Evidence Basis for Psychodynamic Self-Psychology in Eating Disorders – A Review Paper

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ABSTRACT

The purpose of the present study is to present the empirical basis for the capability of the theory of psychodynamic self-psychology to predict in cross-sectional and prospective longitudinal studies, both the development of and the remission from eating disorders. In addition, we present the effectiveness of psychodynamic self-psychological treatment in a randomized control study over two other techniques. Theoretical constructs of the theory and technique suggestions will be weaved into the empirical data.

In the last two decades, studies are beginning to accumulate providing the evidence basis for the self-psychological theory to predict the development of eating disorders (ED) in cross-sectional and prospective longitudinal studies, hence, contributing to the understanding of etiological factors that can predispose the individual to develop these disorders. Other studies, again governed by self-psychology, starting with cross-sectional research, then followed by longitudinal studies, have predicted remission from ED.

At the heart of self-psychological understanding of the etiology of EDs lies the observation that the adolescent who is liable to develop an ED is characterized by self-denial and self-sacrificing behavior for the needs of others. Theoreticians and clinicians who wrote before the emergence of psychodynamic self-psychology also made that observation, mainly Minuchin, Rosman and Baker (1) and Selvini-Palazzoli (2), but limited it to the family realm. Both Minuchin et al. and Selvini-Palazzoli describe the adolescent’s tendency to sacrifice her own needs for the sake of the family needs. Selvini-Palazzoli and Bruch showed retrospectively, in anecdotal case reports, that children who are liable to develop ED feel guilt whenever they require something for themselves (2, 3).

Self-psychology, through the explanatory power of the interesting concept of selfobject and self-selfobject relationships, links these same observations to the patient’s entire range of interpersonal relationships and to her basic view of the world. Through this conceptualization, self-psychology gives us specific therapeutic tools to deal with this basic interpersonal dynamic.

The patient’s tendency to relinquish her own interests and ignore her own needs to serve the interests and well-being of others is apparent in many utterances of patients or recovered patients: “All of my life I lived for other people,” writes one ex-patient, “not out of choice, but because I didn’t know any other way. It wasn’t until years later that I found out that I didn’t actually have a self. I became what other people liked, thought, said and did; without respect for myself, going day by day trying to please other people so that I could be good enough” (4).

Another recovering patient, quoted by Bachner-Melman (5), said: “I was a pleaser from a very young age to my father, mother and other family members and friends, and this took away my freedom to make choices that were right for me…. The happiness of others was primary in my life… I did everything…I volunteered for every job, every week.”

We gathered similar statements using the Selflessness Scale. The scale assesses the individual’s tendency to ignore his or her needs to serve the needs of others (6). The following examples are representative of the responses:

“I am willing to sacrifice a lot for the benefit of others.”

“I usually give in to the will of others.”

“If the family budget is limited I will give up my part.”

“If someone is unhappy I will immediately turn to comfort him.”

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“My own enjoyment is the last thing that is important to me.”

Extreme manifestations of selflessness are also evident in interview responses from patients who were hospitalized for their eating disorder:

“Every breath of mine is at the expense of others.”
“Every pound of mine is a burden upon earth.”

All of these statements express a wish and readiness to ignore one’s own needs and serve the needs of others. These wishes and beliefs ensue from the patient’s (or future patient’s) feeling that she does not deserve to have others serve as a selfobject for her, i.e., she does not believe that other people can give up, even temporarily, their own needs to serve hers.

When individual A refers to 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 to which we have been referring 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 stresses that even healthy and mature individuals do require that their internal self needs be met, at least partially, by selfobjects. However, their reliance upon such selfobjects is flexible and mature. They can endure and even outgrow failures of such selfobjects. The weak self, on the other hand, is dependent, sometimes desperately and totally or archaically, on selfobjects to do what the weak self cannot do.

EXTENDING SELF-PSYCHOLOGY TO THE ETIOLOGY AND TREATMENT OF EDS

Though referring to other human beings with the expectation that they will behave as selfobjects for us is universal and natural (though in different degrees of neediness), the ED patient, as we said, does not believe she deserves that others do that for her. Goodsitt (7) (who wrote just before the publication of the DSM III, when all the spectrum of EDs was called anorexia nervosa) identifies in the patient with anorexia nervosa (AN) an extreme manifestation of the inability to refer to human beings to fulfill selfobject needs – she wishes to behave as if she were a selfless human being. 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. Di Luzio (8) adds to Godsitt’s theorizing about the selflessness position by emphasizing the current or future ED patient’s doubts about her “right to exist.”

The typical observations of many parents of patients with AN 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 ED patient as a selfless human being who devotes herself to the fulfillment of other’s needs. Because she cannot rely on human beings to fulfill her needs, she refers to food as a selfobject.

The patient with AN 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 patients with AN becomes acquainted with their feeling of great triumph that comes with every pound they lose. The elimination or the denial of the need for food fulfills mirroring selfobject needs.

The patient with BN derives satisfaction of her selfobject needs through food, mainly through idealizing experiences (9-11). Food is experienced by her as an omnipotent idealizable power; it supplies soothing, calmness, and comfort and regulates painful emotions such as anger, depression or shame and guilt (9, 10, 12, 13). 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.

