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REVIEW

Considerations on self-psychology and eating disorders

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Abstract In this narrative review article, some considerations are reported on the psychoanalytic point of view of self-psychology on eating disorders in a multidisciplinary team approach, a theoretic and clinical perspective in which the Author recognizes himself. Some author's clinical ideas and concepts as "negative self", "eclipse of the self", "rebound syndrome", "bluff syndrome", "deficit of subjective attribution", related to the topic of the deficit of the Self, are exposed along with technical aspects, clinical material and references to the comparison of psychoanalysis with the EBM literature on psychotherapy of EDs and its contemporary role in an integrated multi-disciplinary treatment of these disorders.

Keywords Eating disorders · Self-psychology/psychoanalysis · Group analysis

Introduction

In this narrative review article, some considerations will be reported on the psychoanalytic point of view of self-psychology on eating disorders in a multidisciplinary team approach, a theoretic and clinical perspective in which I recognize myself.

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From the very beginning, Psychoanalysis has dealt with understanding and curing eating disorders (ED) and in particular anorexia nervosa (AN)[1]; in the course of the last century it represented for a long time the main approach to this syndrome.[2] Various theoretical models have followed and integrated in time through the historic phases of the development of psychoanalysis: the classic model of the conflict between drive and defences, Ego Psychology, the Theory of Object Relations, Relational, Intersubjective and Self-Psychoanalysis [1–3].

An exhaustive description of all the psychoanalytical perspectives, although some of them must be considered very significant (e.g., French School and the Lacanian development, English School and the Kleinian development, etc.), and of other important issues of ED too (e.g., alexithymia, factors of onset, etc.) will not be given, because of the need of conciseness.

For the same reason many psychoanalytic concepts have not been exposed. The understanding of the patient's unconscious, through transference and countertransference and the analysis of the defenses and underlying drives, as central issues of psychotherapy, are considered implicit by me, as an IPA psychoanalyst.

Self-Psychology is an orientation of Psychoanalysis, developed by Heinz Kohut [4] and his pupils, in which the use of empathy and of analysis focused more on the "system" of Self than of defenses/drives (but not

[1] ED's "Eating Disorders", classified in the DSM-5 as "Feeding and Eating disorders", to which reference here is, are: Bulimia Nervosa (BN), Anorexia Nervosa (AN) and "Binge Eating Disorder", BED (Binge Eating Disorder).

[2] Let us recall the case of Dora (S. Freud), identified as a form of eating disorder and that of Ellen West, undergone two psychoanalyses, published by Biswanger.

neglecting the latter) is strongly intensified in the therapeutic relationship.

Therefore, although psychoanalytical speculation regarding EDs could be examined—particularly concerning the study of AN—by means of the two standpoints of the Drive Theory on one hand[3] and the Theory of Self-Deficits on the other, I will cite mainly the authors of the second inclination: Bruch, Harper, Sands, Goodsitt and Geist, of which the last three are explicitly influenced by Kohut's Self-Psychology.

Bruch [5], whose point of view was very close to Kohut's Self-Psychology, was a pioneer of clinical alimentary psychopathology and had life-long experience in this field; she put forward a theory in which it is the inadequacies of parental response that bring about both a deficiency of the sense of separateness and effectiveness of the Self as well as the enteroceptive awareness of the hunger-satiety stimuli and the psycho-perception of the body image. This theory explains the complete orbit of alimentary psychopathology, from hypo to hyper-nutrition, to extreme anorectic emaciation and maximum caloric accumulation, obesity.[4]

At the centre for eating disorders in Toronto, Harper [6] studied the use of analytic group psychotherapy, and focused her work on interpersonal experience in EDs referring to ITP.[5]

Goodsitt's conception (1983), which refers back to Kohut's theorization of the Self (1976), emphasises the importance of the role played by relations in maintaining self-esteem and self-cohesion.[6]

Sands manifests the peculiarities in the characterization of female development which mean that EDs develop primarily in women [7]; Geist has underlined the failure of empathic caregiving on the part of caregivers in the genesis of EDs and the role of empathy in treatment.

