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# SEPARATE BUT NOT ALONE: SEPARATION-INDIVIDUATION ISSUES IN COLLEGE STUDENTS WITH EATING DISORDERS

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*ABSTRACT:* It sometimes seems that the college experience is tailor-made for the development of eating disorders. Overwhelmed and bombarded by their feelings, college students often turn to behavioral means, like eating disorders, to cope. Contemporary research (e.g., Christenson et al., 1994) has shown that good and bad emotions alike can be managed by starvation, bingeing, overeating, purging, and/or obsessive exercise. For college students, many of the overwhelming feelings that are titrated by eating disorders are directly linked to the separation process. Adolescence has been called "a second individuation." While Mahler et al. (1975) viewed separation-individuation as both a developmental stage and a lifetime's work, contemporary therapists often concentrate on the importance of early separation experiences. A postmodern perspective, however, recognizes the importance of connection as well as separation. Our culture is so focused on independence that many parents of college students do not recognize the importance of maintaining active contact with their older adolescents. It can be very helpful to view an eating disorder as representing a college student's attempt to negotiate separation and connection, dependence and autonomy. This article examines some of these dynamics and the implications for therapy with this population.

*KEY WORDS:* separation-individuation; adolescence; eating disorders; college students; bulemia; anorexia; attachment.

It sometimes seems that the college experience is tailor-made for the development of eating disorders. It is fairly well established that these disorders can represent attempts to cope with unacceptable or unmanageable feelings (see Christenson et al., 1994; Fairburn, 1993). Good and bad emotions alike can be softened, managed and even obliterated by starvation, overeating, purging, and/or obsessive exercise; and the feelings

that bombard college students sometimes are so overwhelming that desperate means, like an eating disorder, seem to be the only way to cope with them. In fact, research done in the 1990's indicated that approximately five to ten million women and one million men past puberty in the United States suffered from eating disorders (Christenson et al., 1994; Fairburn et al., 1993). Anecdotal evidence suggests that the figures are even higher today. Just what are the feelings that lead to such a preponderance of eating disorders? There are many possible answers to this question, but one subset of emotions with which many college-aged adolescents struggle, often silently, can be subsumed under the "separation process."

Adolescence has been called the "second individuation," but this is only one dimension of the complex process that occurs as an adolescent moves out of the family home and toward an adult life of her own. From a postmodern perspective, the separation-individuation process, which Mahler et al. (1975) viewed as both a developmental stage and a lifetime's work, is neither unidimensional nor linear, but an ongoing attempt to negotiate the tensions between separation and connection, dependence and autonomy, merger and isolation. In this article I will examine some of the ways that eating disorders can participate in, interfere with and otherwise affect the separation work of college students.

## SEPARATION AND EATING DISORDERS

When she came to my office, Marci, who was 5 feet 6 inches tall, weighed an excruciatingly thin 79 pounds. Her liver functions, blood and hormones were compromised and her doctor was seriously considering hospitalization. But Marci had convinced her parents to let her try therapy first. She was in the second semester of her freshman year of college and desperately wanted to remain in school. "It would just be so humiliating to go into the hospital," she said in our first interview. "I'll do anything to avoid it." Marci's parents had initially contacted the school guidance office for help, but, overwhelmed by student requests for therapy, the school was not able to provide Marci with the kind of intensive psychotherapy she needed. Furthermore, the school was, understandably, concerned about her physical health.

The administration agreed that, if her doctor wrote to say that she was in no physical danger, if I remained her primary therapist and wrote to say that in my opinion she could do the school work without psychological damage, and if she did not lose any more weight, Marci could see the school nutritionist and join a weekly eating disorder group. We all agreed to the program. I set up a treatment plan and weight goal with Marci and her parents and told them that I would try to help her stay out of the hospital, but only as long as the doctor felt it was viable. Marci was to meet weekly with a nutritionist, have bi-weekly weigh-ins with her doctor, and show a slow but steady weight gain.

She was also to have three meetings a week with me, at least in the beginning.

"I won't have time to do my school work or go to classes," Marci squawked.

