Case Report

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Bulimia, separation anxiety, and finding the authentic self

Abstract

Eating disorders, such as anorexia, bingeing, and purging, have recently been widely discussed in the interpersonal/ relational psychoanalytic world. The interpersonal/ relational perspective of eating disorders is that of a thwarted, gendered, agentic self. To these psychoanalysts, the eating disorders represent dissociated self-states[1–5] and express a forestalled sense of personal agency or "not-I-ness".[5–7] Petrucelli[8] maintains that an eating disorder is a maladaptive attempt to be self-protective rather than simply self-destructive. It is therefore useful in working psychotherapeutically with eating-disordered people to reclaim dissociative pockets of their psyche which are paradoxically split-off explosive energies of "not-I-ness" that also contain the seeds of the patient's psychological recovery.[9]

A clinical example illustrates these concepts. At the start of therapy, Michelle's bingeing was multi-determined: part of her wanted to be passive, not grow up, and be taken care of like her mother; her bingeing also represented her conflict of finding it impossible to consciously acknowledge this. In our relationship, Michelle played out her maternal dyad by worrying that our self-representations would "infect" each other. But after five years of therapy she realized she could begin to make choices in her life without debilitating terror. As Michelle became more emotionally self- attuned to her affective needs, her bingeing and purging diminished and ultimately stopped. Michelle found the courage to define and fulfill her desires as a woman. It was no longer necessary to express those dissociated parts of her desire through her eating disorder.

Keywords: bingeing, purging, dissociation, agency, gender, separation, differentiation, relational

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Case report

Eating disorders, such as anorexia, bingeing, and purging, have recently been widely discussed in the interpersonal/relational psychoanalytic world. To these psychoanalysts, the eating disorders represent dissociated self-states[1–5] and express a forestalled sense of personal agency or "not-I-ness".[5–7]

Petrucelli[8] maintains that an eating disorder is a maladaptive attempt to be self-protective rather than simply self-destructive. It is therefore useful in working psychotherapeutically with eating-disordered people to reclaim dissociative pockets of their psyche which are paradoxically split-off explosive energies of "not-I-ness" that also contain the seeds of the patient's psychological recovery.[9]

The interpersonal/relational perspective of eating disorders is that of a thwarted, gendered, agentic self. It assumes a model of gender identity development based on the idea that children establish their gendered self based on the interaction with their parents.[5] These interactions are informed by fluctuating processes of projection and introjections shaped by their parents' own conscious and unconscious gender identifications.[5,10–14] People with eating disorders preserve the illusion of self-sufficiency and control to protect against the vulnerability inherent in wanting and asserting personal agency.[2,3,5,15,16] They have difficulty consolidating an actualized, gendered self who can want and act appropriately to fulfill their desires. A clinical example illustrates these concepts.

The essence of psychotherapy in eating-disordered patients is to consciously reclaim their dissociated self-states. However, in some cases, such as the case of Michelle, there was not sufficient sense of self and object to be able to initiate this work. This article therefore also discusses the preliminary work of helping Michelle achieve object constancy, in order to reclaim her dissociated self states to overcome her bulimia. Initially, Michelle found it too painful to examine her own interiority, so we focused on building a foundation of psychological differentiation and growth. By working through her mistrust and fear that I would leave her, we were able to create her newfound feeling of being secure enough in our therapeutic relationship. Michelle's dissociated pockets were clusters of ego- dystonic impressions which were reactions to her parental identification. Michelle's "not-I-ness" was based in her unconscious identification with her mother's refusal to become a responsible adult and preoccupation with appearances and being thin. These unconscious identifications were the seeds for her eating disorder.

Michelle was a 38-year-old American-born Chinese woman, an Ivy League graduate student in political science, who was fighting her way out of binge eating with purging. She had never been married and lived by herself with her beloved cat, Maxy. She was seen twice a week in psychotherapy for five years. Not being encouraged as a child to exercise, Michelle led a sedentary life. When she began psychotherapy, we worked on her having a weekly exercise regimen both to ensure her having other outlets and to feel better. She was drawn to playing soccer and joined a local team. Her regular physical activity empowered her to have a less hostile relationship with her body.

The origins of Michelle's separation anxiety were a result of her tumultuous, unstable childhood. Her parents divorced when she was 2 years old, and they shared custody of Michelle and her younger sister. She alternated between their houses every week until the age of 12.

