Isr J Psychiatry Relat Sci Vol 42 No. 3 (2005) 154–162

Case Illustration of the Self-Psychological Treatment of Eating Disorders

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Abstract: The theoretical conceptualization of self-psychology and the implications for the therapist's stance open up new opportunities for the treatment of anorexia and bulimia. The major contributions of self-psychology to the treatment of anorexia and bulimia are centered upon the following principles: 1) the conceptualization of food, its consumption and avoidance as fulfilling selfobject needs, 2) the unique therapeutic stance of the therapist as selfobject who tries to empathize with the patient from an experience-near position, and 3) the respect that the theory attributes to the significance of the symptoms for the patient. This paper presents a case which can exemplify some of the principles which underlie the self-psychological understanding of eating disorders and their cure.

As early as 1694 (1), a report on a disease whose description is of Anorexia appeared in the medical literature. Until the beginning of the third decade of the 20th century, there are another seven reports of this disorder. In these reports, the authors hypothesized that the disease has an organic origin and they offered, for its cure, several baths of salts and minerals. Since the 1930s recognition that this disorder has a psychic origin has gained the upper hand, and psychotherapy has become the major tool for treatment.

Psychoanalysis, which undoubtedly plays a central role in the domain of psychotherapies, developed three models to conceptualize the understanding of pathology and cure in man's psyche. As in all other domains in science, so in psychoanalysis the emerging model contains the model which preceded it. The first model is the drive-defence model. The development axis, according to this model, is the psychosexual one. The second model is the object-relations. In the development axis, according to this model, the individual proceeds along stages of separation-individuation. The third model, self-psychology, deals with a development along the narcissistic axis. One of Kohut's (2) major contributions in his conceptualization of this developmental axis is that narcissistic reliance on others is not a developmental stage that has to be abandoned through maturational development as it is perceived in the object relations model. Kohut's theory legitimizes this need of the individual to rely narcissistically on the other during all his life. The healthy development on this axis, according to Kohut, is from a total desperate and archaic reliance on the other into a flexible and mature reliance.

When the child is reared in an environment which permits him to rely on his significant others in an optimal narcissistic reliance — in that kind of reliance, the person on whom the child is relying is ready to give up his needs and his viewpoint and is ready to act within the perspective of the child relying on him (selfobject) — then the child will be able to develop a strong and healthy sense of self and will be able to operate from within himself the calming and regulating functions which previously were operated by the selfobject. This process proceeds through swings between environment which is empathic enough and presents optimal frustrations in empathy.

An adolescent girl who develops an eating disorder does not believe that she can rely on human beings for the fulfillment of these selfobject needs. During the rearing process of these girls, a reversal of roles between the daughter and her parents takes place. The parent relies in a narcissistic manner on his child, i.e., expects that the child will not behave as one who has interests and viewpoints of his own, but will be attentive and will fulfill the parent's need in calming, soothing and alleviation of painful affects. Under such circumstances the child might feel that he does not have the right to live his own life. Such

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children who devote themselves to the parent's well being while ignoring their own internal needs and believe that human beings will not be able to fulfill for them their selfobject needs are prone, according to self-psychology, to develop eating disorders (3, 4).

The fragility of the anorexic or bulimic patient, and her tendency to ignore her needs, feelings and interests, necessitates 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 freefloating 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 (5).

According to Wolf (5), 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 without necessarily joining the patient in all of his/her judgements. The therapist, according to Kohut (6), experiences 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 is supposed to be kind and gratifying, to substitute in the here-and-now for the deprivation that the patient 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 environment, 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 patients' 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 (6) 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 in 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 (7).

Barth (7) 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 (7).

Self psychology views eating disorders as disorders of the self. The core of this conceptualization of the disorder and its cure is that the bulimic and the anorexic patients cannot rely on human beings to fulfill their selfobject needs. Rather, those patients resort to food to fulfill these needs (7-13).

