

# CHAPTER 7

## Eating Problems

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**H**er worried parents brought a 20-year-old woman to a clinic for help. Excruciatingly thin, she had an engaging smile and a friendly personality, and the body of a prepubescent child. She acknowledged that she exercised a great deal, running six to seven miles a day and setting her alarm to wake up in the middle of the night so that she could work out, because, as she said, "I don't want to gain weight while I'm sleeping." However, she denied that she restricted her food intake, saying that she wasn't hungry for breakfast but ate "a huge lunch and dinner every day." A detailed inquiry revealed that those meals were salads that consisted of lettuce, tomatoes, and baby spinach and nothing else and that her only other calories came from a single power bar consumed daily at 4 PM. She drank large quantities of diet soda and coffee with artificial sweetener. She had no fat anywhere on her body, but she said that she would stop dieting as soon as she "stopped jiggling." According to her, she had "jiggly thighs and upper arms" that she was determined to turn into solid muscle. She had not had a menstrual cycle since she was 12. Her diagnosis was anorexia nervosa.

Because physical as well as psychological factors can contribute to an eating disorder, and because of the potential physical damage to the body from the symptoms, clients presenting with any eating, weight, and diet issues should have a complete examination by a physician as part of the initial workup. The medical exam on this young woman showed signs of possible damage to her heart, liver, and kidneys, as well as osteoporosis, or thinning of her bones. She

denied any physical discomfort, but the doctor also found that she was suffering from edema, or swelling, of her ankles, which was possibly associated with heart disease. Her medical condition was so precarious that she was hospitalized until she could be stabilized. What led her to engage in such a dangerous diet and exercise regimen? Did she hate herself? Was she trying to commit suicide? What else might have been going on? In other words, what makes someone vulnerable to developing an eating disorder? What factors protect other people from these symptoms? And what are the best ways to help them recover?

Problematic eating like anorexia nervosa, bulimia nervosa, and binge eating is extremely complex and often the result of a combination of biological, psychological, social, and environmental determinants. At times these behaviors can be transient and need no intervention, such as when a toddler going through an individuation phase refuses all foods except those colored white or orange or when an otherwise healthy teen worries about and tries to control her changing body. When unhealthy, self-destructive behaviors continue for a period of time, they generally require professional assistance. In some cases, individuals do not recognize that they need help and are brought in by concerned family or friends. Even those who reach out to a clinician may not reveal the extent of their eating and related difficulties until they have developed some trust for a counselor, often months or sometimes even years into therapy. Sometimes there is an obvious condition, for example when an anorexic

is starving or a binge eater has become obese, but at other times there may be no physical evidence of an eating disorder.

Weight and diet-related struggles can signal the presence of other areas of difficulty, including physical illness, cognitive processing, and a variety of psychological issues, including obsessive-compulsive disorders, body dysmorphic disorder (i.e., obsessive focus on a part of the body that seems flawed to the individual but not to anyone else), anxiety, depression, personality disorders, and some forms of schizophrenia. For example, anorexia is not uncommon in the elderly and can be reflective of depression, loneliness, a lack of physical mobility or ability to care for oneself, and/or physical illness not yet diagnosed. Sometimes, when underlying problems are dealt with, eating issues resolve on their own. At other times, nutritional and behavioral intervention is required along with supportive and/or insight-oriented work. Some individuals recover quickly, while others may struggle with the symptoms and the related psychodynamic issues for a very long time, even when they are working hard to change. A full psycho-social-medical assessment of anyone who presents with eating issues can help alert a clinician to psychodynamic, family, work, and other current and long-term life stressors, as well as physical difficulties such as diabetes, thyroid or celiac disease, infections, and cancer.

A clinician's empathic interest in the details of a client's symptoms can be key to discovering significant information. For example, a young woman was referred to her college counseling department for difficulty concentrating, inability to get out of bed, and a sense of hopelessness and helplessness. She was diagnosed with depression and referred for medication and group therapy. The counselor also saw her for several individual sessions. As a trusting therapeutic relationship developed, the student revealed that she had always disliked her body and had a long history of food binges. She had gained a great deal of weight during her

freshman year, which she believed contributed to her depression. She also had a history of cutting herself on her arms and legs. She was not trying to kill herself, but the cutting gave her some relief from her painful feelings. She had been too ashamed to tell anyone before, but she believed that the counselor understood and cared about her. "I'm ready to try to work on this," she said.

Eating disorders often go along with other self-harming or potentially self-destructive activities like cutting, excessive tattooing, unsafe sexual encounters, kleptomania (compulsive stealing), and excessive shopping, drug, and alcohol use. Research has found that these behaviors are often related to difficulties in *affect (or feeling) regulation and impulse control* (Christenson et al., 1994; Connors, 2006, 2011; Fairburn, 1995; Krueger, 1997; Schore, 2003). Numerous authors suggest that rigid dieting, binge eating, purging, and over-exercise are all attempts to regulate the self (e.g., Albers, 2009; Bromberg, 2001; Connors, 2006, 2011; Fairburn, 1995; Schore, 2003). Despite their potential destructiveness, these behaviors are frequently *attempts to adapt* to otherwise untenable or unmanageable situations, experiences, and feelings. When faced with these behaviors, it is important for a clinician to remember that food is about much more than nutrition, in that it has psychological, familial, social, and cultural meaning. The behaviors, which help cope with pressures and feelings coming from all of these sources, can therefore be very difficult to "give up" until other coping methods are in place. As one client put it, "bingeing and purging saves my life and my sanity." Change may therefore occur very slowly. While learning other techniques for soothing herself (taking warm baths, listening to music, reading, watching television, calling a friend), another client said, "when I'm really upset, nothing stops the feelings as well as bingeing and throwing up."

A relationship with a professional who listens without making judgment and responds with both understanding and techniques for

managing feelings can be an opportunity to develop new ways of self-regulation. Neuroscientists hypothesize that talking to another person can change brain chemistry (Schoore, 2003; Siegel, 1999). Yet, although naming feelings and talking about them is a crucial tool in the process of healing, many clients also need more direct, concrete interventions. Symptom-focused dynamic psychotherapy (Connors, 2006, 2011) and relationally and psychodynamically oriented behavioral therapy (Wachtel, 1997) are among a growing number of approaches that integrate psychodynamic and behaviorally based techniques.

