close human relationships to calm and mitigate dysphoric moods. For the therapist, such an endeavor requires special patience and effort and is very time consuming. The basic self-psychological assumption, as correctly stated by Sands,[12] is that if the therapist provides an empathic environment and analyzes the patient's fear of retraumatization in her relationship with the therapist, the archaic narcissistic needs will be mobilized into the transference. However, in eating-disordered patients this development is slow[12] because the archaic narcissistic needs have been detoured into the disturbed eating behavior and are not readily available to fuel selfobject transferences.

Differences from Borderline Personality Disorder

Geist[10] draws attention to the difference between borderline personality disorder and eating disorders with regard to this issue of object relations. Whereas the borderline patient can swing between feelings of anger, fantasizing about destroying the object, and great attraction towards and wishing to unite with it, the eating-disordered patient gives up the option of relating to human objects as a source of comfort, calming, and soothing. Perhaps Kohut's[4] distinction between symbiosis and selfobject ties can be helpful in clarifying this difference between the borderline and the eating-disordered patient. In symbiosis, the two partners reinforce one another. In self, selfobject ties, only one partner derives satisfaction of selfobject needs. According to self psychology, the parents of the eating-disordered patient failed to satisfy the selfobject needs of their child and used the child to supply their own selfobject needs. Therefore, the eating-disordered patient does not expect human beings to fulfill her selfobject needs. Conversely, because the future borderline patient is assumed to have been involved during his childhood in an intense symbiotic relationship with the mother,[17,18] the borderline patient is deeply involved in human relation-

ships, though unhealthy ones, with great swings between approaching and distancing.

The following clinical vignettes illustrate the issues aroused by self psychology in the treatment of anorexia and bulimia.

Problems for the Therapist to Feel Empathy

Many aspects of an anorexic's or bulimic's behavior are very difficult to empathize with, mainly the destructive parts. How can a therapist empathize with the great triumph that the anorexic patient feels when she loses more and more weight? True, neither a therapist nor a normal parent should or could empathize with every feeling or behavior of his patient or child, but a basic empathic milieu should be established in order to enable growth. Basic understanding and acknowledging of the patient's perspective should be given.

One therapist on our staff, recognizing the need of an anorexic patient to satisfy her need for grandiosity, told the patient, "For you losing weight is a great achievement, and even a triumph. It is a pity that no one else in the world can admire you for that." In a subsequent session, the therapist succeeded in conveying a message of experience nearness[7] to the patient through mentioning the tension between his responsibility for her health and her own perspective. He succeeded in doing this by telling her the following metaphor: "You are like the pilot who suffers from vertigo, who plummets towards the sea convinced that he is rising towards the sky. All his senses tell the pilot that he is correct and one can easily understand him, but I am in the control tower, warning the pilot that he is falling." Bombastic manifestations of the patient's grandiose self during a session is another example of a taxing challenge for the therapist who wishes to acknowledge the patient's perspective.

Vignette 1

B., a bulimic patient, told her therapist, "I'm so talented. My ideas are equivalent to those of the great philosophers. I am the best student in the whole school. I'm more original and skillful than my teachers." She went on complaining that her teachers do not appreciate her abilities, and that they lowered her marks because of simple mistakes. The therapist commented that she understands the patient's justifiable wish to be admired and added that it is a pity that teachers do not show the same efficiency in pointing out the merits of their students as they do when pointing out their shortcomings. B. went on, saying, "There is something maddening about teachers that do not look for the skillful aspects of their students."

Vignette 2

F., a 28-year-old lawyer, already free of bulimic symptoms in this phase of therapy, in a burst of grandiosity, demanded that the judge and the opposing lawyer dismiss themselves from a case because of their incompetence. She felt that they did not appreciate the merits and intellectual achievements that she had demonstrated in her logical arguments. The therapist knew that his patient's reaction of grandiosity was the result of a lack of confirmation and appreciation from her environment. He knew that to confront her with the harm that her grandiose self inflicts upon herself would not be curative. Yet, he felt that he could not empathize with her behavior on that occasion. The therapist solved this dilemma by referring to the tension between what he understood was the patient's need at that moment and his perception of reality by saying, "I am sure that at this moment you would have liked me to be on your side, like the child who returns home beaten and dejected after fighting with the other children. He needs his mother to calm him and not to investigate what his part in the fighting was." While admitting the potential empathy failure, the therapist pointed out the discrepancy between F.'s need for total approval from him and then mentioned the elements of her behavior that were not to be investigated at that time. Perhaps curiosity was mobilized in the patient because F. said, "Specifically it is about my academic merits that I cannot stand criticism or even a lack of appreciation." The therapist confirmed this observation warmly, connecting it to the circumstances of her childhood that rendered this area of her life very vulnerable.