Kohut (2) 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 of 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 (7, 9). 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 (7, 9, 14-16). 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 (3) 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 (8, 9) assumes that eating disorders originate, like other disturbances of the self, from chronic disturbances in empathy.

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 (8) 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 (8), 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 (8), 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 (9) 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 (12) 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 (14) 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 regula-

tors 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 (9), is that if the therapist provides an empathic environment and analyzes the patient's fear of retraumatization in his relationship with the therapist, the archaic narcissistic needs will be mobilized into the transference. However, in eating-disordered patients this development is slow (9) because the archaic narcissistic needs have been detoured into the disturbed eating behavior and are not readily available to fuel selfobject transferences.

Case Presentation

The following case report exemplifies some of the foundations upon which the self-psychological conceptualization of an eating disorder and its cure are based.

Adi was 21 when she came to therapy (The patient agreed to the publication of her story provided all identifying details will be changed. This was done to her satisfaction) at her family's initiative and pressure. A year before her referral to therapy, her sister got married. This sister elicited in Adi strong feelings of envy and competition. In order to be more beautiful than her sister, the bride, at the wedding party, she inflicted upon herself a severe diet, which included refraining from almost all food. The minimal amount of food that she ate, mainly on Saturday evenings, she vomited. She lost many kilograms and reached a weight that was 20% less than the norm for her height. Her menstruation stopped. She was diagnosed as suffering from anorexia-restrictive type. There were no binges.

Adi was the third of four children in the family. The first-born son was Yotam and the next child was Tzippy, one year older than Adi. After Adi came Danny, four years younger than Adi. The competition with her older sister, Tzippy, filled Adi's entire psychic life. The closeness of their age brought about many comparisons, which friends and family members used to make between the two girls. From Adi's point of view, the crucial issue for competition and comparison was her outward appearance. Unfortunately, it seems that the family members also emphasized outward appearances. Adi remembers painfully how she heard her older brother telling one of his friends that he had two sisters, one is beautiful (meaning Tzippy) and one is "plain" (Adi). (Adi chose a much more derogatory idiom to describe that comparison between sisters, i.e., "Beauty and the Beast," the famous fairytale title.) According to this comparison, Adi felt herself to be awkward, clumsy and as ugly as a beast.

Adi experienced her mother as cold, who could not give love and warmth and could not see her child's point of view. The mother preferred the eldest son, whom she idolized, perhaps because he was a male, or because of his being the firstborn, or more probably due to both of these reasons. Due to his privileged and important position in the household, his preference for her sister, Tzippy, was especially painful for Adi.

Adi felt that her mother also preferred Tzippy over her. Adi reacted in a supreme effort to please and placate her mother in many domains: in the physical domain, by trying to devote herself to assisting her mother; in the social sphere, in her mother's many "misunderstandings" with her friends, and in the psychological sphere, where she was always alert to cheer up and delight her mother, whenever she felt that her mother was depressed. Adi never missed an opportunity to buy her mother presents at the expected events, such as holidays and birthdays. A sharp pain was raised in Adi more than once when her mother had transferred these gifts to Tzippy.

Adi experienced her father to be much more attentive to her than her mother. More than once he had been available to Adi when she needed his help, but, nevertheless, the gains that she could attain from his behavior were dimmed for two reasons: first, the father's positive attitude was distributed equally to all his children, while Adi expected her father to behave in a corrective discrimination in order to compensate her for her mother's estrangement; second, it would seem that the father hesitates to support a child if this behavior would have been interpreted as an opposition to his wife.