Thus, according to the orientation of Self-Psychology, the ED is an attempt at Self-cure of a structural lesion of the self due to empathic failings and a caregiving deficit on the part of the parental figures. Consequentially the EDs causes a defensive withdrawal from interpersonal relations, replaced by relations with "not human" objects (thin ideal body image, ambivalent experience with food, etc.).

But from history let us now come to the present. In my opinion there are two areas of comparison which cannot be ignored by a psychoanalysis of EDs which sets out to relate with the present-day: the experience of treating EDs in institutions, especially those in the public health service and Scientific research concerning the cure of EDs, but for motives due to space we will omit these and refer to them in the notes.[7]

[3] Freud (1893, 1895, 1905) assimilates the anorectic restriction to hysterical conversion where eating is assimilated to an erotic drive. In "Minuta G" (1895) anorectic restriction is linked instead with "melancholia".

Regarding the orientation of the Drive Theory we cite: Abraham, Klein (1934), Fenichel (1945), Waller and Coll (1940) and Berlin (1951), Mintz, Lacan.

Regarding the orientation of the Ego/Self deficits and care-giving we cite: Meng (1935), Biswanger (1945), the International symposium of Gottingen (1965) in which new trends emerged which transferred attention from food to the relation with the body and the personality specificity, Brenner (1983), Casper (1983), Sugarman and Kurash, Lerner (1983), Swift and Leven (1984), Thoma (1961), Masterson (1972), Hilde Bruch (1974).

[4] I adhere to Bruch's and Fairburn's trans-nosografic hypothesis that AN, BN BED, NOS belong to a similar psychopathological core albeit with different semiotics; epidemiological data support migrations in the same person, for example, from AN through BN to BED and vice versa.

[5] ITP (Interpersonal Psychotherapy) was born in the United States in the 70's (Adolph Meyer, Harry Stack Sullivan, Bemporad, "New Haven-Boston Collaborative Depression Project").

[6] According to this approach, the anorectic, unable to recognize her own Self as the nucleus of her personal identity,implements defensive measures regarding the control of her body and environment in order to defend her Self.

[7] The main points regarding the two most accredited international guidelines, NICE and APA, are outlined below.

NICE guidelines (UK, National Institute for Clinical Excellence, 2004):

Psychotherapies indicated as effective in AN: CAT (cognitive analytical therapy, CBT (cognitive behaviour therapy), ITP (interpersonal psychotherapy), "focal psychodynamic therapy" and familial therapy focused on the ED.

Psychotherapies indicated as effective in BN: CBT-BN (cognitive behaviour therapy for BN) and if there is no result or if the patient refuses it ITP (interpersonal psychotherapy) is indicated. Psychodynamic psychotherapy is not referred to.

P.sychotherapies indicated as effective in non-BED ED's -NAS are those indicated for the form of ED closest to the NAS in treatment (AN, BN,BED).

Psychotherapies indicated as effective for ED's-NAS, BED, are BED-CBT (cognitive behaviour therapy for BED), ITP-BED (interpersonal psychotherapy for BED) and the DBT-BED (Dialectical Behavioural Therapy for BED)

APA guidelines (American Psychiatric Association, 2006):

For AN, the only therapy with a high evidence-based efficacy indicated is familial therapy for patients in the years of growth. Psychodynamic empathic psychotherapy, CBT and ITP are indicated on the basis of low evidence-based efficacy.

For BN only CBT has high evidence-based efficacy. ITP and familial therapy are indicated as useful. Psychodynamic therapy is considered as having no evidence-based efficacy.

As the NICE and APA guidelines point out, all the psychotherapies mentioned in the first instance are of cognitive orientation. ITP (interpersonal psychotherapy) is mentioned in second instance because even if it is just as effectual, it is a longer-running therapy. Therefore ITP is seen as an alternative to CBT, while in the psychodynamic area only CAT (cognitive analytical therapy) and "focal" psychodynamic psychotherapy are mentioned and only as a therapy for AN.

The conclusion that issues is that analytic therapy is only considered useful in the specific disorder of AN but not in its acute phase and only by means of forms of psychodynamic psychotherapy named "cognitive analytical therapy" and" psychodynamic psychotherapy": thus psychoanalysis seems to be the "great absentee" from the International Scientific Communities' treatment of ED.