Vignette 3

G., a bulimic patient in her mid-20's, is recovering from her long-term bulimia and is now in the phase of her first attempts to relate to human beings in the hope that people, rather than food, will fulfill her selfobject needs. G. persistently required that the therapist adopt her viewpoint and judgment and vociferously condemned his inability to do so. "I want you, I need you to be happy with the emergence of my femininity. I need you to be happy with my new love affair." Noticing the ambivalence of the therapist, she went on to say, "Even though it might seem to you like another dangerous relationship with a married man, I need your approval and your joy about it. Through this relationship, my femininity will flourish and perhaps there will develop in the future a more stable relationship with a man. Right now I don't need your interpretations about my compulsion to repeat the painful abandonments of my father through these relationships." The therapist, knowing, on the one hand, the potential growth experience

of this relationship, but seeing, on the other hand, the destructive elements of this man's questionable intentions, managed to say, "I do know how important it is for you that I be joyous and approve of this relationship, but I want to be on the side of all your parts; for example, the part of you that also sees the broader picture of this relationship." She replied, "Put aside for a moment that part and join in my happy and flourishing femininity." When the therapist could not fulfill this well-articulated wish of the patient, she said, "It seems to me that you are stuck. Go and get some supervision."

Vignette 4

The therapist failed to empathize with the self needs of D., her 24-year-old bulimic patient. D. had devoted all her life to serving as a selfobject for her disturbed mother and for her younger brother. Only in her latest relationship with her boyfriend could D. enjoy fulfillment of her selfobject needs. But as is the case with many eating-disordered patients who begin to rely on human beings rather than food as providers of selfobject needs, she had related to him in a somewhat bothersome and exaggerated manner. After a period of several months, the boyfriend complained, "I am there for you, but you are not there for me." He claimed that she does not listen to his needs. The therapist, on that occasion, aware of the truthfulness of the boyfriend's claims, pointed out to the patient the reality-testing aspects of her behavior. Perhaps the therapist was eager to keep the relationship of the patient with her boyfriend from being destroyed. But in supervision, therapist and supervisor felt that the patient's self-needs required more attention and empathy than the judgment skills of her ego. The therapist, then, in a subsequent session, said, "How painful it is for you to see that even in this relationship in which you just wanted to be cared for and listened to by another, you are also required to listen to his needs."

Counseling parents of anorexics and bulimics poses a special challenge to the therapist. The self-psychologically informed therapist wishes to understand and stay with the subjective experiences of the parent. This is a very crucial step because these parents suffer from their own narcissistic deficiencies. Understanding and acknowledging their perspective not only is necessary for handling their deficiencies, but also provides them with appropriate modeling for instances when they try to be empathic with their daughters' subjective experiences. Staying, however, with their subjective experience and acknowledging it may make the therapist feel that at least temporarily they are doing it at their daughter's expense.

Vignette 5

J., an archeologist, the father of a 16-year-old anorexic girl, is a vivid example of this. During a vacation, both his daughter and his wife requested that the three of them take a trip into the countryside. The archeologist agreed but suggested that they travel to the hills where the site of his present excavation was located. The daughter insisted upon traveling anywhere but to the excavation site. The father's immediate reaction was to become furious. The family remained at home in a depressed mood. During the parent counseling session, the father was told that his daughter apparently wanted assurance that he would be ready to give up his own interests for the sake of the family's enjoyment of their trip. "True, hills are hills everywhere," agreed the therapist with the father's claims, "but your daughter wanted proof that you are ready to devote time and interest to her and to the family by your putting aside your work." The parent counselor went on to say that perhaps the daughter was able to articulate such a wish due to her therapy. The father seemed to show an understanding of this new way of thinking and looking at things. Then the therapist spoke of how difficult it is for this father to act on what he now understands and perhaps wishes to do for his daughter, namely, to give up, even for a while, his own needs and interests for the sake of fulfilling hers. The parent counselor had known the family history of the father, whose parents had caused him great suffering by constantly ignoring him and his needs. The counselor said, "I know that after so many years of putting aside your interests and your wishes, you cannot afford once again, even temporarily, to put them aside." The father, moved by the therapist's empathy, burst into tears. "Do you believe," he asked, "that this new awareness in me will help me, even to a small extent, to curb my outbursts?" "Not really," answered the therapist, "and certainly not very soon. But when outbursts occur, you will be able to understand what happened and settle matters more quickly."