The first weeks of therapy were characterized by

Adi's great hesitation and wonderment with regard to what she termed as dependency on me. When one of the therapeutic sessions was cancelled, she said at the beginning of the next meeting, "What happened to me? Do I begin to feel dependent on you?" When I asked her to say more about this, she said, "It is surprising to me to become aware that never did I feel dependent on people. I could not feel a dependency on my parents, especially not on my mother. This relationship (meaning the relationship with me) is the first stable relationship I've had. It seems to me," she went on to say, "that the first days after the session are okay from the point of view of eating, but it is only sufficient for two to three days. Towards the second half of the week, I cease eating, wait for Friday dinner and vomit it. How would I be able to transfer this dependency that I'm beginning to feel towards you to someone else? If I transfer this dependency onto a friend or friends, it will mean that I have to give up my individuality and to give up the door which closes me up in my room, to give up the comfort and the orderliness that the engagement with food provides me. In the meantime, all that I can see that exists in relationships between human beings (she meant in the relationship between her parents) is only manipulation and tensions." I said that I feel that a relationship to a person cannot yet compete with the rewards she gains from the engagement and preoccupation with the food and its avoidance. She seemed to have felt relief and perhaps even surprise that I am not adversarial towards her feelings with regard to food and the preference that she gives to the food over relations with people.

In one of the sessions which followed, she related a dream in which she stood near the grave of her parents. In her associations to this dream, she said that she feels that she is not allowed to "stand up to" her parents and especially to her mother, in order to demand what she deserves. For example, she felt that if she requires that the gifts she received should be equal to what her brothers received, or if she insists that her brothers should share her chores, such as cleaning or preparing the Friday dinner, it might bring about the death of one of her relatives. I interpreted that she feels that if she demonstrates presence in the world, it will be at the expense of somebody else. She accepted this interpretation with a feeling that something of importance was revealed here. She added, "It might be connected also to this image that I have that I invented about this issue of the 'Beauty and the Beast' with regard to my sister and myself." When I asked about what she meant, she said that she feels that it is like a closed system. "If I am the beauty, then she is the beast, and if she is the beauty, then I am the beast, as if there is not enough space for two beautiful girls." Adi repeated this thought several times in the following session. In one of those sessions she added that she thought several times in the past that the arrival of Danny to the world will bring about the death of one of his older siblings.

On the allegory itself of "Beauty and the Beast," according to which she is the Beast, I commented in what seemed to me to be a comment with a somewhat cognitive color, "Even animals allow themselves to enjoy food and you do not." She accepted this and said that now she realized that in order to facilitate vomiting, she imagines a disgusting animal. "Now I am thinking to myself that my sister and her husband can enjoy so much a tasty humus with olive oil, and what about me? When the dietitian suggested that I can add a daily sandwich with food that I love so much, how can I permit myself to indulge in such pleasure?" I added that in her avoidance of food, she does not seek beauty as much as she is trying to reassure herself that she doesn't deserve being indulged or fed.

In the following session, Adi spoke copiously about her craving for her mother's love. "I feel that until she reciprocates the love that I so missed, I will not be able to love myself or indulge myself."

After several months in therapy, Adi met her first boyfriend, Eran. In one of the sessions, she said that Eran also does not bestow upon her love and indulgence. When she noticed my surprise (because my impression was that Eran used to indulge her a lot), she explained that he did not surprise her with flowers when they celebrated a certain event at a restaurant. My statement, "He did not perform the ceremonies that you hoped he would" (a statement that apparently conveys an attitude that belittles Eran's 'misbehavior')," elicited the reaction, "You can call it what you want, ceremonies or not ceremonies." I felt that she was offended because I did not view the situation from her perspective and I had said something that could have been construed as accepting

his point of view. I clarified to her this understanding of mine. Her reply surprised me in its clarity and sharpness. While crying she said, "Here is the only place that is truly mine. You are always on my side, even more than I, myself, am on my side. I know that certainly Eran has also got needs and matters of his own, but I didn't expect that you, during my session, would refer to them and not to me." I said that I understand that it is very crucial for her that I will see things through her glasses and I added that I understand her pain when I'm not doing this. These acknowledgements of mine in my empathy-failures ameliorated, to a certain extent, the pain and the anger, but she continued for weeks to feel the indignation and according to her reports, there was an aggravation in her eating patterns. It was clear that her reliance on me and on Eran increased during these several months. We understood that, to the extent that she gradually gives up her preoccupation with the disordered eating patterns and increases her referral to Eran, so does her expectation of warmth, support and love from him increase, and so did her disappointment and pain at every misunderstanding, as small as it may have been, between them.