"You won't be able to go to classes if you're in the hospital," I reminded her.

If her health had not been in danger, Marci would have presented an almost amusing picture of the conflicts that were riddling her psyche. She arrived at my office on time for every session. She appeared compliant and sweet-natured. She brought flowers to the nutritionist, the doctor, and me. But she quietly, consistently and stubbornly refused to eat more. "She's terrified of getting fat," the nutritionist told me. But as we all knew, getting fat was not the issue for Marci. It was far more likely that she would die of complications of starvation than that she would get even slightly rounded. Nonetheless, psychologically, the fear of getting fat was greater than the fear of death for Marci. Just what was this about? How could something like this happen to an apparently healthy young woman? What was she trying to work out with this horrible flirtation with death? What could we do to help her?

## LATE ADOLESCENCE AND SEPARATION ISSUES

Levinson (1996) wrote,

> The process of entering into adulthood is more lengthy and complex than has usually been imagined. It begins at around age 17 and continues until about 33 (plus or minus two years at either end). [It takes] about fifteen years to emerge from adolescence, find [a] place in adult society and commit [one]self to a more stable life. This time is an intrinsic part of adulthood. It is not, even in its most chaotic or immature form, a 'delayed adolescence.' (p. 71)

The period from approximately age seventeen to age twenty-two, which Levinson (p. 71) called the "Early Adult Transition," is of course the time when many adolescents leave home for college. There is great potential for conflict and confusion over this separation, because of both internal and environmental influences. This developmental stage can be exciting, challenging, and rewarding, but also sometimes distressing and difficult, offering what Erikson (1968) described as "a combination of experiences which demand . . . simultaneous commitment to physical intimacy (not by any means overtly sexual), to decisive occupational choice, to energetic competition, and to psychosocial self-definition." (p.166).

This is, therefore, obviously a time of great emotional vulnerability. What Guntrip (1969) described as the "schizoid dilemma," that is, a simultaneous wish for merger, fear of loss of self, wish for independence, and dread of isolation perfectly captures the dialectic between connection and separation, which is particularly active in adolescence. Drugs, alcohol, and sexual acting out can be attempts to cope with and/or lessen the impact of these challenges. Eating disorders can frequently serve the same function. Human psychodynamics are extremely complicated, however, and eating disorders are no exception. Every eating-related symptom represents the convergence of any number of disparate and sometimes

unrelated psychological, emotional, social, intellectual, physical, and cultural factors. Similarly, the college years are not the same for every adolescent, and generalizations about this period of life are therefore bound to oversimplify and reduce a stage that is as complex and variable as adolescents themselves. Not all young men and women with eating disorders suffer from the particular issues that afflict the adolescents in the examples in this article. (In fact, there is still significant question about the dynamics of young men with eating disorders. Although this population is unfortunately growing, my examples will all be drawn from young women who struggled with the issues under consideration.) In this article, I will focus my discussion specifically on only one area of difficulty for many adolescents going off to college: a significant conflict between a need to remain attached to parents and family and a need to develop a sense of self outside of the family.

## BEGINNING TREATMENT

One of the first tasks a therapist must accomplish with any client, and perhaps particularly with an adolescent, is to engage them in a working relationship. Active bulimics and starving anorexics can sometimes talk quite articulately about their dynamics without being able to use this knowledge to do anything about the symptoms. Before insight-oriented therapy can be put into place with an anorexic, whose mind and emotions are temporarily controlled by her starving body, the concrete matter of weight gain has to be the pivotal focus of the therapy. While Marci, for example, was at such a dangerous weight, the work revolved around building a relationship with her and setting up a structure in which she could begin to put on some weight. SSRI medication has been shown to be highly effective in the treatment of eating disorders, but Marci's liver had been compromised by her weight loss, so her physician felt that it would be dangerous to prescribe even a low dose of antidepressant medication. Once her liver functions improved, Marci could begin a course of treatment that included 25 mg Zoloft daily and a low-dose of birth control medication to begin the work of re-building her fragile bones.