### Defining and Explaining Eating Disorders

The symptoms of eating disorders are complex and varied. They often coexist with other diagnostic categories, including mood and affect disorders, impulse control disorders, body dysmorphic and other somatoform disorders, adjustment disorders, and even psychoses. They are usually multi-determined, dependent on a variety of psychological, biological, social, and environmental factors. In a world that idealizes both thinness and athleticism, it is not surprising that so many people focus not only on changing and controlling their bodies, but also on increasing their self-esteem, through diet and exercise. The three major categories of eating disorder are anorexia nervosa, bulimia nervosa, and binge eating disorder. Anorexia nervosa and bulimia nervosa are defined in the *Diagnostic and Statistical Manual of the American Psychiatric Association*, 4th edition (*DSM-IV*; American Psychiatric Association, 1994). While binge eating disorder was not given formal diagnostic status in the *DSM-IV*, it is recognized by many professionals and has been included in *DSM-5*.

*Anorexia nervosa* is characterized by a combination of refusal to maintain a healthy body weight that is at or above the lowest possible normal weight for an individual's age and height; intense fear of gaining weight or becoming fat, even when objectively underweight;

disturbed body image and a self-evaluation that focuses on body weight, shape, and size; denial of the seriousness/and or extremity of current low body weight," and in females who have reached menarche, the absence of at least three consecutive menstrual cycles and/or the inability to have a period without the administration of hormones such as estrogen (American Psychiatric Association, 1994, pp. 251–52). Some people with anorexia lose weight by dieting and exercising excessively; others lose weight by self-induced vomiting, or misusing laxatives, diuretics, or enema. Eating, food, and weight control become obsessions. A person with anorexia typically weighs herself or himself repeatedly, carefully portions food, and eats only very small quantities of certain foods. Some who have anorexia recover with treatment after only one episode. Others get well but have relapses. Still others have a more chronic form of anorexia, in which their health deteriorates over many years as they battle the illness. Studies have suggested that anorexia nervosa has the highest death rate of any mental illness (National Association of Anorexia Nervosa and Associated Disorders [ANAD], 2012a). Some, but not all, of these deaths are purposeful suicides. Low body fat can lead to heart, kidney and liver, and bone difficulties.

*Bulimia nervosa* is characterized by recurrent episodes of binge eating, which involves eating, in a discrete period of time (such as within a two-hour period), an amount of food that is comparatively larger than most people would eat during a similar time frame. It is also characterized by a feeling of not being able to control the eating during the episode, that is, not being able to stop eating or take charge of how much or what one is consuming. Bulimia also includes "recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise" (American Psychiatric Association, 1994, p. 253). The *DSM-IV* defines two types of bulimia nervosa: "purging

type,” in which an individual regularly self-induces vomiting or uses laxatives, diuretics, or enemas excessively and/or inappropriately, and “nonpurging type,” in which an individual uses other inappropriate compensatory behaviors, such as severe restriction or over-exercise, after a binge. Individuals with bulimia often fall within a normal weight range for their age and height. The behavior is frequently carried out in secret and is accompanied by feelings of shame. As with anorexia, self-evaluation of individuals with bulimia is overly dependent on physical factors such as body shape and weight. Both groups often also “have co-existing psychological illnesses, such as depression, anxiety and/or substance abuse problems.” (ANAD, 2012c) Bulimia nervosa can cause esophageal and stomach irritation, electrolyte imbalances, and serious and expensive dental damage.

*Binge eating disorder*, which is a new diagnosis in the *DSM-5* (American Psychiatric Association, 2012) is characterized by recurrent episodes of binge eating, that is taking in an abnormally large quantity of food in a discrete period of time and a feeling of not having control over eating during the episode. This sense of lack of control is an extremely important part of a binge eating disorder diagnosis. It is not simple “overeating,” but eating that is out of control. Symptoms of binge eating disorder include rapid eating, eating to a point of severe discomfort, eating large amounts of food when not hungry, eating alone or in secret because of shame about the quantities one consumes, and feelings of guilt and disgust about the eating behavior (American Psychiatric Association, 2012). The behaviors can occur any time of the day or night and are often ways of dealing with stress. Unlike bulimia nervosa, there is no compensatory behavior to eliminate the possible weight gain caused by a binge.

Binge eating disorder is more common than either anorexia nervosa or bulimia nervosa. About 5 million women and 3 million men in the United States suffer from binge eating disorder.

It is also believed to be equally common in African American, Caucasian American and Hispanic American cultures (ANAD, 2012b). Despite the significant behavioral dissimilarities, the disorders also have a number of psychodynamic aspects in common. Individuals who begin with one disorder may over time switch to another. According to Tozzi et al. (2005) up to 62 percent of individuals with anorexia develop bulimia. Many also become binge eaters. People with binge eating disorder often speak of wishing they could be bulimic or anorexic, but complain that they are unable to vomit or restrict. Former anorexics who successfully gained and maintained a healthy weight have often revealed, years after they stopped restricting, that part of the reason they forced themselves to eat so little was because of their secret wish to binge.

The behaviors often begin with a desire to control weight and improve body image. Perfectionism, self-criticism, shame, and mood dysregulation are features of many eating conditions. Obsessive concern with flaws that seem minor or invisible to others is often present in individuals with these disorders. These symptoms may be indicators of body dysmorphic disorder (BDD), in which concern about these so-called flaws can interfere with an individual’s social, school, and work life. Body dysmorphia is a disorder that the *DSM-IV-TR* (American Psychiatric Association, 2000) categorizes as one of a group of somatoform disorders, which are generally characterized by complaints about medical or physical conditions that have no ascertainable physical or psychological cause. BDD has been linked with obsessive-compulsive disorder (Bjornsson, Didie, & Phillips, 2010) and needs to be treated with medications and cognitive behavioral tools. Given the cultural pressure on both men and women to achieve some sort of physical “perfection,” however, obsession with perceived bodily flaws is often a “normal” and transient symptom of adolescence. It can also be a symptom of an eating disorder without signaling

the presence of BDD. In such cases, the focus on a specific bodily imperfection improves as the other symptoms begin to diminish. Studies have shown that disordered eating is frequently related to both unregulated or unmanageable affects and a concomitant inability to control impulses, and that there are often links to other impulse control disorders such as compulsive shopping, kleptomania, self-mutilation, drug and alcohol abuse, and harmful sexual activities (Christenson et al., 1994; Connors, 2006, 2011; Fairburn, 1995; Schore, 2003). There is some suggestion in the literature that these clients suffer from attachment disorders, which makes sense given the current literature linking attachment disorders with disorders of affect regulation (e.g., Connors, 2006, 2011; Fonagy, 2002; Schore, 2003; Siegel, 1999). Viewing these conditions as adaptive as well as maladaptive leads a clinician to look not only for problems in a client's life that led to the development of psychological and emotional difficulties in adulthood, but also for the positive experiences that may have contributed to an individual's resilience throughout his or her life. Feelings of shame and a tendency to self-isolate in order to hide the behaviors can lead to a loss of social support. Recognizing that the behaviors are adaptive can help alleviate some of the shame.