Perhaps a similar phenomenon to the greater place which Eran takes in her life as a source of confidence and comfort, replacing the food, can be seen in her lesser and lesser referral to superstitious beliefs (e.g., black cat, broken mirror) as a tool of obtaining calmness and a sense of arranging her life.

In this period in therapy, she once remembered that during their studies in high school, her sister, Tzippy, once told her that she is "too enmeshed in my life, too attached to me." Her first reaction was to think of committing suicide. "Look how quickly I was willing to give up my life if she said that our closeness is crowding her." At that time, she dreamt a dream in which her father tells Tzippy to take a sweater which belongs to Adi. Tzippy answers her father in that dream, "No, that belongs to Adi." And then the father answers, "Never mind. Adi doesn't need it and she can always give up clothes." Associating further to the dream, she remembers that whenever she gained weight, as the therapy progressed, her father used to happily comment, "You will return to be what you used to be…smiling." She felt somewhat ill at ease with this comment of her father's. She continued in her flow of associations and remembered that her father complained in an unclear manner that he is not satisfied with her "independent behavior." He complained that she "deceived others." For example, when he invited her to join him in his hobby, traveling with his jeep in nature reserves, she initially agreed and then refused. She went on to say, "I think that what happens is that whenever he asks something of me, I automatically agree, like to all the requests of all my family members. I really hate traveling with him in the jeep, but I always knew how important it was for him and I agreed. Now, after automatically saying 'yes,' I check if I really want to."

The last third of therapy was characterized by Adi's fear of what she termed "losing control," "a failure of the brakes." She is afraid that if she begins to express her wishes and desires, she will not be able to stop. "If I start eating freely, I will not stop until I become as big as a barrel," or "If I could have met you with the frequency that I wanted, it would be every day." I told her that now that she begins to wish and to express herself, she is afraid that she lacks something within herself that can regulate her behavior, as if she does not believe that her capacity to steer and lead herself was grown inside of herself. "I especially worry how I would be able to transfer the confidence that I have acquired in the relationship with you to the relationship with Eran. If I trust only him and not the preoccupation with eating or not eating, he will not be able to be there all the time for me." Gradually, another fear in her relationship with Eran was unfolded — sexual attraction and enjoyment in her relationship with him on the one hand, and a feeling of tension whenever she was with him in bed, on the other hand. She forbade him to mention her father or brothers whenever they are in bed. A further careful and cautious therapeutic elaboration yielded, somewhat, clarification of Adi's fears. "Since adolescence, I thought or hoped that my father would be aroused and have sexual desires towards me. I do not have any realistic basis for such a thought — perhaps I saw a small glance that he did or did not send my way. I'm sure that had I had enough love from my mother, I wouldn't have had to look for or think or imagine that he desired me."

At that period, I had noticed a somewhat strange behavior on her part whenever she entered my office. It was summertime and whenever she entered

and was near the door, she took off her sandals and walked barefoot to her chair. When this phenomenon repeated itself consistently, I asked her about it. At the beginning, she belittled my curiosity. "It is summer and it is hot." But after a while, my question did arouse curiosity in her and then she related that she always walked barefoot. Reflecting on this behavior, she went on to say that perhaps this behavior fulfills two functions for her: the first is some kind of "striptease" behavior or a kind of intention to provoke men, especially her father, and the other is a kind of intention of asceticism, i.e., she used to walk barefoot even when it was cold and especially when it was inconvenient for her. "Striptease" is allowed because it is not so much sexual and therefore she can act this "striptease" also in front of her father. Secondly, the barefootedness (in her opinion) should convey the message of asceticism and making do with less, features which her father approves and values. Such behavior as making do with less and mortification, which characterized her personality, could be added easily to her behavior which she thought also would yield sexual gain. The impact of this therapeutic intervention was surprisingly immediate. It brought about a quick relief of tension in her sexual relationship with Eran. It is worth mentioning here that according to Kohut(2), the emergence of the oedipal layer after treating layers which are connected to the injured self is a probable and common phenomenon.