Until that time, however, was there a way to begin helping Marci work on some of the issues that had brought her to this point? Could her parents help? I have found that with adolescents in their first years of college, discussion of separation issues can be a very useful tool for beginning the work. Putting the eating behavior in the context of separation and attachment, as Parker (2002) notes, "helps us to construct a coherent narrative for the thoughts and feelings of individuals who are experiencing a variety of symptoms that do not make sense to them" (Parker, p. 116). I generally start with manifest and sometimes even concrete aspects of

this process. For example, I will ask a client to talk about previous separation experiences, like camp. I will also ask how the family prepared for the college separation. Did they talk about what it would be like, or did they just assume that it would take care of itself? Were they prepared to be sad? How was the summer before freshman year? Did the family spend time together? Did they argue a lot or a little before college started? Far from being mundane or insignificant, simply asking these questions, without making any interpretive comments, can be illuminating therapeutically and provide a context for beginning discussions of many different aspects of a college student's life.

For example, Marci and her parents appeared to have a very close, perhaps even enmeshed relationship. Yet as Marci answered some of the questions I posed about the summer before she started college, it became clear that the family had not discussed the impending separation. Marci told me that she had been frightened, "but I didn't want to upset my parents, so I didn't talk about it." I began to see that Marci's eating behavior captured something of the family's general coping style. As Marci later put it, "Either you're eating everything in sight, or you eat nothing." Many dynamics contributed to Marci's eating disorder, and it took time for us to explore them. But even when she was too thin for insight, Marci could be engaged in a discussion of separation and connection. Some years later, we were able to talk about her family's approach to separation as similar to Marci's eating process: it's either "all or nothing."

## ATTACHMENT-INDIVIDUATION

Although not everyone's struggle with the "separation-individuation" phase of late adolescence is as dramatic as Marci's, it is not at all uncommon to find that one issue for many youngsters with eating disorders is this "all or nothing" idea of separation. Many disparate dynamics can crystallize around this sometimes overly concrete attitude, including problems with object constancy and difficulties with self-soothing (Barth, 1989). It is often useful to focus on the separation-individuation issue not as the sole or even primary cause of a college student's eating disorder, but as an important experience that may be contributing in some way to the symptoms. One extremely helpful aspect of this process, in my experience, is to help these young women and their families actually rethink some of the traditional perspectives on separation-individuation.

I have found Lyons-Ruth's (1991) discussion of this issue with regard to toddlers to be extremely useful in my work with adolescents. She has suggested that we change the name "separation-individuation" to "attachment-individuation." According to Lachmann (2001), Lyons-Ruth made this suggestion based on her viewing of Mahler's tapes of babies

and parents, in which she "observed far more evidence of the continuing attachment behaviors of Mahler's toddlers than of 'separation' behaviors" (Lachmann, 2001, p. 174). Furthermore, says Lachmann, Lyons-Ruth's

> proposal is consistent both with a rarely advertised idea of Mahler's (that symbiotic needs are really lifelong) and with Kohut's proposal that the need for selfobject experiences is lifelong. The implication . . . is that attachment and separation are not necessarily in conflict but work cooperatively with each other. (Lachmann, 2001, p. 174)

It is this idea, that attachment and separation are interacting cooperatively, that is crucial—and often extremely difficult—for college students and their parents to begin to comprehend.

## ATTACHMENT, INDIVIDUATION AND AGGRESSION

In an effort to allow Marci to develop a "healthy independence," her parents had avoided confronting her with the problems of her eating behavior and weight loss until it was almost too late. They were now, however, eager to help in whatever ways they could. In some ways it seemed unfortunate that Marci was not living at home where her parents could supervise her food intake and exercise. On the other hand, it is equally problematic when parents, a boyfriend, roommates, or even, in my experience, a hospital attempt to take over all responsibility for eating from an older adolescent with an eating disorder. In my work with Marci and her family, I tried to help her parents take a more active role in her life, to tolerate conflict with her, and to find a more manageable balance between separateness, individuation, and attachment. (As I will discuss later in this article, this process can be de-railed if the therapist attempts to place blame for these problems on either the parents or the adolescent.) Older adolescents learn to make healthy choices by being given responsibility for themselves within the context of caring and concerned adults. Such caring and concern is sometimes experienced by these adolescents, however, as a "mixed bag." In Marci's family, as in many families of individuals who develop eating disorders, aggressive feelings were considered unacceptable. Like sadness and anxiety, feelings like anger, frustration, and irritation were difficult to process for this family.