### Demographic Patterns

At one time eating disorders appeared to affect mainly upper-middle-class Caucasian women, especially those in their late teens and early twenties. However, while adolescent girls are still more vulnerable than adolescent boys (National Institute of Mental Health, 2012a), there is growing evidence that the symptoms of all three of the major categories can be found in girls and women of a wide range of ethnic, cultural, and socioeconomic backgrounds, and that an increasing number of males are also struggling with these issues (ANAD, 2012a; National Institute of Mental Health, 2012a; Martin & Baugh, 2009; Steiner-Adair, 1986; Striegel-Moore & Smolak, 2000). The range of

nationalities of individuals suffering from problematic eating behaviors has also expanded. For instance, in the 1980s clinicians working with college students with eating disorders who wanted to spend a semester or a year abroad had difficulty finding colleagues outside of the United States who were familiar with enough with the problems to counsel these clients while they were away. Today, students traveling to ever more countries as part of their college experience are easily referred to clinicians who are knowledgeable about these dynamics. In 2012, for example, alarmed by deaths of several overly thin fashion models, Israel joined Italy and India in banning women under a specified weight from appearing in fashion shows (Reuters, 2012). In cultures where food is relatively plentiful, eating disorders have become almost universal, although adolescents, the elderly, and women are most vulnerable (ANAD 2012b; National Institute of Mental Health, 2012b).

### Societal Context

While not everyone in contemporary "first world" cultures suffers from a diagnosable eating disorder, it would not seem to be a great leap to suggest that many contemporary societies are breeding grounds for problematic eating behaviors. Cultural emphasis on thinness, athleticism, and perfection offers a perfect environment for the development of eating problems. International media, the fashion industry, and much advertising present images of thin, even emaciated women (and recently, more and more men) as the model of attractiveness. The medical profession, school and public officials, friends, and family communicate that slenderness is a sign of both physical health and psychological well-being and leads to happiness and success, whereas a heavier body represents poor health, unhappiness, and the potential for failure. Even in cultures in which a larger body size is appreciated, self-esteem and self-value may depend on physical appearance. Air-brushed and enhanced pictures in advertising,

film, and magazines offer unrealistic images of men and women. Some \$10.1 billion were spent on cosmetic plastic surgery procedures in the United States in 2010, and the number of people utilizing Botox, liposuction, fat injections, and other forms of cosmetic surgery all over the world has been climbing every year (American Society of Plastic Surgeons, 2011).

Eating issues are common in high schools and colleges, with their high levels of competition and peer pressure. For many years research on eating disorders with female college students in the United States has focused mainly on Caucasian women (Mulholland & Mintz, 2001), but current findings show that all ethnic groups struggle with a variety of eating disorders (Martin & Baugh, 2009). Recent data has shown that while young women are still at higher risk than young men for developing anorexia nervosa and bulimia nervosa, young males are increasingly at risk for binge eating (Mayo Clinic, 2012). Distorted body image, dissatisfaction with their bodies, and a desire to be lean, muscular, and “fit” can lead to eating issues in both males and females. Male athletes in sports in which weight is carefully monitored—e.g., lightweight crew, jockeys, and wrestlers—often regularly purge, restrict, and use diuretics prior to competition in order to qualify for a lower weight group. Male body builders, gymnasium users, and ballet dancers are also highly vulnerable to display problematic eating behaviors, although they do not always meet all of the criteria for a diagnosis (Byrne & McClean, 2001; Ravaldi et al., 2003).

In the United States, where thinness is overvalued and obesity considered one of the largest health risks to the population, the diet industry brings in \$40 billion per year (Reisner 2008), yet 2.8 percent of the adult population of the United States suffers from binge eating disorder (National Institute of Mental Health, 2012b). Not only does dieting not solve the problem, since “most dieters regain about one third of the weight lost during the next year and are

typically back to baseline in three to five years,” (Wing et al., 2006, p. 1564), but the constant focus on weight and the value placed on self-deprivation may actually promote eating issues, because restricting food intake can actually contribute to binge eating (Albers, 2009; Eating Disorders Review, 2009; Fairburn, 1995; Mayo Clinic, 2012). Parents, educators, and medical professionals, wanting children to be healthy, may actually be promoting eating problems.

### **Vulnerabilities and Risk Factors**

It is not uncommon to assume that eating disorders result from childhood trauma or neglect. However, many people with these conditions have no history of significant trauma, and others with serious childhood neglect do not develop eating issues. What makes one person vulnerable to these difficulties and another not? Because of the complexity of eating disorders, there is no simple explanation for why they develop. One universal risk factor, however, appears to be a cultural overvaluing of thinness, in which an individual’s body shape and size come to represent his or her personal value. The presence of family members with difficulties with food and/or some of the other common accompanying issues, such as drug and/or alcohol abuse or addiction; shopping compulsions, sexual issues, gambling, pornography; problems with impulse control (including difficulty managing one’s temper); and/or depression and/or anxiety disorders (Corcoran & Walsh, 2010; Tozzi et al., 2005) can also be a risk factor. Children who grow up in families with these tendencies may learn to use food and other substances to help manage their feelings (Connors, 2006; Fonagy & Target, 1997; Schore, 2003; Siegel, 1999). However, a growing body of research indicates that, like depression and other mood disorders, the predisposition to develop an eating disorder may also be biological, or genetic (DeAngelis, 2002). Other potential vulnerabilities include poor social skills, lack of general coping mechanisms, and low self-esteem (Corcoran & Walsh, 2010).