Several months before the termination of therapy, Adi married Eran. Steady improvement in her symptomatology continued. The vomiting had totally ceased. Gradually, she gained weight until a normal weight was signified by the return of her menses. She became pregnant and after termination of therapy, she gave birth to an infant girl. In the follow-up session after the termination of her therapy, she expressed great happiness with her marriage and child. "One smile from Eran or the child is worth a thousand times more than the stupid joy that I once had with each kilogram that I succeeded in getting rid of."

Discussion

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 (17). In attempting to summarize her life-long contribution to the field (17), she said that the theory of self-psychology systematically conceptualizes the clinical phenomena and techniques to which she intuitively pointed.

Swift (18) 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" (19, 20). 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 (19, 20). Swift (18), 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 efficacy of the self-psychological approach to the treatment of anorexia both in ameliorating the symptoms and in achieving intrapsychic change was demonstrated in a randomized controlled study (11).

Self-psychological conceptualization of the eating disorders is much closer to the clinical observation and the theoretical formulation of other psychological approaches with regard to these disorders. The therapist's stance and the therapeutic modes are, of course, different and diverse. But, it is enthralling and enriching to see the similarities in the clinical observations and the theoretical conceptualizations of different approaches in the understanding of the etiology of the disorder. Such similarities between such different and diverse observations and viewpoints strengthen the validity of the understanding of the roots which underlie the etiology of the disorder.

The Kleinian approach is considered within psychoanalysis as polarized with the self-psychological approach. Nevertheless, neo-Kleinians, like Williams (21) in the sphere of eating disorders, reached a conceptualization which is fascinating in its similarity to that of self-psychology. Williams (21) describes role-reversal of container and contained between the future eating-disordered adolescent girl and her parent. The mother, according to this approach, cannot operate for her child what Bion (22) termed alpha-functioning, i.e., the ability of the parent to contain painful feelings that her child feels and to modify them for him. Not only can't the mother of the future eating-disordered child fulfill these functions for her child, but rather she projects her own painful feelings onto the child and expects that he will contain them. One can find in this perception verification which comes from a different theory to the observation and conceptualization of self-psychology to the reversal of roles between self and selfobject between parent and child. The range of functions which a selfobject fulfills for a self who needs him is much wider than containing functioning which Bion (22) and Williams (21) mention, but containing is no doubt not insignificant among them.

The cognitive-behavioral approach is considered within psychology to be polarized with all of the psychoanalytical approaches. Nevertheless, again, it is enthralling that with regard to the characteristics which underlie the disorder and the therapeutic aim which ensues from them, this approach sees eye to eye with this new approach of psychoanalysis — self-psychology.

Garner and Garfinkel (23) view low self-esteem and the inability to insist upon one's viewpoint and to express it as precursors of anorexia. Garner et al. (24) suggest reinforcements whenever the anorexic child demonstrates behaviors which express her self-determination.

Family therapy (25, 26) also tries, using different therapeutic techniques than self-psychology or cognitive-behavioral therapy, to achieve emancipation or the release of the adolescent girl from the enmeshment and the overprotection of her family. The therapy, according to this approach, tries to enable the anorexic adolescent girl, via improving the communication pattern in the family, to search for autonomous will and to express it.