EMPATHIC UNDERSTANDING

It is essential for the self-psychological viewpoint that the therapist adhere to a "from within" experience-near stance, rather than offering an experience-distant interpretation "from without."

The following vignettes describe a situation in therapy in which the patient could have been approached by interventions that can be regarded as experience near, (experience by the patient near to his subjective experience), or experience distant. In the following three vignettes, the therapists found themselves giving interpretations that can be regarded as experience distant, interpretations "from without."[7]

Vignette 6

The female therapist came from a Kleinian background and had recently gained acquaintance with self psychology. The improvement in L., her patient, subsequent to her shift in theory, was very substantial.

L., a 27-year-old bulimic patient., was enthusiastically and with great joy telling of a new boyfriend who, she had thought, was not interested in her, but was now calling and courting her. The therapist intervened and commented upon L.'s way of speaking: "You are talking quickly, like the way you eat. In both cases, you do this in order to cover up deeper feelings of sadness and anger." L. abruptly stopped her cheerful story about the new boyfriend and a few minutes later burst into tears.

Discussing this incident with the supervisor, the therapist explained that she had reached the conclusion about the patient's anger because she, herself, could not trace her own anger and wondered whether it came from the patient through projective identification, (a remnant of the therapist's previous Kleinian training). The supervisor commented, "This was interpretation from without. This might be correct, but it is experience distant. It did not address the subjective experience of the patient and, therefore, it was not an experience-near intervention." After the supervisor had reviewed other cases in which a therapist failed to approach the inner feelings of the patient, the ability of this therapist to feel and acknowledge the inner experiences of her patient improved markedly. There was great improvement in L.'s symptomatology and her ability to relate to other human beings also improved. L. ended that therapy saying that the greatest improvement she felt was not only in the relief from her symptoms, but also in the new feeling that she could initiate and trust her own judgment. This feeling of being an independent center of initiative heralds the emergence of a healthier self.

In the following two vignettes, the two therapists were acquainted with the self-psychological viewpoint, but failed to adhere to it.

Vignette 7

M., a 23-year-old anorexic woman, came to the session stating that the progress in her condition and in her life had begun when she started to make notations about her thoughts, her therapy and, especially, about her dreams. "Therefore," she went on to claim, "I have to give credit for my improvement to my notes and not to the therapist." The female therapist interpreted that the patient was competitive and somewhat belligerent. The supervisor thought that this was an unfortunate example of a failure to

empathically understand the patient from her subjective experience. The therapist, assuming an outside observer's perspective, had interpreted completely "from without" from an experience-distant perspective. The content of the interpretation might have been correct, but what the patient needed, according to self psychology, especially during the longest beginning stage of therapy, was to feel her therapist's efforts to empathically understand her "from within." M's newly developing capacity to search for her own existence and presence should be approved of and acknowledged. She needed to feel successful, competent and skillful by contributing to her own improvement.

The proper order for intervention in such a case, according to self psychology, would be to first make a patient feel that the therapist feels and acknowledges what the patient feels, discovering one's competence and capacity to understand herself and contribute to her development. The interpretation concerning competitiveness, which is more on the level of object relations than of self, selfobject relations, should be postponed until the final stages of therapy or perhaps not be presented at all, depending on whether other material on such a level is accumulating.