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When her parents fought over shirking their financial responsibility for her, Michelle felt "used as a pawn". When she was 5 years old, her mother went back to night school to obtain a BA. During this time, her mother also worked and traveled internationally for business. Michelle recalled at the age of 5 being told that her mother would be gone for 2 weeks and not having a sense of how long this was. As she depicted her feelings, "It felt like forever." Despite these long maternal absences, Michelle felt living alone with her mother and sister was the most stable period of her childhood since she received tenderness from her mother.

Despite her mother's occasional tenderness, Michelle felt unwanted by her parents. Michelle's mother was preoccupied with external appearances and rigidly enforced not allowing anyone to wear shoes in her home so as not to dirty her lush white carpet. Her mother valued being thin and having thin children and was blissfully unaware of her inner, emotional state. Towards the middle of therapy, it came out that her mother got pregnant by accident with Michelle and felt forced to marry as they did not believe in abortion. When Michelle was 12, her mother remarried a highly successful Chinese American business man and they all moved into his opulent home. Her stepfather had unpredictable violent outbursts. During one of these episodes, her stepfather hit Michelle. She moved out of their home to live with her father and stepmother. From the age of 12 to 16, she lived with her emotionally distant father and had no contact with her mother. This period was particularly painful for Michelle as she had no maternal support while developing into a young woman. She has no memory of her mother trying to initiate contact during these four years. At the age of 13, Michelle developed panic and terror when separating from others; she worried "that I am going to die".

Michelle felt abandoned and betrayed by her mother's remarriage. When Michelle was still living with her mother and stepfather, her mother focused everything on her second husband, who demanded nothing less. Michelle felt that in order to secure her financial security her mother gave up her happiness and independence to take emotional care of her second husband. Feeling neglected, Michelle began at the age of 13 to binge on sweets and chocolates. Her internalized sense of her mother was to become obsessed with her weight. The food was always there, as opposed to her parents, who were mostly emotionally unavailable. Bingeing provided the illusion of feeling in emotional control. She was in charge of eating and it comforted her temporarily. Michelle was in a pre-separation state and did not have enough interiority and sense of self, which prevented her from becoming an empowered woman. She clung to the futile hope that if she remained a little girl that she would be loved by her parents. Bingeing was Michelle's attempt to emotionally nourish her starved soul.

Michelle's rage towards her mother was a dissociated self-state that resulted in bulimia. At the age of fourteen, her bingeing increased and she gained 20 pounds. Unconsciously, her rage towards her mother for not getting the love she craved was acted out by taking in sweets and then vomiting them out. During this time, she developed a major depressive episode, which lasted for a year, and entailed Michelle's inability to get out of bed to go to school. Despite her difficulty functioning, her father, who was a physician, refused to get her professional help. Instead, he became more frustrated and angry with Michelle.

Michelle's lack of agency and refusal to take responsibility was another example of a dissociated state. Because she felt unwanted by her parents, she unconsciously aborted discovering what she desired and would bring her happiness. Michelle had obtained numerous professional degrees; feeling safer being a professional student, she avoided defining herself through a chosen profession. She infantilized herself by continuing to get yet another professional degree to both avoid being criticized by her demanding stepfather as "not successful" but also proving him right that she was a "failure". In contrast, her stepfather left school at the age of 17 to become a highly financially successful international businessman. The paralyzing anxiety she experienced when trying to make any decision was debilitating. She found it too exposing and dangerous to figure out what she wanted. For Michelle the conflict was "What can I, as a girl, want?" For Michelle, a "good girl" did not express her displeasure when getting a salad with too much dressing and refused to request a new one. She maintained that if she did request a new salad, Michelle anticipated it would fall on mute ears. She struggled with the fear of being like her mother, who was miserable and trapped in her second marriage, but unable to assert herself to leave.

In our relationship, she unconsciously worried that I would take on qualities of her mother to limit us or that she would be like her mother and infects me. Michelle worried that when I moved my office there would be no room for her. She became so anxious that she told me she went to my new office address three months prior to my moving. She obsessed over worrying if my furniture would be the same. Growing up, she had never had a room of her own and would keep her clothes in her car to travel between her parent's houses. She relived a traumatic experience from her childhood with my new office by worrying that there would not be emotional room for her. We worked on her feeling dependent, insignificant and helpless. Gradually, she examined her defense of being "a helpless little girl".

Initially idealizing me while warding off aggressive feelings toward me, Michelle saw me as an independent, American, physician who was "always there" for her regardless of her successes or failures. She maintained that I was strong and reliable. However, there was, despite her denial, a subtle undercurrent that I would abandon her by "going crazy" as her mother's psychoanalyst did and contaminate her with my delusions. Her mother's therapist became psychotic and committed suicide while she was in treatment. Becoming unraveled during this period of time, her mother became depressed and despondent for several months.