References

1. Morton R. Physiology of consumption. London: Smith & Walford, vol. 2, 1694: pp. 5-6.
2. Kohut H. The analysis of the self. New York: International University, 1971.
3. Goodsitt A. Eating disorders: A self-psychological perspective. In: Garner DM, Garfinkel PE, editors. Handbook of psychotherapy for eating disorders. Second edition. New York: Guilford, 1997.
4. Goodsitt A. Self psychology and the treatment of anorexia nervosa. In: Garner DM, Garfinkel PE, editors. Handbook of psychotherapy for anorexia nervosa and bulimia. New York: Guilford Press, 1985: pp. 55-82.
5. Wolf ES. Treating the self: Elements of clinical self psychology. New York: Guilford, 1988.
6. Kohut H. How does analysis cure? Chicago: University of Chicago, 1984.

7. Barth D. When the patient abuses food. In: Jackson H, editor. Using self psychology in psychotherapy. Northvale, New Jersey & London: Jason Aronson, 1991: pp. 223-242.
8. Geist RA. Self psychological reflections on the origins of eating disorders. J Am Acad Psychoanal 1989;17:5-28.
9. Sands S. Bulimia, dissociation and empathy: A self-psychological view. In: Johnson C, editor. Psychodynamic treatment of anorexia nervosa and bulimia. New York: Guilford, 1991: pp. 34-50.
10. Bachar E. The contributions of self-psychology to the treatment of anorexia and bulimia. Am J Psychother 1998;52:147-165.
11. Bachar E, Latzer Y, Kreitler S, Berry E. Empirical comparison of two psychological therapies: Self-psychology and cognitive orientation in the treatment of anorexia and bulimia. J Psychother Practice Res 1999; 8:115-128.
12. Ulman RB, Paul H. A self-psychological theory and approach to treating substance abuse disorders: The intersubjective absorption hypothesis. Prog Self Psych 1989;5:121-141.
13. Bachar E. The fear of occupying space: Self-psychology in the treatment of anorexia and bulimia. Magnus: Jerusalem, 2002 (in Hebrew).
14. Levin J. When the patient abuses alcohol. In: Jackson H, editor. Using self-psychology in psychotherapy. New Jersey and London: Jason Aronson, 1991.
15. Kohut H. The addictive need for an admiring other in regulation of self-esteem. In: Elson M, editor. Kohut's seminars on self-psychology and psychotherapy with adolescents and young adults. New York: Norton, 1987.
16. Kohut H. Preface to psychodynamics of drug dependence. In: Blain JD, Julius DA, editors. Psychodynamics of drug dependence. Washington, D.C.: Government Printing Office, 1977.
17. Bruch H. Four decades of eating disorders. In: Garner DM, Garfinkel PE, editors. Handbook of psychotherapy for anorexia nervosa and bulimia. New York: Guilford, 1985.
18. Swift WJ. Bruch revisited: The role of interpretation of transference and resistance in the psychotherapy of eating disorders. In: Johnson C, editor. Psychodynamic treatment of anorexia nervosa and bulimia. New York: Guilford, 1991.
19. Bruch H. Psychotherapy in primary anorexia nervosa. J Nerv Ment Dis 1970;150:51-66.
20. Bruch H. Eating disorders: Obesity, anorexia nervosa and the person within. New York: Basic Books, 1973.
21. Williams G. Internal landscapes and foreign bodies, eating disorders and other pathologies. London: Duckworth, 1997.
22. Bion WR. Attacks on linking. Int J Psychoanal 1959;40: 308-315.
23. Garner DM, Garfinkel PE. Cognitive treatment of anorexia. In: Garner DM, Garfinkel PE, editors. Handbook of treatment for anorexia and bulimia. New York & London: Guilford, 1985.
24. Garner DM, Rockert W, Davis R, Garner MV, Olmstead MP, Eagle M. Comparison of cognitive-behavioral and supportive-expressive therapy for bulimia nervosa. Am J Psychiatry 1993;150:37-46.
25. Minuchin S, Rosman BL, Baker, L. Psychosomatic families. Cambridge: Harvard University, 1978.
26. Palazzoli MS. Self-starvation: From individual to family therapy in the treatment of anorexia nervosa. London & New York: Jason Aronson, 1985.