Young children and adolescents, who are particularly vulnerable to messages from the media, advertising, and social networks, and who long to “fit in” with peers, are highly susceptible (Steiner-Adair, 1986). College and other times of separation are common triggers (Barth, 1989, 2003; Connors, 2006; McKinley Health Center, 2012; Stortelder & Ploegmakers-Burg, 2010). Individuals who suffer from alexithymia, or an inability to use thoughts or words to process emotions, are also vulnerable (Barth, 1998, 2008; Krueger, 1997; Krystal, 1988; McDougall, 1989; Schore, 2003). McClintock Greenberg (2009) notes that alexithymia involves “difficulties identifying and describing feelings, differentiating between emotional and physical sensations, and exhibiting a concrete and externally oriented cognitive style” (p. 136). Connors (2006) has found that a lack of sense of agency, or a sense that one cannot have an impact on one’s world, is also a contributing factor. Throughout history, food has been part of celebratory and mourning rituals. Individuals at risk for developing issues around eating are often vulnerable because they have learned to use food as a primary method for managing strong feelings. A young woman who had been anorexic explained that she felt strong and safe when she starved herself. A man said that when things got “rough” at work, he calmed himself down by eating a couple of candy bars from a stash he kept in his desk drawer. The problem was that often once he started, he could not stop.

Poor or traumatic attachment experiences may cause eating conditions, but rather than focus on specific attachment styles or assumptions about history, when a client reveals an eating disorder it is more helpful to think about the specifics of an individual’s current attachment behavior or “attachment state of mind” (Dozier, Stoval-McClough, & Albus, 2008). Safran and Muran (2000) concur that it is more useful to focus on a client’s characteristic style of attachment as it unfolds in the present than to make definitive historical statements based

on that attachment style. In their research on suicide in adolescent girls, for example, Gilligan and Machoian (2002) found that girls are simultaneously at their most optimistic and most vulnerable when, in their thirteenth and fourteenth years, they begin searching for relationships. This is the time when many eating disorders begin to develop. It is also, according to the authors, a time during which girls are at the highest risk of suicidal behavior. The authors suggest that these girls often find themselves in a catch-22: Threats of suicide can obviously be maladaptive, for example, when people begin to respond with irritation at repeated threats, and of course when a suicide attempt is successful. But paradoxically, they can also be adaptive, such as when the behaviors act as a wakeup call for attachment figures. The same can be said for problems in the arena of weight and eating. The behaviors are both an attempt to self-regulate and a request for help. When the request is heard and responded to, the behaviors have served an important purpose.

As Gerber (2006) writes, it can be difficult to distinguish adaptive behaviors from pathological ones in adolescents. Neuroscience has established that the brain does not finish maturing, particularly in the area of judgment and decision making, until the age of 21 (Stortelder & Ploegmakers-Burg, 2010), yet many cultures, like that of the United States, place tremendous value on independence and put pressure on young people and their parents to separate before this developmental process has been completed. This combination of factors can leave adolescents alone to manage difficult social situations for which they have neither adequate internal resources nor adequate support from adults. At an age when they search for acceptance among peers who are often neither generous nor kind, youngsters can emerge from this time with a sense of inadequacy and inferiority. The more resilient manage to find other ways to build self-esteem and a sense of agency. Paradoxically, an eating disorder can be one of these ways.

### Resiliencies and Protective Factors

Since the early resilience research in the early 1980s, a number of studies have shown “that the achievement of signifiers of psychosocial success, in spite of significant adversity, is an ordinary rather than a remarkable outcome.” (McMurray, Connolly, Preston-Shoot, & Wigley 2008, p. 300) Resilience, or the capacity to “spring back” in the face of “significant challenges to adaptation or development” (Masten & Coatsworth, 1998, p. 208) is believed to be influenced by a number of biological, psychological, and/or environmental processes. “In essence, the phenomenon of resilience is a reflection of the relationship between personal characteristics and factors in the environment that result in one’s (i.e., individual or group) ability to meet the stress and adversity with coping and adaptation” (Ahern, 2006, p. 176). Because symptoms of eating disorders can be obviously harmful and self-destructive, it is understandable that family, friends, and professionals look for the negative aspects of personal and family life. Yet in many instances, these symptoms can actually be part of an adaptive process and, therefore, represent both the vulnerability and the resilience of the individuals struggling with them.

Contemporary western culture, social structure, and beliefs provide a fertile breeding ground for the development of eating disorders. Families and educators who do not buy into widely accepted expectations that link physical and emotional health to slender, athletic bodies can help youngsters stand against the pressures coming from outside. Such support can encourage children to develop an independent sense of self and can emphasize a wider set of values by which to judge themselves, something Steiner-Adair (1986) has called teaching a child to be “wise.” Feelings of self-esteem and a sense of competence are frequently linked to resilience (Masten & Coatsworth, 1998). While many individuals with eating disorders have difficulties with low self-esteem, years of clinical work have shown that many of those who are most resilient have a sense of competency

in some area—e.g., sports, social relationships, academic pursuits, and/or work skills. Many times these feelings of competence are not integrated into a whole sense of self, and clinical work involves helping clients overcome a sense that the competent self is a false one and integrate their strengths into a more complex and realistic self-view.

It is hypothesized that a positive relationship with one or more adults in childhood (parent, grandparent, aunt or uncle, teacher, minister or rabbi, etc.) can be a protective factor in a child’s development. Often these important others are idealized and negative thoughts about them are split off or unprocessed because they feel disruptive or dangerous. Individuals who have learned to manage such disillusionment without feeling cut off from important caregivers appear to be more resilient and less vulnerable to the development of difficulties with eating, weight, diet, and body image (Basch, 1980). One trait that appears to be predictive of resilience is a capacity to tolerate contradictions. Like Gilligan and Machoian (2002), Steiner-Adair (1986) suggests that there is an adaptive component of eating disorders that underscores the resilience of those who suffer from them. Paradoxically, eating disorders are often a sign of difficulty and, at the same time, of an individual’s potential resilience.

Biological gifts, such as temperament, a sense of humor, and an ability to step back from a situation and look at it without taking it personally (which is also something that is learned) also promote resilience and protect individuals from developing eating disorders. And perhaps most of all, an ability to remain “wise” in the ways that Steiner-Adair (1986) formulates—that is, to separate oneself from the popular view of what one is supposed to be, to accept and value oneself for who one is, and to value what one has to offer—is most protective.

### Programs and Social Work Contributions

A wide variety of programs are available for individuals with eating problems, including



outpatient psychotherapy and counseling, day programs (often called “partial hospitalization”), and inpatient or residential treatment. No single method has been found to be most effective. In many programs, social workers form part of a team with nutritionists, psychologists and psychiatrists, and nurse practitioners. Individual psychotherapy, family and group counseling, medical attention, and nutrition education are frequently offered in inpatient settings, day hospitals, and clinics, but even when clinicians are working in private practice, it can be useful to work with a psychiatrist and physician and possibly a family therapist, to address the many different facets of these symptoms. In some techniques, such as the Maudsley model (Duke University Health System 2004), in which parents are put in charge of their child’s eating, families are an active, even central part of the therapeutic work.