Michelle injected into me her fear that I would go crazy and a part of me worried "Is her concern valid?"One day, she noted I had pink in the back of my hair, and to her, this indicated I was "mentally unstable". Being unaware of the pink dye that had permeated into the back part of my hair from a red baseball cap while running, and knowing that I did not have the predisposition to become psychotic, there was still a small part of me that began to question my own sanity. I became infected by her concerns, which she put in me, that I was crazy.

When Michelle began owning the feelings of anger and abandonment she experienced when I was away on vacation, we began to work through her separation anxiety. She came to realize that she blocked her anxiety when I was away and as a result her bingeing and purging increased. She zoned out at home with her cat, Maxy, to avoid her terror over our separation. But by our tackling her old pattern of anxiety when separating, she realized she was playing out both roles in our relationship: Maxy became the little girl dependent, like Michelle, on her, and Michelle was the powerful independent mother, like me, to Maxy.

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Michelle slowly realized that she could trust me and that I was not going "to go crazy." She had more emotional distance from her anxiety over feeling abandoned. She felt safe enough in our therapeutic relationship to begin to take chances to find out what brought her happiness. These were the building blocks of her developing a sense of object constancy.

Initially, she saw me as having it all, "thin, with a successful professional and personal life". We played out her maternal dyad of have and have not. I had "it all" like her mother who was thin and comfortable financially; she was not thin and "had nothing". My being thin was in line with her aspirations. As our relationship deepened, she began to see me as a symbol of a combined parent figure: masculine woman, mommy- daddy joined.[10]

Michelle struggled with finding her agency as a woman, but by reclaiming a positive self-state, she was able to lose weight and obtain a rewarding career. She realized that she was "begging for love" by trying to please others, which prevented her from figuring out what would make her happy. By grappling to define what brought her happiness, she submitted less to her reflex to please others. She discovered she loved playing soccer and joined a local team. I encouraged her to continue working out. During the third year of therapy, Michelle lost 20 pounds and kept the weight off. In addition, Michelle discovered that she was unhappy as a graduate student, so she dropped out during the second year and started a new job as a social worker. Initially, she struggled with refusing to assert herself with her boss, who tended to micromanage her. With much work in psychotherapy, she became able to voice her anxiety when he popped up behind her and leaned on the back of her chair when she was charting on the computer. Instead, she suggested that they have a scheduled time to meet. Her job brought her more joy and newfound independence from her enmeshed family.

In her sexual life, Michelle continued at first to avoid making decisions that would make her accountable. For instance, she dated men who were successful in their careers but were enmeshed with their families and unable to commit in a romantic relationship. Michelle had dissociated sex with men, in which physically she had orgasms but it was not connected with any feeling of intimacy. She was repressed sexually and found it difficult to talk about sex and she dressed to hide her body. Despite not being comfortable with her body or sexuality, she found herself jumping into bed with various men because it meant nothing emotionally except for an affirmation of her attractiveness, and sex provided physical comfort. It was only possible for her to have dissociated sex with men without any emotional attachment.

Working through her noxious maternal introject, she slowly freed herself from her mother's expectations to marry rich. Instead, she focused on finding her happiness. As Michelle transitioned to adulthood, she began to date a man who loved, respected and treated her as an equal. After several years of dating, they married. She became pregnant, and dealt with her anxieties over her changing body without contempt. She processed her irrational fear of having a complicated pregnancy and delivering a "monster" baby. Her pregnancy marked the first time she let go of her fear of her expanding body to use her body in a healthy way. Much to her surprise, Michelle gave birth vaginally without medical complications to a beautiful son. Sharing responsibilities for their son, she and her husband both received time off from their jobs to alternate taking care of him. Despite, at times, regressing into wanting to be taken care of by a wealthy man and becoming irrationally angry with her husband for not being wealthy, she felt fulfilled in her marriage.

At the start of therapy, Michelle's bingeing was multidetermined: part of her wanted to be passive, not grow up, and be taken care of like her mother; her bingeing also represented her conflict of finding it impossible to consciously acknowledge this. But now she realized she could begin to make choices in her life without debilitating terror. As Michelle became more emotionally self- attuned to her affective needs, her bingeing and purging diminished. Michelle found the courage to define and fulfill her desires as a woman. It was no longer necessary to express those dissociated parts of her desire through her eating disorder.