In short it can be state that a review of recent literature about the evidence for psychological treatments [8–17] provides some evidence of effectiveness of psychodynamic psychotherapy of EDs only for the “focal psychoanalytic psychotherapy” of AN and the psychoanalytic psychotherapy of bulimia.

Observations on the theoretical and technical aspects

The specific aspects regarding the treatment of EDs require that the analyst makes changes to both the theory, setting and technique.[8]

Theoretical observations

As mentioned previously I refer to the psychoanalytic models, which are centred around Self-Psychoanalysis.

I found the use of empathic immersion and the “focalization” on the eating disorder as a reparative procedure for self-deficits particularly productive. The deficits relate to identity, the right to exist and individuation, the perception and “interpretation” of affects (alexithymia[9]), the regulation of emotions, vitality, assertiveness, sense of efficacy, the subjective attribution of talents and abilities and the regulation of self-esteem and is expressed by means of feelings of self-negativity, inadequacy, lack of self-esteem, feelings of being “flawed”, “monstrosity”, “emptiness”, confusion between emotional and physical perceptions and dissatisfaction with the body image.

The empathic understanding of the ways in which the symptomatic apparatus, acting like an “archaic auto-therapeutic strategy” which is a sort of “regression” to relate to old infantile objects, provides support to the fragile Self and carries out defensive functions regarding dealing with the interpersonal experience is fundamental. It is central to establishing a therapeutic alliance, and then subsequently, in searching out new and less self-destructive forms of “care-giving” regarding the vulnerability of the Self.

The psychotherapist, who works with these types of patients and goes beyond the symptomatic aspect, cannot not notice the fact that these patients’ subjective experiences almost constantly rotate around a nuclear feeling of self-inadequacy, often present from childhood; this feeling increases dramatically at the beginning of adolescence: in fact their fragile Self must face intense changes of identity and body image, sexual development and comparison with peers, often in a family “transgenerational” pathological context plus predisposing factors, e.g. “dieting”, “negative body image”, obesity, etc.,: this is probably the main reason of the frequent onset of EDs during adolescence [18]. About the female prevalence Sands argues that the development of self-esteem in adolescent females relies heavily on female body image, the appearance of the body, whereas in males much more on the acting effectively and so the male could be less vulnerable regarding his body image.

The phenomenology of this feeling is so diversified from case to case, that in a previous article I felt compelled to define the basic common feeling regarding the “deficit” with the generic term of “feeling of self-negativity” or “negative self”, while awaiting to find a better one.[10]

Therefore, the hypothesis is that this feeling literally reflects the self-deficit and that the majority of the pathological phenomenology is structured around this deficit.)

Furthermore, as Lydia Pallier [19][11] has already explained, in these situations of self-deficits, the analyst who works with EDs is often in the presence of two typical phenomena, which are also present in other symptomatologies. These can be defined as the “bluff syndrome” and the “rebound syndrome”, and are closely linked both to each other as well as with the subjective deficit of attribution/appropriation.[12] In the “bluff syndrome”, whenever the patient is appreciated physically or for other qualities she may have, she thinks and feels that in reality she is a “bluff”: she does not believe she really has those qualities, but believes that it is a “trick” and expects to be exposed at any moment to her great shame. For example, a bulimic patient tells me that a young man is attracted to her but she is sure that he must be wrong to be interested in her. Another anorexic patient, Ilenia, is not able to recognize the capabilities others see—and therefore increase her self-esteem—in her as really belonging to her. Therefore, we

[8] Learning from my experience, a psychoanalyst should accept to be faced with the following aspects: severe disorders of growing epidemiologic gravity; a multi-disciplinary treatment; a diseased body suffering from extreme malnutrition and self-destructive behaviour; the necessity of adapting technique to the specificity of the disorder and the institutional; the International Scientific Communities’, the “Evidence Based Medicine” and the International Guidelines; phase of adolescence, frequent age of onset of the disorder and the patients’ troubled families; the increasing EDs’ neurosciences data.

[9] Lack of development of “reading” of the inner perceptions, closely related to the deficit of the Self. See literature for more in depth knowledge of this particular issue of EDs. l.