The social work maxim to “start where the client is” is an important part of any therapeutic approach to eating disorders. Social workers are taught that one of the central questions of motivational interviewing, for example, “what does the client want,” has many different possible answers, and that a client’s first response is often not a complete one. What do eating behaviors tell us about what a client wants? Starving, exercising, bingeing, and purging have a variety of meanings, including a belief that a “perfect body” is the key to happiness. They also represent a wish to be in control, to manage her or his needs, to be loved, to manage distressing feelings, and more. The information does not appear at the beginning of any therapeutic encounter but emerges over time. According to Kohut and Goldberg (1984), a clinician’s interest in what is important to a client is the most important aspect of any therapeutic relationship and is a key to therapeutic change. Connors (2006) points out that an approach in which affect regulation, limit setting, symptom relief, and understanding are integrated can be the most effective. Research (National Institute of Mental Health, 2011) has

shown that combining educational and nutritional guidance, psychotherapy to understand the causes of the behavior, mindfulness techniques, and cognitive behavioral approaches can be most effective. Social workers are particularly well positioned to work with this multifaceted approach. Medication for depression and/or anxiety can be effective in conjunction with these other techniques, although assessment of compliance and physical condition is important. Starving anorexics, for example, cannot physically utilize antidepressants. While inpatient hospitalization is sometimes necessary when a client is in physical danger, there is some controversy about its long-term effectiveness (Wiseman, Sunday, Klapper, Harris, & Halmi, 2001). A team-based model is particularly valuable for this population, who often require a combination of individual, group, and family counseling; medication and medical supervision; and nutritional and educational guidance. A client’s tendency to use splitting as a defense (e.g., seeing one person as “all good” and another as “all bad”) can be disruptive to the work. Frequent contact with one another and discussion of dynamics can help a team manage disruptive behaviors and model a more integrated view of self and others for a client.

### **Assessment and Interventions**

What does a clinician need to think about when a client presents for help with an eating disorder? Given that these disorders can run through a number of other diagnostic categories, a full mental status and social and medical history are of paramount importance. Information about eating issues must be understood from within a broader picture of how an individual has functioned throughout her or his life as well as how he or she is functioning at the present time. Some of this material can be elicited in the first few sessions, and may come not directly from a client but from family members, friends, and other professionals. When taking such information, it is important to be aware that clients in

the throes of a severe eating disorder are often not very accurate self-reporters. Current medical status is a primary concern, because physical issues can both cause and result from these conditions. Therefore, any client presenting for help with eating problems needs to be referred for a full medical workup. It is, of course, helpful if the medical evaluation can be done by a physician or nurse practitioner who is familiar with eating disorders.

With more than 400 different types of therapy available, it may seem hard to decide what approach to take with a client. At this point in time, no specific type of therapy is considered best for individuals with eating disorders, although a mix of cognitive behavioral and psychodynamic approaches; individual, group, and family work; nutritional education; and medication where appropriate are probably used most often. Assessment of a client's needs, the severity of the symptoms, and the client's psychosocial and biological strengths and vulnerabilities, as well as of the support system available to him or her, helps a clinician decide where to begin the work. Although some clients have experience with therapy and others have none, it is also important to assess the current level of psychological functioning as well as apparent insight. Clients with these difficulties can sometimes be extremely articulate and insightful without being able to use that self-knowledge to help themselves (Barth, 1998, 2003).

It is important for a clinician to begin to think about both psychodynamics and practical needs from the beginning. Collaboration with other professionals, including medical, dental, educational, psychiatric, and nutritional, helps to work with the whole person, rather than just focus on the eating symptoms. Starving anorexics are a special case, in that their physical state makes it almost impossible for them to make use of "talk" therapy or insight. In these cases medical and nutritional concerns are a clinician's primary concern. The severity of a client's physical condition

can require hospitalization, but Gowers et al. (2010) suggest that outpatient care supported by brief inpatient stays when medically necessary is more effective over the long term than inpatient for anorexic clients.

Once the questions of physical and emotional stability have been addressed, and it is determined that a client is stable enough to engage in outpatient work, an ongoing assessment of his or her support system is also crucial. Who provides support for a client? Is it a family member, friends, someone at school or at work? Sometimes clients have difficulty managing activities of daily life such as regular bathing, sleep, and meals but are highly functional at work. A detailed inquiry into the small and apparently insignificant day-to-day routines of an individual's life provides important information. For example, some articulate, charming, and apparently high functioning individuals reveal, on being asked about their daily activities, that they are isolated and unable to do much other than eat and watch television. Others do well when a boyfriend, spouse, parent, or child is present, but when they are alone, they often engage in unhealthy eating behaviors. Both those who self-isolate and those who have difficulties when they are alone may have problems with separation and with object constancy—for example, they may have difficulties holding onto a positive image of others when they are not present. Clients with eating issues may lose friends because they are hiding their symptoms, ashamed of the amount they eat or afraid to be tempted by foods outside of their usual restricted range. Alternatively, other individuals drink heavily to manage social anxiety and suppress their appetite, although alcohol and drugs can also disinhibit their eating restrictions as well. All of these issues need to be unpacked and discussed over time. Sometimes simply having put them into words to a counselor may be enough to initiate change. Sometimes other interventions, including teaching tools for self-soothing and long-term psychotherapy with a focus on separation issues, are most helpful.

While some clinicians do not like to engage a client's family in the work, feeling that it is better to protect a client from the dynamics that may have created the problems, it is useful for a clinician to think about how and when a family might provide support for a client. Family work is often extremely useful. Engaging with a client's support system instead of rejecting it can send a number of important messages. An accepting and empathic attitude toward family members can shift problematic interactions, which may lead to a decrease in the behaviors and begin to change some of the underlying dynamics. Sometimes family work is done by one clinician while individual work is done by another, but both professionals must maintain a balanced stance toward all family members, acknowledging both negative and positive aspects of a family's dynamics. Similarly, one will want to request regular information about other aspects of a client's life—friends, work, school, religious and other communities in which a client is involved and which offer sustenance and/or create conflict for a client.