As in many families who are uncomfortable with aggression, healthy assertiveness was also experienced as potentially dangerous. Not surprisingly, then, Marci's parents had difficulties setting reasonable and consistent limits, particularly in the face of Marci's almost implacable resistance. They were, however, able to utilize the therapy and the medical supervision, which I required as part of our work, to help them stand up to their daughter. With my support, they told her that if she lost even a single pound, she would lose the privilege of remaining in school while she tried to work on her eating disorder. Her mother cried and her father's eyes misted when, in my office, Marci sobbed that no one understood her, no one cared, no one was going to help her get through this problem. They were able to use the support we offered to send the clear message that if she lost any more weight she would be hospitalized, to stand strong with their daughter. Their ability to set limits with Marci and to survive her obvious resentment was, I believe, an extremely important aspect of her healing.

On the other hand, I also encouraged her parents to recognize that Marci

was going to have to make some decisions for herself. For example, she would have to decide that she wanted to gain the weight, and what she was going to eat to do so. Although she needed help changing her eating habits, it was her body and her life, and she needed to have some autonomy in this process as long as she was not killing herself. In fact, I believe that finding a working balance over food intake with an anorexic is a wonderful opportunity to work on some of the conflicts over control and autonomy that can contribute to the disorder in the first place. With the nutritionist's guidance, Marci agreed to try some foods that she had taken out of her diet, but she also chose some that she would not add, at least for the moment. She did not lose weight, but neither did she gain in the early weeks of our work together. Her mother called me on the phone several times, sobbing, to tell me that Marci had called her in terror that she was going to get fat.

"She was crying and crying and crying. Poor thing. What do I do?" the mother asked helplessly.

I suggested to Marci and her parents that it was a major accomplishment that Marci could cry and express her fears to them. I added that Marci had such a need to be a good girl that she could not allow herself to express resentment that we were trying to control her life. Her only rebellion was through her weight and her eating. She was simply not going to do what we wanted. I also told them all that I believed that her rebellion was, in some ways, quite healthy. Adolescents need to be able to try out thoughts, opinions, and even behaviors that their parents do not like, if only to prove that they are separate, independent individuals. It is normal, I told them, for an adolescent to view parents, teachers and other adults—and even friends and boyfriends at times—as controlling, demanding, and needy. What is crucial is for parents to remain active and involved, without taking over or treating the adolescent like a younger child. Without a strong parent to rebel against, an adolescent cannot risk testing her own independence. She will worry too much that she will hurt—even destroy—her parents by doing so. Like so many families of college students with eating disorders, Marci and her parents had to find a balance between support, connection, and overinvolvement, on the one hand, and independence, autonomy and detachment, and neglect on the other.

Although her eating disorder had many different meanings, one of them seemed to be that Marci was trying to control her own behavior in order to avoid hurting her parents. Ironically, of course, her severe restrictions were actually hurting her parents terribly. While some therapists would suggest that the pain her parents felt was actually unconsciously intended by Marci, I find that this theory is often more harmful than helpful. Eating disordered adolescents often have difficulty expressing anger because neither they nor their parents can tolerate these feelings. When they do express such feelings, their parents may become angry in response or may become frightened, overwhelmed, or self-critical in the face of their child's aggression. It is therefore often far more productive to explore the adolescent's fear of harming her parents than to look at her behavior as intentionally (even if unconsciously) aggressive. However, having said as much, it can sometimes be helpful to point out that the adolescent is angry and that her self-destructive behavior may be a result of her feelings, including her fear that her feelings might hurt her parents.