[10] In a previous paper I named “Eclipse of the Self” because this phenomenon resembles the subjective experience of these patients who feel their core self (sun) as being “obscured” by a pathologic structure (as the celestial body, e.g. the moon).

[11] Psychoanalyst with training roles in the Italian Psychoanalytic Society.

[12] With this term, R. Cahn describes the process of “becoming-a-subject” and the difficulty of ascribing mental experiences appertaining to the subject to the Self.

could say that this positive appraisal "rebounds" off her without affecting her feelings of the self and without touching or increasing her positive feelings; when Ilenia's boss awards her a pay rise that she has not put in for, for excellent productivity, she is not able to credit herself with possessing such high professional qualities and therefore increase her self-esteem. It is precisely this "psychic anorexia" and incapacity of "nourishing" the "dearth" of the self with interpersonal experiences which plays an important role in the development and continuance of the eating disorder. In fact, if the self is "malnourished", devalued and "confined" to the phantasmal world of the body and food, one feels inadequate to take on the interpersonal sphere. One of the specific mainstays of the pathology is to attempt to explain this painful perception of defects in the Self and to try to repair it. After a sufficient relationship of familiarity and trust has been established with the therapist, these patients relate that ever since childhood they have felt "inadequate", "different" and "unpresentable", which is namely not able to tolerate the experience of exposing his own Self to others when dealing with them. This feeling of being "unpresentable" can grow into the sensation of not having the "right to live"; in others the feeling of negativity can grow to a point where one feels a dark sense of "defectiveness" and "monstrosity". At times this feeling takes on a strong phantasmal aspect such as: "there is a black hole inside me, a dark shadow, something negative…". The almost physical description of an "empty space" or a "hole" which is usually situated inside the stomach, and drives one to fill it by gorging oneself is also very frequent. On the contrary, the perception of an overload of fullness and negativity drives the subject to the act of expulsion by means of self-induced vomiting. The "disgusting full up" and the distressing "empty space" are referred to as a sequence in the same scenario. To illustrate this aspect I will refer to the case of Clara who was an anorexic-bulimic patient, who after years of therapy, had made considerable progress in her capacity for "insight", and who recounted the following dream to me:

> "*…I was looking at myself in the mirror… then I noticed something that looked like a spot, like a "cuniculus" in the skin of my face…* "*I examined*" *it scratching it with my nails… I was disgusted to find a long and revolting worm under the skin… going further in I saw that there was nothing under the skin… just an enormous empty white space, like an enormous white room…*"

For years the patient had unwittingly tackled the "revolting-worm-self" by trying to attain a "thin" ideal physical self by means of alimentary restriction, perceiving the "revolting self" as "hidden" in the fat. The damage to the Self had caused an "alexithymic" state in which only two strong emotions survived, anger and the feeling of "emptiness". The gorging, which was fostered physiologically by the nutritional restriction filled the "empty space" she perceived in the event of frustration or desertion. The food gorged on would suddenly "magically" make her feel fat and to perceive a "revolting-Self" which she would violently try to expel by self-induced vomiting. In the course of therapy a sort of process of "emotional alphabetization" had helped her increase the understanding of her emotions. The persecution on the part of the "all-powerful-perfectionistic Self" increasingly reduced and the feeling of self-worthlessness (the "worm-self" in the dream) and new emotions had subdued the feeling of emptiness. Years later—the patient is still in therapy—the bulimic crises have disappeared completely.

Hilde Bruch underlines the fact that for these patients, as it is for their own bodies, their thought and emotions do not seem to belong to them. They do not feel in the condition of being in charge of themselves in their own lives and it is only in this "theatre of the body"[13] and in the world of food that they seem to be able to find a form of self-expression. In the case of Ilenia, who is anorexic, it is only after a few years of analytical therapy, that she realizes that the thoughts and ideas with which she judges the world and others are not really her own but her mothers, and during a session she exclaims: "…but I am thinking with my mother's mind!"