The purging behavior in BN patients ensues according to self-psychology (9) from the patient’s inability to maintain the comforting soothing emotions derived from the binge, seeing them as an act of self-indulgence that she feels she does not deserve.
When an ED patient (or potential patient) does promote her own interests, according to this theory, she is liable to feel self-guilt. As a result, she often finds herself living life in its narrowest parameters, relinquishing her own interests, compromising her development, giving up her well-being and denying even her most basic needs, including nourishment (7).

In 2010, we (14) found empirical support to the theoretical conceptualization of self-psychology, which points to the etiological role of the selflessness position and being selfobject for others in EDs. The selflessness scale, to which we referred above, predicted the development of ED in a prospective longitudinal study, over a two- and four-year follow-up. We followed seventh grade females in a large community-based sample, over four years. The selflessness scale predicted the development of ED in these people with a sensitivity of 82%, that is, in 82% of the cases the scale predicted correctly that they would develop ED from the baseline to a two and four year follow-up. While a high score on the selflessness scale predicted the development of ED, a normal or lower score on the selflessness scale (i.e., when the adolescent did not tend to ignore her own needs and serve the needs of others), served as a protective factor from developing ED, even in an at-risk population (14).

An interesting finding by Bachner-Melman et al. (15) shows that the patient with AN, while being ill, is “proud” of her selflessness position. They found that the higher the score of selflessness, the higher the tendency of the patient with AN for higher self-esteem, while no such correlation was found in normal controls. She suggests that it is as if the patient with anorexia nervosa is asserting: “I do not deserve to treat myself well, I should be attuned only to the needs of others.”

Self-psychology (10, 16) assumes that EDs originate, like other disturbances of the self, from chronic disturbances in empathy emanating from the caretakers of the growing child. The uniqueness of EDs is that at some crucial point in her development, the eating disordered child, whose crucial selfobject needs were not being met empathically, invents a new restorative system in which disordered eating patterns (as we showed above) are used instead of human beings to meet selfobject needs. The child relies on this system because previous attempts to gain selfobject-sustaining responses from caregivers were disappointing and frustrating.

Again we found empirical support to the difficulties of mothers of daughters with AN, to fulfill the expected role of behaving as a self-object for their daughters (17). We, of course, expect parents to demonstrate the ability to be selfobjects for their offspring and not vice versa. In this study we found that the selflessness levels of mothers of daughters with AN were significantly lower than the levels found in control mothers of normal adolescents. We also found a very high correlation between a daughter with AN’s selflessness scores and mother’s signs of depression, hinting to the possibility that when the patient with AN identifies signs of emotional distress in her mother, she increases her tendency to behave as a selfobject for her. No such correlation was found in the control group between normal adolescent girls and their mothers (17). Yet in contrast with the previously mentioned community-based prospective longitudinal study and forthcoming longitudinal follow-up study, this correlational study (17) should be supported by a prospective longitudinal study in order for the direction of causality to be corroborated.

We have mentioned the well-known observation that Selvini-Palazzoli (2) made long ago that children who are liable to develop EDs feel guilt whenever they require something for themselves. Our prospective study (14) showed that children who are high in selflessness tended to develop EDs within two and four years. Moreover, we quoted parents’ observations regarding the self-sacrificing behavior of their daughter that later developed an ED. It might well be that children who are afraid “to occupy space in the world” and who do not feel they have the right to exist and to require that their needs be met, may not challenge their parents’ selfobject skills enough, and not provide opportunities for them to practice those skills sufficiently. The end result may be a reduced capacity to serve as effective selfobjects for their daughters (18).

Thus far, we reviewed etiological and predisposing factors, and showed the empirical support for the ability of self-psychological constructs quantified in the selflessness scale, to predict the development of ED. Before presenting the therapy and the evidence basis for self-psychology in treating EDs, we will review cross-sectional as well as prospective studies showing the capacity of the selflessness scale to predict remission from EDs.

Bachner-Melman et al. (15) found, in a cross-sectional study, that selflessness levels decreased according to levels of remitting from AN. Similarly, Pinus et al. (19), in a prospective longitudinal follow-up study of adolescents who were discharged from a day care unit, with an average of 5-year follow-up, found that only low selflessness level in admission significantly predicted remission from ED in follow-up. In contrast, admission
level of depression, trait or state anxiety, and initial level of symptomatology (assessed by clinical interview or self-report EAT-26 scale) could not predict remission in follow-up. When EDI total score was divided into its 11 subscales, only maturity fears (from the 11 subscales of EDI-2) and selflessness scale in admission could significantly predict remission at follow-up, but the strength of selflessness was the greatest.

THE THERAPY

In therapy, the therapist should reverse the pathological cycle, i.e., the belief that human beings cannot serve as a selfobject for the ED patient and that she has to refer to food to supply her selfobject needs via consumption of food in BN or via deriving self-esteem from avoiding food in AN. The therapist looks for opportunities to revive the patient's hope, expectation and belief that other people are able and willing to behave as selfobjects for her, 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. Technically, the therapist should stay more than the classic psychoanalytic/psychodynamic therapist, in a therapeutic stance, which can be called “experience near” (near to the patient's subjective experience), rather than an experience distant stance. This stance will be exemplified through the following vignette.