Adolescents, of course, are riddled with strong and often painful emotions. As Marci began to experience and then articulate her feelings, she initially felt tremendous anxiety. One day she softly complained that I was trying to control her. I translated, with a smile to let her know that I approved of her ability to express this feeling, "You mean I'm a controlling witch?" She grinned. "Not a witch," she said in her soft voice. "But controlling?" I asked. She nodded.

I find that it is also helpful to focus on the here and now rather than on the past,

especially when one senses that parents may feel guilty about their daughter's problems. In family sessions, I encouraged Marci and her parents both to acknowledge and to tolerate the fact that Marci would very likely feel resentful that her parents were suddenly setting such firm standards for her. I recognized that they might all also feel angry at me for pushing them to be so strict. Explaining that these feelings are normal, I encouraged them to talk about even the "bad"—that is, rageful and hostile—thoughts they had during this process. Although none of them ever became particularly comfortable with or articulate about such emotions, Marci and her parents gradually began to see that rebellious feelings are part of the adolescent process and to feel less frightened and disturbed when these feelings occasionally surfaced. They began to understand, at least intellectually, that there was room in their relationship for negative feelings as well as loving ones.

As an anorexic begins to gain weight, she can also begin to work on some of the dynamics of her disorder. Both anorexic and bulimic college students often struggle with what Bollas (1987) has called "the unthought known," and Stern (1997) has called "unformulated experience," that is, thoughts or knowledge which cannot be put into words and therefore cannot be made conscious. This does not mean that an anorexic can be cured by putting feelings into words. First, a sense of safety and comfort, and a capacity to think about the self has to develop. The capacity to think and reflect about oneself is a developmental achievement of later adolescence and is often delayed in young women with eating disorders. For Marci as with most of this population, the therapy must focus for some time on simply providing an opportunity and experience in self-observation. Elsewhere (1997, 1998, 2000) I have discussed the importance of paying attention to small, seemingly insignificant details with these clients. Doing so offers them practice in self-observation in non-threatening arenas, so that they can eventually begin to think about themselves in some of the more distressing areas of their lives.

In Marci's case, some of these thoughts had to do with her mother's lack of competence. "Sometimes I feel like Mom and Dad treat me like a baby, and that makes me so mad I start to act like one," she told me in one session nearly a year into the therapy. "But I'm starting to see that they've got their own problems." For the first time in her life, she was able to see herself and her parents as separate entities, and as this occurred she began to be able to put into words some of the characteristics that she had always "known but not known" about both parents. However, it was still several years before she could say, "I've always known that my mom could be a flake, but I never really let myself think about it. I mean, somehow having the thought seemed disloyal—and kind of scary. But now I feel safe enough that I can take care of myself, I don't have to pretend she's stronger than she really is. And I can have thoughts about both of them without feeling like I'm doing something bad or betraying them. And now we can have actual discussions about differences between us. It's kind of amazing!"

Benjamin (1992) has beautifully elaborated on Winnicott's discussion of the importance of parents' and therapists' abilities to survive hatred. As Winnicott (1949) demonstrated, part of surviving includes being able to set limits so that neither the child nor the parent is badly hurt. Many parents today feel uncomfortable setting these kinds of limits on our children. Perhaps we are afraid of or uncomfortable with the feelings of anger and resentment that often come as a response to limits; yet, if a child cannot trust her parents to provide reasonable boundaries, she cannot feel safe with either her own emotions or her exploration of the world.

The parents' capacity to survive allows them to be experienced as separate—and allows the child to separate from them. Adolescents need to find a balance between the old union with the family and a new separateness. Eating disorders are often the result of difficulty finding such a balance not only with families but

also with peers. Not surprisingly then, some adolescents struggle to find a way of connecting with uninvolved parents, while others look for ways to separate from overly involved, intrusive, and controlling parents who cannot allow their children to struggle on their own, to make their own decisions, and live with their own mistakes.

Adolescents with eating disorders are often struggling to define themselves in the context of relationships with parents and families in which there are numerous issues in the area of dependence and autonomy. Marci's self-destructive diet was, I believe, the attempt of a poorly formed and underdeveloped self to cope with a separation that she was developmentally unequipped to process. The eating disorder was, as in my experience they often are, an attempt to adapt to an intolerable situation. But of course it was a highly dangerous effort with extremely maladaptive consequences.