With another bulimic patient, Giulia, the link between her bulimic crises and her difficulty in expressing her assertiveness with her boss at work with anger and efficacy emerged in the course of therapy. Her boss tended to underrate her, and these bulimic crises seemed to "relieve" the frustration over a "inter-human" relationship by means of transferring her affects (e.g., The anger is converted into the violence of the bulimic behaviour) into an area of relations with "non-human objects" (food)[13]. In this case it is obvious that her "oral apparatus" cannot be filled-up with words that come out and address another person with effectual anger. Due to her self-devalued Self, she does not feel she has the right to defend herself or to sustain and express intense emotions, nor to have the courage to take upon herself to face another person. Consequently, in her oral apparatus words are substituted by food, which is then expelled violently, in the place of energetic communication.

Therefore, we can conclude that from the point of view of Self Psychoanalysis, EDs are disorders of the Self in which the fight for psychic survival, sense of identity,

[13] Term used by H.S.Searles, psychoanalyst.

self-esteem and the ideal Self has transferred defensively onto the body and food due to the excessive vulnerability of the Self in confronting the interpersonal scenario.

In the context of integrated inter-disciplinary operation (in a team made up of medical experts in nutrition, psychiatry, etc.), analytical therapy has the function of recognizing this fight with its ambivalence, of liberating the "caged" Self and to restart the individuation process, the passage from the corporeal phantoms to the psychic representations.

Technique

The technique should take into account that the analytical approach must integrate other forms of treatment, including, motivational, psycho-educational and rehabilitative processes, intervening in specific phases of the treatment plan.

For most patients who refer to an institution in public health facilities, analytical therapy can be an advanced phase of the treatment, also because often the patient and/or the family (in the case of minors) are unaware of the disorder. In the case of AN especially, the disorder is denied or concealed; this explains the necessity for an in-depth look into the motivation for treatment and for a "motivational procedure" which will not be familiar to the more traditional psychoanalyst.[14]

The first phase in this procedure is often a "preparation" for the therapy, and is widely based on "psycho-education" [20] or "therapeutic education", which consists in providing a theoretical understanding and awareness of the disorder, starting from the signs and symptoms and finally to structure a therapeutic alliance, without any purpose to fill the patient with knowledge but only to stimulate him to become an active therapeutic agent towards himself in order to obtain new and different points of view about his behaviour and thoughts related to food, eating and his body.

Psycho-education can also take place as an integration of the individual treatment, by means of small homogeneous groups of motivated patients who are sufficiently homogeneous from a symptomatical point of view, for a fixed number of meetings, in fact the interpersonal exchange between patients with similar experiences has a strong educational impact.

There are sometimes difficulties with the cohesion of the treatment team, especially in the more serious cases: for example, in the cases of AN, there is the risk of falling into the "trap" of transferring the "body-mind scission" to the therapeutic team. The patient accepts to cure his/her mind but refuses to cure nutrition and the body. Here we must underline the absolute necessity of the team being aware of any resistance and scissions on the part of the patient, and by means of efficient communication, keeping the integration of the treatment "cohesive" in the long-term, and not allowing the patient to deviate or contravene from following the therapeutic programme in its entirety. My proposal is for a "psychoanalytic team approach", also to deal with a frequent massive transference that simultaneously conveys archaic needs for care (e.g., "to be seen" and communicative projective identifications (e.g., anguish of death in AN patients). The psychoanalyst, better if he is also a group-analyst, can be the figure that analyzes, understands and integrates all the puzzles of the several clinical manifestations (eating, fear of being fat, social avoidance, somatic signs, etc.) and helps the team (dietician, psychiatrist, etc.) to achieve a more unified image of the patient and to avoid fragmentation of the clinical picture and misunderstandings between professionals.

In fact, it is only with a solid multi-inter-disciplinary treatment team that it is possible to advance to the psychotherapeutic phase.

The analytical psychotherapy can be in individual or group form, preferably initially individual and only subsequently integrated with a concurrent analytical-group.

Group analytic psychotherapy, as underlined by Harper, can be extremely useful: the patient has a great need of interpersonal experience to individualize him/herself, but fears it due to negative self-identity, lack of self-esteem, negative body image, the perfectionistic ideal, etc. Interpersonal psychotherapy focuses specifically on increasing interpersonal efficacy.