Vignette 8

R., a 21-year-old bulimic patient, treated by a male therapist had just recently begun to date men. In her first steps in searching for human beings rather than food to fill her selfobject needs, she had gone about it with great intensity. "You need people's attention in a manner that is more than they can or wish to give," stated the therapist. The members of the group supervision team felt that although not incorrect, this statement of the therapist seemed to reflect greater empathy on his part towards other people rather than towards his own patient's desperate need to rely on others. The therapist went on to tell R. that the boyfriends that she wished to date were the "cream of the crop" of the boys in her environment. The therapist spoke accusingly to her about her being too greedy and of her having "big eyes." Instead, he should have empathically understood that the patient's subjective experience of feeling weak caused her to look for boyfriends on whose strength and popularity she could rely.

SELF, SELFOBJECT RELATIONSHIPS

During therapy, when patients come to realize that the pattern of their mode of being in the world is as selfless human beings who are trying to fulfill others' selfobject needs, they are, on the whole, very much moved by it. However, their ability to integrate this realization is very slow and

difficult, and does not always proceed simultaneously on emotional and intellectual levels.

Vignette 9

K., a 27-year-old bulimic woman, was already in a very advanced stage of therapy and was symptom free. She had begun mature object and selfobject relationships with a boyfriend. The maturity of her relationships both with her boyfriend and her therapist was expressed through her capacity to rely on her own judgments and preferences as a source of finding the direction to her life, for regulating her moods and for attaining self-esteem. Human beings, at this stage of therapy, become the potential source of filling selfobject needs, and her reliance on them was mature rather than archaic. However, even in so advanced a stage of therapy, she said, "Only you," ("you" being plural, perhaps referring to the whole clinic staff), "have supported what I am, even before I could notice that I am someone. Now it's very strange for me to feel that I can rely on my own judgments and preferences and that I can act for my own benefit and interests and pay no internal price for it. I feel, though, that it is difficult for me to believe that there is a place for me in this world. I understand it in my intellect, but I don't feel it yet and cannot completely believe it."

Vignettes 10, 11

A 20-year-old bulimic woman in the initial phases of therapy, spoke of her difficulty in seeing herself as an independent center of initiative. "How are other people able to reach a decision? I am empty inside. If I want to look inside of me to see what I want, I see just emptiness. I can either fill it with food or with the wishes of others."

A 23-year-old anorexic woman said, "I am accustomed to look for what fits the others. If my boyfriend Danny needs me to smile, I smile. I've become an expert in reading facial expressions. Depending on what my sister and my father need, I will be there to fulfill it. I can spend hours calculating whether my brother will need to take a shower in the bathroom and then wait for hours, avoiding occupying the bathroom because he might need it." At one session, after her therapist's interpretations pointed out this feature of her being, namely, her trying to be a selfless human being by fulfilling others' needs and by avoiding the occupying of space, the patient remembered her father's attitude towards her. It was after she began to grow feminine curves that her father had said, mockingly, "You have developed a rear end." (In Hebrew, this phrase also connotes a sense of entitlement to occupy space, and a sexual innuendo). She felt this double entendre was criticizing her for feeling well in the world and occupying

space in it, as well as criticizing her sexual development. During this same session and in subsequent ones, there came to light vivid examples in which the patient spontaneously remembered many times and places in which she felt ill at ease with occupying space, such as while traveling on buses. With progression in therapy, she is now happy to occupy space. At dances and parties she can enjoy herself and make her presence known.

The next two cases dealt with girls who just started to develop ego-dystonic feelings towards their tendency to devote themselves to the fulfillment of the needs of others.

Vignettes 12, 13

A 19-year-old anorexic girl found herself very much involved in the arrangements needed to build two new rooms in her family's house. She frequently mediated between her quarreling parents and encouraged her mother to help her father adjust to his newly developed illness. She performed all these activities from a hospital during the last phases of her hospitalization. Then, in a moment of insight, she asked her therapist and afterwards her parents, "Who is the daughter here and who are the parents? Who is the mother of whom?"

A 19-year old bulimic patient, after a year in therapy, was struck by a sudden insight into her family's attitudes. Surprised to find that they enjoyed her pattern of fulfilling their needs, she said, "I must have been stupid to sacrifice myself in order to fulfill their needs." She then became very adept at finding incidents in which family members constantly expected her to pay attention to their point of view. She felt that they had automatically included her newly acquired boyfriend into their expectations that she would attend to his needs while ignoring her own.