As we discussed some of these psychodynamics in the therapy, Marci and I also gradually began to open up some of the other areas of difficulty that can turn into an eating disorder. I have talked about the ways that eating disorders can be a way of coping with intolerable and overwhelming feelings (1997,1998). Competition and envy, sadness and loneliness, fear and anxiety, and even, surprisingly, happiness and excitement, which are all aroused in college students on a regular basis—and are often dealt with through the symptoms of an eating disorder. One of the most effective mechanisms for helping a college-age adolescent avoid these symptoms is for parents to find ways to open up conversations about feelings. This of course is much more easily said than done with an adolescent and it is made more difficult if parents are not comfortable with the emotions under discussion.

## COUNTERTRANSFERENCE

Adolescents and their families often need help—and need one another—to negotiate the ongoing tension between attachment and individuation, yet it is often excruciatingly difficult for these families even to try to balance these opposite poles of relatedness. The therapist of a college student with an eating disorder can play a crucial role in helping that adolescent maintain meaningful involvement with her family while also developing new connections and a sense of herself outside of the family unit. Therapists often have to walk a difficult line as we carry out this task. One common countertransference reaction takes the form of blaming the parents and wanting to rescue the adolescent. Identifying with the adolescent's feelings of helplessness, hopelessness, lack of control, and concomitant rage and/or depression is another common response of therapists working with this population.

Other reactions include blaming the culture in which we live, identifying with the parents, and/or blaming the client herself. While such feelings can be useful tools at times, they can also interfere with the therapeutic process. Therapists today recognize that countertransference can, once understood, make an important contribution to the therapeutic work. One way to make productive use of the countertransference with an adolescent is to recognize that the intensity of our feelings may reflect the severity

of the family's difficulties balancing their own emotions. As a therapist struggles to "digest" these powerful emotions, to understand the problems, and to maintain sympathy for both sides while also recognizing and confronting mutually problematic interactions, tactics, and demands, she is also actively modeling the process of attachment and individuation for her clients.

A therapist's focus on mutual problem-solving rather than fault-finding can provide both parents and adolescent with a new skill set in this process. College students still need their parents to help them make decisions, but they also need their parents to support them as they begin to make choices on their own. This delicate balance is particularly important as issues revolving around separation, or attachment and individuation, emerge in relationships with peers and boyfriends as well.

## ATTACHMENT AND INDIVIDUATION OUTSIDE THE FAMILY

It is well-documented that late adolescence is a time for building relationships outside of the family circle. If an adolescent has difficulty being connected to and separate from her family, she will very likely have problems in the same emotional arena in her new relationships. It is not at all unusual for the adolescent's focus to initially be only on either family or friends. In either case, one of the major tasks of the therapist is to help the adolescent begin to tolerate and manage the often conflicting, confusing, and contradictory wishes to be close without losing the self and to be independent without losing the other.

## CLINICAL ILLUSTRATION: SORORITY SISTERS

Audrey was nearing the end of her sophomore year when she came to me for help. Although she had been prepared to be homesick when she left for college—she had been miserable the one time she went away to summer camp—to her surprise, she seemed to adjust well to the college experience. She settled into her classes and started to meet people she liked. Sought after by several sororities, she joined one at the beginning of her sophomore year because, as she put it, she wanted to be part of "a group of 'special' friends." But once in the sorority, she felt overwhelmed by the intensity of the closeness with the other young women. "I love my sorority sisters," she told me. "But it's hard. You can't do anything alone. We all eat together, party together . . . you even have to get the group's approval of any guy you wanted to go out with."

College, as May (1998) puts it, "presents endless opportunities for both idealization and envy" (p. 251), and sororities are hothouses for these emotions. On the one hand, young women expect—and are expected—to connect with their sorority sisters in a kind of blind and loyal merger; and on the other, they are constantly, if silently, comparing themselves with these same comrades. Most find themselves wanting in some way or another. Audrey, an attractive, athletic young woman, felt fat in comparison to her new friends. She started to diet, then

found herself bingeing. Other girls in the house threw up, she knew, as a way to lose weight. She thought it might be the solution. Before long, she was addicted to the process.