A clinician needs to think about the possibility that a client has difficulty integrating positive and negative feelings about others and about him- or herself. Numerous authors have described the ways in which a beloved or idealized parent or spouse will, over time, turn out to have feet of clay; but it is equally true, and less regularly recognized, that people who are viewed in a negative or hostile light often turn out to be extremely significant, *positive* influences (Barth, 2009; Basch, 1980). It is important to remember that clients with eating issues can be very articulate, bright, and insightful (Barth, 1998) and still have difficulty with reality testing and insight. A useful tool for a counselor to use to help clarify a client's experience and to help a client link together feelings with thoughts and words is a variation of Sullivan's "detailed inquiry," (Barth, 1998, 2009), in which a clinician asks a client to talk about seemingly insignificant details of daily life, for example, what time he woke up that

morning, how he prepared for work or school, what he ate for breakfast. It is not unusual, in such an inquiry, to discover, for example, that a client who has said she has no difficulty sleeping actually does not fall asleep until two or three o'clock in the morning, and regularly has troubles waking up and getting to work on time. Such details gradually lead clinician and client to a more integrated view of a client's experience. Not only does it clarify that there are multiple behaviors tied to eating issues, but that these behaviors, which are all part of a client's whole self-experience, also have psychological and emotional meaning.

Given that so many clients develop eating disorders in adolescence, it is useful to think about issues related to this stage of development, even with clients who are not chronological adolescents. Since Erikson's (1968) groundbreaking work on adolescents and identity, adolescence has been recognized as an age of developing an identity separate from the family in which a child grows up. Peer relationships become crucial during this stage of development. However, searching for acceptance among peers who are often neither generous nor kind, youngsters can emerge from this phase with a sense of inadequacy and inferiority. The more resilient manage to find other ways to build self-esteem and a sense of agency (e.g., Steiner-Adair & Sjostrom, 2005). For some, an eating condition can seem to be a solution to many of the problems. Exploring the ways an eating disorder has made it possible for a client to function, in the past and in the present, is often far more productive than looking for historical problems. Focusing on the details of a client's current experience—positive as well as negative—combined with developing tools for managing the small, almost insignificant-seeming feelings that are part of daily life, can be the most effective way to lead to a genuine understanding of the multiple meanings of the symptoms.

Similarly, while clients often appear to be functioning well in the world despite the eating issues, it is useful to assess their object

constancy, which often offers information about their ability to separate and remain connected at the same time (Lyons-Ruth, 1991). Mahler, Pine, and Bergman (1973) suggest that the development of "emotional object constancy" (as opposed to the cognitive awareness that an object still exists when it is not available to the child) "is a complex and multi-determined process" that includes "trust and confidence . . . the relief of need tension . . . and the cognitive acquisition of the symbolic inner representation" of the "unique love object: the mother." They add that "numerous other factors are involved," including innate endowment and maturation (Mahler, Pine, & Bergman, 1973, p. 110). Because failures in the development of object constancy are often associated with borderline personality, it is not uncommon for therapists to look for childhood traumatic antecedents for these problems. Unfortunately, again, this process can lead to parent blaming and a negative view of a client's childhood that can in turn facilitate splitting and truncate the therapeutic process.

Connors (2006, 2011) has found that people with eating issues frequently lack of sense of agency. Recognizing the adaptive qualities of the eating symptoms while also acknowledging the pain that "feeds" the behavior can provide a crucial first step in helping a client begin to feel a sense of agency. An assessment of the need for medication and also of a client's ability to comply with the treatment (e.g., follow a daily routine, take pills prescribed, and follow any dietary restrictions related to the medications) is important, as some medications, particularly those that help with mood and affect management, have been found to be useful. Often interventions will need to be altered over time, as a client's needs or abilities change. As individuals become more adept at managing and regulating their feelings, new emotions may appear. These new feelings may be distressing, but together client and social worker can assess whether they represent a regression or the emergence of something new and important, even though

frightening, because of the work that has been done. Sometimes even regressions, such as a disruption of self-regulation related to a counselor's upcoming vacation or departure from a clinic, can be understood as an opportunity to work with old feelings in a new way.

Acceptance and understanding, as well as new tools for self-regulating, lead to a different relationship with both the self and the important others in an individual's life. Research has shown that simply talking to another person who is interested in the details of one's life can lead to significant neuropsychological change (Schore, 2003; Siegel, 1999). As a client puts into words difficulties with parents, siblings, and other important loved ones, a counselor listens for the multiple components of these relationships, assessing whether it is most important to acknowledge the pain or to explore other aspects of what a client is talking about. Often acknowledgement of pain and unexpressed sadness, anger, and other feelings is the first task of a clinician, and can go on for some time before anything else can be discussed. But over time a social worker needs to listen for and begin to help a client integrate some of the positive aspects as well. Integration of split-off or dissociated images of others is closely tied to the development of an integrated self-image, which contributes to the ability to manage feelings, regulate the self, and maintain object constancy. Finding words for unarticulated feelings and knowledge about parents is an important step to self-awareness. Unpacking beliefs about what motivated their behavior is an important step in that process (Demos, 1993; Fonagy, 2005). Mirroring the damage done by parents, as experienced by a client, is important. As counseling progresses, the meanings of parental behavior need to be reviewed and reassessed from the perspective of a client's developing and more complex self-understanding. Basch (1980) suggests that a therapist can aid the work by gradually and empathically offering alternative ways of understanding parental behavior, which might not be available from a child's

perspective. When a parent has been abusive or neglectful, social workers often offer such explanations to counter childhood beliefs that the child deserved the parent's scorn or abuse. Yet given that many abused children also identify with their abusers (see, for example, Barth, 1989; Bloch, 1984; Schafer, 1994), they need to be helped as adults to understand and at times even empathize with some of the emotional underpinnings of certain behaviors even while condemning the behaviors themselves. It is not always easy for social workers to come to such a position. When faced with reports of maltreatment at the hands of parents, social workers naturally feel protective of clients, often identifying with them and becoming critical of and angry with their parents. Eventually, however, a social worker needs to find a way to recognize that behavior that is unacceptable may have at least some understandable underpinnings if one understands something about the parents' makeup and/or needs. Such understanding on a social worker's part often leads to a gradual opening up of a client's ability to think about the multiple meanings of parental behavior and ultimately to understand themselves more fully.