M., a 23-year-old woman with AN, 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 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 within, from an experience near stance 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 long 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 her competence and capacity to understand herself and contribute to her development. One possible comment from the therapist could have been: “How good does it feel to be competent and successful in the way you treated yourself?” In such an intervention, the therapist behaves as a selfobject because she ignores her own perspective (being an active agent in the patient’s cure), and views the situation only from the patient's point of view. The interpretation concerning competitiveness, stemming more from an object relations perspective rather than self-psychological perspective, 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.

Self-psychologically informed therapists, more often than traditional psychodynamic therapists, slip from free-floating attention to the patient into special attention on vicarious introspection (introspection “from within” from the patient's perspective) 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. According to Wolf (20), 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 effectively on the side of the patient's self without necessarily joining the patient in all of his/her judgments. The therapist, according to Kohut (21) sees him/herself as being simultaneously merged with, and separated from, the patient.

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.

Treating ED patients involves many cases in which the therapists find themselves unable to empathize with the patient's perspective. How, for example, can the therapist empathize with the great triumph the patient with AN expresses upon losing more and more weight? A therapist on our staff conveyed his distress to the patient upon his
inability to empathize with her perspective by using 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.” Using this metaphor, the therapist expressed the danger and the fatal consequences that can occur when one's subjectivity cannot be addressed or acknowledged by others. Pointing at the tragedy of the inability to be empathic entails, of course, a great amount of empathy, or at least mention of the wish to be empathic and the tragic circumstances that ensue when that cannot happen.

We found empirical support for the efficacy of the self-psychological approach compared with two other interventions. We (22) compared a self-psychological approach to a specific kind of cognitive therapy – cognitive orientation treatment (23) and a control/nutritional counseling only treatment, without psychological therapy. These interventions were administered over a one-year period. Patients in the two psychological treatments also received nutritional counseling. It is our belief that nutritional counseling, which includes monitoring the symptoms and teaching healthy eating habits, is always necessary. After initial evaluation, patients were randomly assigned to one of the three interventions: self-psychological treatment; cognitive orientation treatment; nutritional counseling control group. Self-psychological treatment achieved significantly better results than the other two interventions, both in removing the ED symptomatology and in an intra-psychic variable of the cohesion of the self.

These results of the greater inner gains achieved in addition to the alleviation of the symptoms in psychodynamic therapy versus other approaches is consistent with the recently published large randomized controlled study published by the ANTOP study, where it was found that the only significant differences among the three approaches: psychodynamic approach, optimized treatment as usual and CBT was that in the variable of recovery (combined BMI and general EDs' psychopathology), psychodynamic achieved significantly better results than the optimized treatment as usual, while the CBT fell in between without reaching significance. The ANTOP (24) study researchers conclude their paper in saying, “Psychodynamic treatments make interpersonal relationships the major theme. Compared with cognitive behavior therapy they are less directive, induce augmented emotional arousal, and target insight more (vs behavior and cognition). In view of difficulties in the field of autonomy that individuals with AN have, we postulate that these specific aspects of psychodynamic therapy contribute to the positive effects of treatment in this patient group” (p. 135).

While the ANTOP study showed the advantageous effect of psychodynamic psychotherapy in AN, another recent RCT study (25) showed that in BN, CBT achieved better results than the psychodynamic treatment in alleviating binging and purging symptoms. But in the variable of “general eating disorder symptomatology” no differences were observed.

CONCLUSIONS

Self-psychology addresses the selflessness trait or selflessness stance of the ED patient which, according to clinical observations from several theoretical viewpoints that we mentioned above and, according to the longitudinal prospective study, is at the root of the disorder. Cross-sectional and prospective longitudinal studies showed that high levels of selflessness predict the development of EDs in a community-based sample, while low levels of selflessness at admission predict remission in follow-up and serve as a buffer against developing EDs in risk groups.

International research across nations is always recommended. A first step in this direction was made (26) considering a joint project regarding mediating variables in psychodynamic psychotherapies, including self-psychology. It is clear that one theory cannot explain fully such complex phenomena as eating disorders. One should bear in mind factors such as societal norms and genetic variables that may play a role in influencing cause and course of eating disorders.

The unique therapeutic stance of the therapist who stays, more than the classical psychodynamic/psychoanalytic therapist in an experience near selfobject position, is especially suited to renew the patient's hope in human beings as potentially able to serve as a selfobject for her. The potential in this relationship can renew her belief in her right to exist, help to develop both her individuality and an independent center of initiative. This stands in contrast to her previously morbid style of living life in its narrowest parameters, ignoring her interests and relinquishing her development.

These gains are no less important than the remission of the symptoms, which were also found to improve in self-psychology treatment significantly more than in the other two interventions, as the empirical study we mentioned above showed in both domains: in the inner
gains and remission of the symptoms, self-psychology treatment achieved better results than the other two interventions.

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References