The countertransference of a therapist from our team can serve as an example of the feelings aroused in a therapist. His patient, a bulimic girl, was engaged in self, selfobject relations with him during the first stages of her expecting human beings to fulfill her needs. "I feel," he said, "programmed, like a robot, when you demand of me to make all sorts of phone calls to various kinds of doctors. I feel that I'm losing my professional judgment." The patient reacted to this in a severely angry outburst. "It is not my business to know how you feel and you should not expose your weaknesses to me!" In a subsequent session, the therapist expressed understanding of the patient's need to see him as a strong omnipotent object who can fulfill all her needs. He said, "In your first attempts to trust

human beings as providers of your needs, you have perhaps an understandable desire to feel in full control over me as you had over the substance."

Vignettes 14, 15

Another bulimic patient said to her therapist, "I need you just to sit here and admire me. I need it very much. I don't want you to do anything else; just sit and admire." This therapist felt somewhat like the therapist in the previous vignette: dehumanized. He explained to the patient, "You are very much afraid that, like your mother, I will not appreciate and enjoy your good points."

A 23-year-old bulimic patient, a year into therapy, is a good illustration of the ability of the patient to observe her first attempt to relinquish food and begin to refer to human beings as potential providers of her selfobject needs. At the beginning of therapy, she expressed her attraction to food: "I so much like it that I've never found any love affair like it." She went on to explain why she prefers cake to a boyfriend. "With cake, you don't have to look at its face after you consume it desperately, but a boyfriend, if you want to lean on him or be with him desperately, you will be embarrassed to look at his face afterwards." With progression of therapy, the patient felt great happiness whenever she chose human beings over food. She was astonished to realize that only the presence of a specific figure, her boyfriend, could totally remove her attraction to bingeing and vomiting. With the beginning of the relationship with this boyfriend, she noticed that his presence, the sight and smell of him and his touch, could overcome all the attractions of food. No other human being, neither her girlfriends nor her family members, had a similar impact on her. "Had I been with him 24 hours a day, I would never binge." In the final stages of therapy, the patient could point out certain sessions and say, "That kind of feeling, being understood, can remove my intentions to binge and vomit."

CONCLUDING REMARKS

Self psychology attributes a central therapeutic role to the therapist's effort to understand and acknowledge the patient's unique perspective. The patient's perplexing and even bizarre experiences are dealt with by the therapist's vicarious introspection, while approving the legitimacy of the patient's archaic needs. Such a therapeutic approach has great curative potentials for eating disorders in two major respects. First, it conveys to the eating-disordered patient the message that she deserves to enjoy the "services" of a human selfobject and that she deserves to be a self and not just a selfobject for others. Second, such a therapeutic stance of the

therapist may restore in the patient the hope that human beings, rather than the substance, can provide her selfobject needs.

Only through these self, selfobject relationships with human beings, in contrast with inanimate selfobjects like food, can her self-structure be repaired through the process of transmuting internalization, in which the therapist is aware of and acknowledges his failures of empathy.

Hilda Bruch, whose pioneering insights into the treatment of eating disorders remain a landmark in the literature, intuitively felt that the two models of psychoanalytic development that existed in her time, the psychosexual and the object relations models, do not fit the therapy of these disorders.[6] In attempting to summarize her life-long contribution to the field[6] she said that the theory of self psychology systematically conceptualizes the clinical phenomena and techniques to which she intuitively pointed.

Swift[19] suggests that Bruch's greatest contribution to the field is in the change that she promoted in the recommended stance of the therapist towards the eating-disordered patient. Long before the emergence of self psychology, she emphasized the necessary confirming of "the internal reality of the patients."[20,21] She opposed the therapist who gives interpretations from a "superior position." (Shall we say, in the language of self psychology, "experience distant"?) She shunned an interpretive approach because she was afraid that interpretation is often experienced by the anorexic as a recapitulation of early trauma in which the anorexic was told what she thought and felt by a "superior other." She believed that interpretative interventions only confirmed the anorexic patient's sense of inadequacy and they also interfered with the anorexic's trust in her own self-expression.[20,21] Swift,[19] though, criticizes Bruch for totally abandoning the important psychotherapeutic tool of interpretation. Self psychology's suggested therapeutic stance can solve this dispute. Interpretations are given only (a) after a long phase in which the patient feels that she is empathically understood, and (b) interpretations are given by a therapist who, the patient feels, is not a distant object, but rather a selfobject. Therefore, interpretations will be felt by the patient not as something imposed from without but given from within.