Individual analytical psychotherapy has the function of making the patient aware of the links between his/her eating disorder and the vulnerability of the Self, regarding the "internal scenario" (e.g., the "ideal self-image"), the "family scenario" (e.g., the roles played within pathological families) and the "interpersonal scenario" (e.g., the difficulties in dealing with individuals of the same age and opposite sex, as well as concerning the discrepancy between the "ideal" body (the fantasy one), and the "real" (the objectively detected one, e.g., by the doctor). The analysis of the multifarious use of food is also relevant: food can comfort and satisfy but it can also be self-destructive, it can hearten but it can also anaesthetize the mind.

In the more advanced phases, the therapy must tackle the confusion between physical and emotional perceptions ("alexithymia"), the negative body image and the "negative self", the omnipotence of the control of food and the ideal physical image and the ideal perfectionism (see the

[14] The Di Clemente's-Protchaska's therapeutic model for addictions, includes pre-contemplative/contemplative phases, which indicate the length of the motivational procedure.

note for other analytic technical aspects[15]). Analysis should slowly but progressively dismantle the protective shell of the ED, in order to allow the patient to live in relation to "human objects" and to abandon "the theatre of the body" (S. Resnick.[16]).

Obviously, the task will be easier in subjects for whom it is the first time and in a favourable context, rather than with subjects with a long history behind them, and live in seriously pathological families.

According to the guidelines, integration with familial therapy is imperative for adolescents whose treatment can be hindered by familial dynamics. Family-therapy, in the form of a psychoanalytic family therapy, can be integrated well with a psychoanalytical individual approach.

The real body, rather than the phantasmal mental body which is distorted above all in AN, and which most patients with EDs have "divorced" from in a sense, and which represents the worthless self, can be a useful tool for specific processes of educational awareness. The function of sensitization regarding the perceptive awareness of the "soma" and its psychosomatic tensions can be gainfully carried out in rehabilitation groups.

Conclusions

Eating disorders are severe long-term psychiatric disorders, which, depending on the typology and phase, require specialistic integrated multi-disciplinary treatment, which can be carried out in various degrees of intensity and in different locations. The psychoanalytic treatment must be integrated into this context, and not aim at working omnipotently in a separate context. Under the international guidelines, this treatment can only be applicable with the patient's full awareness, motivation and collaboration, within a global project, which includes alimentary rehabilitation/re-education and the medical treatment of the body.

Technique and setting must be adapted to the specificity of the disorder, and in concurrence with the other procedures.

The treatment of eating disorders in institutions entails a significant decentralization for the psychoanalyst, with regards both his internal and external "assets".

The omnipotent fantasy of possessing a "special" instrument is strongly put to the test by both the seriousness of the disorder and its resistance to treatment, the scant recognition of the international guidelines for psychodynamic therapies in EDs and the marked integration of psychotherapy with the other multi-disciplinary treatments, which are equally necessary.

However, this hindrance is favourably made up for by the vital stimulation that working in this field affords to the analyst's capacity for flexibility in setting and technique, and to his independent spirit in the theoretical search for more explicative and useful standards for the clinical procedure, in a dimension where the mind and the body, life instinct and the attack upon life are all closely intertwined.

Compliance with ethical standards

Conflict of interest The author states that there is no conflict of interest.

Ethical approval This article does not contain any studies with human participants performed by any of the authors.

Informed consent For this type of study formal consent is not required.

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[15] Other technical aspects of the analytic work are: the elaboration of the dis-identification from the negative Self and from the identity ensuing from the illness, the stimulation of the reflective capacity with reference to obsessive ideation, the heightening awareness regarding emotions especially in the interpersonal field, the elaboration of the deficit of the right to individuation and to subjective attribution and the perfectionistic judgemental activity of the ideal self, the manifestation of the resistance to individuation development including adult sexual identification and the separation process from the familial world, the "de-somatization" or the transformative elaboration of the corporeal experiences in psychic experiences, the counter-transferral analysis of the experiences regarding the body and food induced by the patient's projective identifications and unconscious non-verbal communication.

[16] Term used by a famous psychoanalyst, Salomon Resnick.

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