This process has a second, crucial function in the helping of clients with eating problems. Recognizing some of the complexity of the antecedents of the behaviors, including both (often) loving and hurtful behavior on the part of parents, can be part of the process of coming to grips with the idea that a client also has multiple parts to her- or himself. Furthermore, it makes it more understandable when a therapist suggests that the eating behaviors are not all bad, but that despite their negative consequences, they may be a sign of resilience and adaptability. For example, they may have served to help a client regulate emotions and thoughts that threatened to disrupt their sense of wholeness as a person. Viewing these symptoms (as well as frequently concomitant behaviors of self-harm, alcohol and drug use, sexual addiction, over-shopping, and so on) as serving an adaptive, albeit still problematic, function

helps a client recognize that he or she is not "all bad" or "all disordered," which gradually helps in what Lachmann and Stolorow (1980) describe as "the establishment of a cohesive, stable, and positively colored self representation." (p. 222). In the process of developing a more integrated, cohesive sense of self and of others, a client both taps into and increases his or her personal resilience.

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#### ILLUSTRATION AND DISCUSSION

Elyse, a petite, delicate-looking woman in her mid-twenties, came to the social worker for help with her eating problems. She had been anorexic in middle school and had begun bingeing and purging in high school, but had been asymptomatic for several years and thought she was "cured." She was both embarrassed and worried about the recurrence of the symptoms. A professional performance artist, she was engaging and articulate and quickly gave me a clear synopsis of the history of her symptoms. She had developed anorexia at the age of 12, because she was feeling "fat and sluggish." At this time she had her first menstrual cycle. Her family took her to her pediatrician, who put her on a regimen to gain some weight. Elyse was not sure that the regimen would have worked without the accompanying threat from her parents that she would not be allowed to attend gymnastics camp that summer if she did not put on ten pounds. At camp that summer, Elyse learned to control her weight by throwing up her meals. Combined with the intense exercise regimen of the camp, this new "diet" helped her lose several pounds and became a daily habit throughout middle and high school.

Elyse described her father as emotionally and physically abusive and her mother as neglectful and disorganized. Family meals were seldom served with any regularity. "My dad would have a temper tantrum and Mom would run into the bedroom and lock the door, just as she was starting to prepare dinner." Elyse and her sister would either finish cooking what they could or, more often, would have a bowl of cereal or peanut butter and jelly sandwich

for dinner. Elyse's father was obese and, as time went on, the social worker and Elyse concluded that he had a binge eating disorder. Her mother was tiny and extremely proud of her body. She was a heavy smoker, and Elyse suspected that she used cigarettes to control her weight. Elyse's older sister was also thin, but Elyse did not believe that she had an eating disorder. The social worker was curious to know how Elyse understood her sister's escape from what appeared to be a family tendency, which suggested both biological and psychological underpinnings. Elyse was unable to answer this question, in part because she idealized her older sister and was unable and unwilling to consider any potential "flaws" in her personality.

Elyse had overcome her symptoms with the help of a beloved dance teacher. After a particularly frustrating dance class, during which Elyse had been unable to perform some of the more difficult steps, Elyse was sitting in the dressing room unable to make herself change out of her exercise clothes. One of the other girls got the teacher, who took Elyse into her office. She told Elyse that she was a talented dancer, but that if she did not eat more healthily and keep some weight on her, she would never professionally get anywhere. She said dancers have to respect and nourish their bodies in order to get the best work from them. And then she wrote down exactly what Elyse needed to eat and when she needed to eat it every day. Elyse followed the diet but at first continued to throw up daily. Within a short time, however, the purging "seemed to go away by itself."

She was deeply disturbed by the return of the symptoms and could not understand what had caused their reappearance. At the social worker's invitation, she began to describe the events in her life just before she began to binge and purge again. Elyse said she had gained a few extra pounds and decided to diet to take them off. The diet had quickly spun out of control and before she knew it she was eating huge amounts and throwing up. The social worker explained that this was a not uncommon pattern, but then added that although it was distressing, the social worker had found over the years that it was

also a sign that her body and her psyche were working to find a healthy solution to some things that were disturbing her. Not surprisingly, she looked doubtful. The social worker acknowledged that she could see that this did not make sense to her, and that she understood that it was hard to take in, given that the behavior was potentially physically dangerous and certainly problematic in terms of her social and professional activities.

The social worker explained that there were two parts to her thinking. First, she believed that her initial urge to diet might have been motivated by something more than a feeling that she was gaining weight, and that their job would be to tease that out. The social worker continued that most eating disorders develop as an attempt to manage painful or confusing feelings, and as a way of adapting to something that we cannot quite figure out how to cope with or even to think about. Furthermore, it was often a sign of both physical and psychological health that she was not able to starve herself anymore. Her body had managed to override her mind's wish to make it live without enough food by forcing her to binge. The social worker saw that as highly adaptive and, at the same time, highly problematic. Their job was to figure out what she was struggling with, find other ways to help her cope with the difficulties, try to help her undo bad habits, and take a realistic look at her eating, nutritional, and exercise needs.

These ideas seemed to help Elyse settle into the work. Although the social worker knew she still had anxiety about her symptoms, on the one hand, and the possibility of gaining weight if she stopped bingeing and purging on the other, they were building a good working alliance that would, over time, help regulate some of the emotions she was currently using bingeing and purging to manage. The relationship was also important in helping her to find and begin to use some specific techniques for changing the behavior. The worker offered both concrete suggestions about how to eat, and also ideas about managing her feelings. For example, with the worker's encouragement she began eating small snacks of

foods she considered healthy and manageable, such as yogurt, almonds, and fruit—without bingeing or throwing up. She also began to notice when certain feelings—including both stress and pleasure—triggered a binge cycle. (Many clients call a cycle of bingeing and purging, a “binge,” so social workers must ask them to be specific about what they are referring to.) Several weeks into the work Elyse realized that just before she had decided she was fat and needed to lose weight, her boyfriend, Rich, had proposed to her. “I was thinking about wanting to look good in my wedding dress,” she said. She described her feelings about getting married as “euphoric! It’s what I’ve wanted forever!” Rich was a wonderful man, she said, adding that she did not know how she could have gotten so lucky.

Not surprisingly, the fairy tale romance had some difficulties. Some days before Rich joined Elyse in her session he had gotten into an argument with her father. Although her description of the event was a little confusing, the social worker had the sense that some sort of physical threat was exchanged between the two men. When the social worker met with Elyse and Rich, Rich immediately began to inform the social worker that he was concerned that she was not taking Elyse’s symptoms seriously enough. “I want to marry this woman,” he said. “And I want her to be healthy.” The social worker told him that we all had the same goal and asked if he could explain why he thought she was not taking the symptoms seriously. He said that I was telling her that her behavior was adaptive. “This is not adaptive behavior,” he said adamantly. “This is sick behavior.” He added that he wanted me to know that Elyse’s family was toxic to her, and that she had to get away from them. “They’re making her sick.”