The self-psychological view of symptoms and defenses is another major element that renders self psychology potentially helpful in the treatment of eating disorders. The eating-disordered patient ferociously defends her eating pattern, like someone defending the existence of the self itself. This is because she feels that if she gives up the eating ritual before genuine selfobject responsiveness can be substituted, she is seriously endangering her self-cohesion. Ornstein[22] states that the self-psychological approach to

defenses and symptoms is very different than the confrontational approach adopted by classic psychoanalysis. Whereas, in the latter approach, according to Ornstein,[22] defenses were viewed as obstacles that should be removed layer by layer, self psychology views them as performing the crucial psychological function of protecting a vulnerable self from further depletion or fragmentation.

The eating-disordered patient treated according to the self-psychological approach will feel that even her self-defeating and self-destructive behavior patterns, which were thus far the target of condemnations and confrontations, are looked upon respectfully as her attempts to restore and maintain a sense of cohesion, wholeness or vigor of the self. It is consistent with the message that the therapist conveys to the patient, that her unique self deserves attention and her archaic needs warrant acknowledgment. Instead of being confronted with her behavior, the behavior is explained to her. She learns that she cannot abandon this behavior until she can rely on human beings to act as potential providers of her selfobject needs, and before inner structures are established to take some of the roles of the external selfobjects.

Sands[12] vividly described a case in which the patient was astonished by the understanding attitude of her self-psychologically informed therapist who had explained her disturbed eating patterns. The patient asked, "How can you say to a young girl that the Ipecac that she took to bring on vomiting was taken by her as an attempt to feel psychologically better?!" The therapist answered, "I'm trying to understand many aspects of your behavior, amongst these, the reasons for your bingeing and vomiting." Her previous therapist viewed those eating-disordered behaviors as suicide attempts. While the destructive nature of those behaviors did not escape the therapist's attention, the self-psychological therapist did not overlook the curative attempts these behaviors had tried to fulfill. When the patient sees the genuine attempts of the therapist to understand her subjective viewpoint, suspending for a while the judgment of the reality-testing elements of that behavior, she will take the next step by mentioning these elements.[3] Perhaps the patient's puzzled response about the Ipecac is an example of her taking such a step.

Idealization of the therapist is a frequently occurring emotion in patients. Idealization arises partially as a reaction to the great relief and gratitude towards someone who affirms and acknowledges the patient's subjective experience, and mostly because of the developmental need to have an idealizable figure who can supply calmness and soothing and with whom the individual can merge. More often than not, a therapist will find

this even more difficult to bear than devaluation. Self psychology warns the therapist[23] against rejecting or interpreting this developmental need as a defense against other feelings, e.g., aggression or hatred (as Klein[24] might have interpreted). Sands[25] calls on therapists to check on whether patient's devaluations of them are manifestations of their defenses against their long-term unmet needs for idealized selfobjects.

The efficacy of the self-psychological treatment of eating disorders was recently investigated in a randomized, controlled study of 33 patients, comparing it with a specific kind of cognitive therapy (C.O.).[26] Self psychology achieved significantly better results both in removing overt symptomatology and also in the intrapsychic dimension of the cohesion of the self.

SUMMARY

This article reviews the contribution of self psychology to the treatment and understanding of anorexia and bulimia. It tries to show that the unique conceptualization of self, selfobject relations, and this theory's conceptualization of resistance and defenses constitutes a therapeutic stance which especially fits the therapeutic needs of eating-disordered patients.

Clinical vignettes illuminate three main issues exemplifying the opportunities and dilemmas that this new development in psychoanalytic theory brings to the fore in the treatment of eating disorders: (1) empathy with deeds and attitudes of the patient that the therapist finds difficult to empathize with; (2) empathic understanding "from within" from an experience-near stance vs. experience-distant interpretation "from without"; (3) self, selfobject relations with food and as a result of progress in therapy, with human beings.