In terms of my countertransference, there was a part of me that identified with Michelle's ambivalence to develop into a fully defined woman. I disliked her "baby talking" as it mirrored an aspect of my thwarted feminine self, at times, refusing to have a voice. Michelle rattled my "good girl" cage to become aware of my inability to surrender in my personal relationships. Our relationship helped move me towards differentiating surrendering to expand to new heights of faith and inspiration with submitting to another. Surrender involves discovering one's authentic self, wholeness and unity with other living beings. In contrast, submission is being a puppet to another. As a result, I began to let go of submitting to a false sense of being invincible, to learn how to surrender and become vulnerable to reclaim myself. As Michelle let go of submitting to her mother's values and worked towards finding her authentic self, I learned how to surrender, which deepened my personal relationships. Both Michelle and I confused submission to the will of another with surrendering to expand the true self as a way of surviving our childhoods. Although I had achieved "masculine" success in my professional career and as an athlete, I struggled with being vulnerable in my intimate relationships.

Michelle's relationship with food was her attempt to secure a healthy attachment with her parents. Taste, texture, and quantity of food became Michelle's focus, desperately attempting to represent elements of affective life she missed growing up. It was her attempt to create a temporary sense of self-sufficiency. Bingeing allowed her the limited gratifying experience of feeling emotionally fed and avoiding her dreaded sense of dependence and vulnerability. Food acted to cement her dissociated sense of self together. Because she lacked the emotional relationships that permitted the daily give and take of being in intimate contact, she had not developed a sense of emotional competency. Binging was a way to try to hold on to her mother. Psychologically, it is much more difficult to give up on searching for a parent's love when it is something one never had. When one has loving parents it is easier to separate to differentiate oneself. It was exquisitely painful for Michelle to give up on begging for her mother's approval, as that approval was something Michelle never experienced.

Michelle's history is characteristic of eating disordered people. Her conflict between dependence and autonomy arose from her arrested development in individuating in her early relationship with her mother. Encouraged, Michelle began to explore the interplay of masculine and feminine attributes; she freed herself from her "good girl" cage to find her authentic self. By resisting Michelle's insistence that I "take over" and assume responsibility, I encouraged her to examine more deeply her feeling "out of control" in order to find who she really was.

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Similar to other eating-disordered patients, she suffered extensive childhood trauma, chaos and abuse. Bingers like Michelle often are unable to self regulate and self-soothe.[17,18] Binge eating became Michelle's adaptive and maladaptive manner of self -soothing.[19] Healthy self-soothing is a learned behavior through a relationship with another person.[17] Michelle was not taught how to self-soothe, as her mother did not have this coping mechanism. Instead, Michelle remained in an infantile-like state, feeling completely dependent on others. From an interpersonal/ relational perspective, binge eating is not only a dysfunction but also an adaptive attempt to be self protective and a coping mechanism.[2,20,21] By refusing to make a decision, Michelle desperately avoided feeling loss, as it was too painful, and she became paralyzed when having to make a decision. How could Michelle have revealed herself when her stylish, thin mother withdrew from her own aspirations for independence and her daughter's desires for her? She had suffered traumatic losses through her unstable childhood, including not having any maternal guidance throughout puberty. But, now, Michelle's resistance to experiencing loss by refusing to make any choices only brought her more loss and prevented her from becoming an empowered, adult woman.

Austin[9] maintains that Jung's[22] view of the psyche as healthily dissociable is useful in understanding and treating people with eating disorders. In Jung's view of the psyche, our neurotic and psychotic fragmentations drive us to try to see who we authentically are and how we relate to the world. We were not able to assess these dissociated parts of Michelle until she developed a sense of trust and object constancy. Only after Michelle felt reasonably assured that I was not going to abandon her by going crazy, were we able to access her pockets of "not-I-ness". Michelle's unconscious dissociated states also contained insights that brought with them their own possibilities. Initially, she resisted accessing these split-off pockets of aliveness because they were too painful and scary. Eventually, she became able to feel her terror instead of bingeing during stress. Jung's[22] view is that our insight will come through the exploration of these split off pockets of madness. These pockets contained the seeds of her recovery rather than defenses against it.

Michelle's psychotherapy seemed too good to be true, with a fairytale ending of a rewarding career, loving husband and joyful son. But it also happened to be true. After several years of building our relationship, she trusted me enough to be treated with a low dosage of Prozac for a year. After five years of psychotherapy, her bulimia and purging resolved, Michelle felt ready to terminate. Feeling like I had given birth to a daughter, I was fulfilled seeing Michelle blossom into a substantial woman.

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None.

Conflict of interest

The author declares no conflict of interest.

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