The social worker had the feeling that Rich’s reactions probably represented some of Elyse’s own feelings. She may have had the thoughts herself, but have been afraid to voice them to the worker, or they may have been part of what Bollas (1989) calls “the unthought known” or what Bromberg (1998) and others think of as unformulated, unarticulated, and/or dissociated material. It was also a

symptom of alexithymia (Barth, 2003; Krystal, 1988, McClintock Greenberg, 2009; McDougall, 1989), the inability to use language to help process emotions, which is frequently to be found in individuals with eating disorders even when they seem to be able to talk clearly and insightfully about feelings. Elyse had traditionally been the family diplomat, soothing hurt feelings and calming volatility while unable to access her own feelings or manage them with the use of language. Perhaps she was repeating this experience with Rich, and perhaps he was expressing some of her split-off anger, frustration, and resentment with both her family and with the social worker. Because eating disorder symptoms are often part of an individual and a family ecosystem (Gitterman & Germain, 2008), the social worker should attempt to help a client begin to think about her or his feelings within the context of that system. In this case, the social worker tried to work with both Elyse and Rich to help them begin to talk about their feelings and thoughts as part of an interactive experience. Elyse’s symptoms represented part of that system. Her family was also part of it, and whatever they stirred up in Rich was also part of the relational system he brought with him.

Yet as a new part of the system, the social worker had to reflect her understanding that Rich’s concern had meaning. She said, “I know that the behavior is extremely troubling and can even be dangerous. I don’t particularly like calling it ‘sick,’ but I do understand that it seems like it is an illness that needs to be managed.” The social worker then went on to explain that she thought the hardest thing about eating disorders in general was that they contained so many opposites. Elyse seemed skeptical, so the worker explained that one has to deal with both the compulsive behavior and the psychological cause—which creates conflict, since it’s hard to get at the one without taking care of the other. The social worker understood that Rich was in a hurry to get Elyse “better,” but that she thought she would heal more completely if we could go a little more slowly. Because Rich also represented some of the issues Elyse struggled with in her family, the social worker asked him to tell me more about how her parents were

“toxic.” While he shared his observations, Elyse of course felt the need to defend her parents. The social worker suggested that they might think of their reactions as two aspects of a larger picture, or as pieces of a puzzle. “If we start to put them together, we start to get a more complex, but maybe also a more realistic perspective.”

Both Rich and Elyse had difficulty with this idea. Rich began to launch into a description of the negative family dynamics. Elyse stopped defending them and said that she thought he was right. She was sick and her family was sick and she needed to get away from them. The social worker’s reactions in that moment could have led the work into a difficult situation. She was feeling that Rich, himself, was toxic to Elyse, and the worker wanted to get her away from him. Instead, the worker reminded herself that Elyse and Rich had brought her into the center of the kinds of interactions that probably fed into the eating symptoms. She was probably feeling what Rich felt with Elyse’s family, although in this case it was directed toward Rich instead of the parents. The task at the moment was to try to help them process the tension between the opposites that neither of them could manage. Elyse was smart, articulate, and competent; yet in that moment, she felt helpless and incompetent. Both qualities were parts of her. Rather than reject her relationship with Rich, and thereby encourage her to split off part of herself, the social worker focused on helping her integrate and manage both these and other contradictory qualities in her person.

Rich’s presence helped the social worker become far more aware of an underlying conflict between helplessness and competence that had been a major part of Elyse’s dynamics throughout her life. They worked not only on recognizing her desperate sense of inadequacy and her need to be nurtured, but also on her real capabilities and strengths. For Elyse, as for many clients with eating disorders, this paradox of being both needy and competent is both extremely difficult to integrate and also a trigger for eating symptoms. This and similar contradictions exist in this population no matter what their social class,

ethnicity/race, gender, sexual orientation, religious affiliation, developmental phase, and diagnostic categories. In fact, the difficulty in managing the clash of opposites is a central issue in the world today and perhaps one of the reasons that eating conditions are on the rise.

The work with Elyse continued for several years, during which she became much more comfortable with the contradictory, often conflicting and paradoxical aspects of herself that had all been part of the development of her eating disorder. In time she realized that she had been experiencing Rich as though he were a part of her—a part that could stand up to and disagree with her parents and protect her in some ways, but also one that could express anger, frustration, and a desire to be in control. Elyse learned to soothe some of her anxiety and other overwhelming emotions through talking, exercising, sleeping, and a variety of other non-harmful mechanisms. Over time, she began to have a richer and more complex self-image. With this understanding of herself came a more complete sense of her family, her friends, and her boyfriend. She gradually decided that Rich was not helping her get better but was in fact, albeit unconsciously, reinforcing her anxiety and her need for her eating behavior. As she became more comfortable with herself, Elyse also became more able to discuss her feelings with her parents—even when they did not understand or actually disagreed with her response to any given experience. Eventually, she ended the relationship with Rich and became involved with a man who, as she told her therapist, “likes to talk about things—maybe even too much—but he gives me lots of space to know what I’m feeling.”

## Conclusion

Eating disorders are extremely complex and can be surprisingly complicated. They are often symptoms of difficulties in many areas, most having little to do with diet and weight. They have meanings, causes, and repercussions in cultural, psychological, physical, professional (or school), personal, and family areas.



No single treatment approach has been found to be most effective with these symptoms, but a combination of several different approaches, such as family, individual, and group therapy; supportive, psychodynamic, and cognitive behavioral therapy; medication; education and nutritional guidance, seems to be the most useful. A social worker is often a member of a team working with different aspects of a client's difficulties and needs. Because individuals with difficulties in these areas often have some trouble integrating different aspects of themselves and others, one important task for a social worker is to assess moments in which there is been a splitting off of emotions, thoughts, and experiences, whether with family, friends, self, or in the clinical work. It is important to help clients begin to articulate these unknown or unspoken

experiences, but psychodynamic understanding and articulating feelings is usually most useful in conjunction with other more directive interventions. Nutritional guidance and education, techniques for self-soothing, and focused symptom management need to be integrated into the work as well. Finally, recognizing that an eating disorder itself is part of a client's capacity for resilience is an important part of the work. This is not to suggest that eating disorders are healthy, but to remind clients and workers that the symptoms, like everything else in life, are multifaceted, neither all good nor all bad. The overall goal with these clients is to help them develop tools for managing their need for food differently while also developing a perspective in which their self-value is no longer exclusively dependent on their weight and physical appearance.

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