REFERENCES

1. Berger, D. (1987). *Clinical empathy*. Northvale, N.J.: Jason Aronson.
2. Wolf, E. S. (1988). *Treating the self: Elements of clinical self psychology*. New York: Guilford Press.
3. Kohut, H. (1984). *How does analysis cure?* Chicago, IL.: Chicago University Press.
4. Kohut, H. (1987). Building psychic structure that regulates self-esteem. In M. Elson (Ed.), *The Kohut seminars*. New York: W.W. Norton & Company.
5. Barth, D. (1991). When the patient abuses food. In H. Jackson (Ed.), *Using self psychology in psychotherapy*. Northvale, N.J. & London: Jason Aronson.
6. Bruch, H. (1985). Four decades of eating disorders. In D. M. Garner and P. E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia*. New York: Guilford Press.
7. Schwaber, E. (1984). A mode of analytic listening. In J. Lichtenberg, M. Bornstein and, D. Silver (Eds.), *Empathy*. New York: Analytic Press.
8. Tolpin, M. (1980). Discussion of psychoanalytic developmental theories of the self: An integration by Morton Shane and Estelle Shane. In A. Goldberg (Ed.), *Advances in self psychology*. New York: International Universities Press.
9. Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.

10. Geist, R. A. (1989). Self psychological reflections on the origins of eating disorders. *The Journal of the American Academy of Psychoanalysis, 17,* 5–28.
11. Goodsitt, A. (1985). Self psychology and the treatment of anorexia nervosa. In D. M. Garner and P. E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia.* New York: Guilford Press.
12. Sands, S. H. (1991). Bulimia, dissociation and empathy: A self psychological view. In C. Johnson (Ed.), *Psychodynamic treatment of anorexia nervosa and bulimia.* New York: Guildford Press.
13. Kohut, H. (1977). Preface to psychodynamics of drug dependence. In J. D. Blaine and D. A. Julius (Eds.), *Psychodynamics of drug dependence.* Washington, D.C.: Government Printing Office.
14. Kohut, H. (1987). The addictive need for an admiring other in regulation of self-esteem. In M. Elson (Ed.), *The Kohut seminars on self psychology and psychotherapy with adolescents and young adults.* New York: W.W. Norton.
15. Ulman, R. B. & Paul, H. (1989). A self-psychological theory and approach to treating substance abuse disorders: The "intersubjective absorption" hypothesis. *Progress in Self Psychology, 5,* 121–141.
16. Levin, J. (1991). When the patient abuses alcohol. In Jackson, H. (Ed.), *Using self psychology in psychotherapy.* Northvale, N.J. and London: Jason Aronson.
17. Mahler, M. S. (1975). *The psychological birth of the human infant.* New York: Basic Books.
18. Masterson, J. F. (1976). *Psychotherapy of the borderline adult: A developmental approach.* New York: Brunner/Mazel.
19. Swift, W. J. (1991). Bruch revisited: The role of interpretation of transference and resistance in the psychotherapy of eating disorders. In C. Johnson (Ed.), *Psychodynamic treatment of anorexia nervosa and bulimia.* New York: Guilford Press.
20. Bruch, H. (1970). Psychotherapy in primary anorexia nervosa. *Journal of Nervous and Mental Diseases, 150,* 51–66.
21. Bruch, H. (1973). *Eating disorders: Obesity, anorexia nervosa and the person within.* New York: Basic Books.
22. Ornstein, A. (1990). Selfobject transferences and the process of working through. *Progress in Self Psychology, 6,* 41–58.
23. Kohut, H. (1968). The psychoanalytic treatment of narcissistic personality disorders: Outline of a systematic approach. *Psychoanalytic Studies of the Child, 23,* 86–113.
24. Klein, M. (1957). Envy and gratitude. In M. Klein (Ed.), *Envy and gratitude and other works.* London: Hogarth Press.
25. Sands, S. H. (1989). Eating disorders and female development: A self-psychological perspective. *Progress in Self Psychology, 5,* 75–103.
26. Bachar, E., Latzer, Y. & Kreitler, S. (in press). A randomized, controlled study of two psychotherapies: Self psychology and cognitive orientation in the treatment of anorexia and bulimia. *Journal of Nervous and Mental Disease.*