For Audrey, as for most young women, bingeing and purging had many meanings. Consciously, she saw it as a way of achieving the body she wanted, the admiration of her friends, and the interest of young men. Unconsciously, however, it seemed to be a perfect method for being both attached to and separate from her sorority sisters. She could be "the life of the party—I eat anything I want," she told me, while managing to lose weight at the same time. Any negative feelings were buried in the eating and purging behaviors, and her sense of belonging, of feeling attractive, and of being admired were all "fed" by these behaviors. Unfortunately, instead of developing a more cohesive and positive sense of her own identity, Audrey developed a feeling of fraudulence."I wasn't there," she said some years later. "Nobody knew who I was, really, or what I was like. And neither did I."

Her decision to go for therapy was a desperate attempt to find a home for her "separate thoughts." Audrey had not told any of her friends that she was going for therapy. She was sure that they would disapprove. Some years into our work, Audrey and I were discussing the links between her eating disorder and her feelings about her sorority. "I didn't realize it at all," she said, "but my bulimia really said exactly what was going on for me in terms of relationships with the other women. I would take in everything, do anything anybody in the sorority wanted—you could say I binged on the closeness—and then I would get rid of it symbolically when I threw up. Nobody knew I was bulimic. And nobody—not even me—knew how claustrophobic I felt." Wolf, Gedo and Terman (1972) suggested that adolescence is a time for developing new identifications and relationships, separate from the family. Unlike Erikson, who believed that each developmental stage had to be resolved successfully in order to ensure healthy resolution of the next step, Wolf et.al. believed that an adolescent who had difficulty with earlier separations can, through these new relationships, develop the ability to separate in a healthy way. While we know that we cannot escape ourselves—we bring old problems with us to new situations—nonetheless, college offers an opportunity for what Balint (1968) called "a new beginning."

My own experience with college aged adolescents, however, is that they are constantly negotiating and re-negotiating issues of intimacy and closeness, separateness and independence with family and peers. While they frequently long for intimacy, they are, at the same time, afraid that the closeness they want will destroy their newly developed, but still fragile sense of independence and autonomy. Eating disorders can sometimes be used, as was the case for Audrey, to manage this dilemma. "I knew I had to get out of the sorority," Audrey said later, "but I didn't know how. I felt ashamed. Like there was something wrong with me." I once asked if Audrey had discussed her concerns with her parents. "Oh, I tried," she told me. "But they don't really know how to help. My mom is a 'joiner.' She loved her sorority, and she belongs to several organizations in our town now. She just can't figure out why I'm feeling so claustrophobic." Audrey's father was more sympathetic, but he had difficulty understanding why she didn't just leave. "For him, it's like, 'if you're not happy, then get out of the situation.' He doesn't get how worried I am about making the girls angry. Oh, I guess I shouldn't be so concerned with what they think—after all, it's my life, isn't it? But I do worry. I don't want them to hate me. I just don't want to be with them all the time, either."

Adolescents often feel that if a parent (or other adult) does not feel the same way they feel, they can neither understand nor help with the

problem. Yet recognizing that people who love us can be different from us and still understand something of our experience is, as Benjamin (1992) suggested, a crucial part of psychological and emotional development. I encouraged Audrey to try to explore her parents' thoughts about newly difficult situations. I helped her find words to explain to them just what the predicament was, what her concerns were, and then to ask them if they had ever had similar experiences themselves? I also suggested she ask them to tell her what they would do if they were in her shoes. I encouraged her to use these conversations not to make any kind of decision, but to let herself play with possible solutions to the problem. In most cases, the goal with adolescents in college is neither for their parents to tell them what to do, nor for them to decide on their own. It is, instead, to engage in a process of mutually supported problem solving. In my experience, teaching adolescents and their parents how to establish such a process can be one of the most productive uses of a therapist's time.

Sometimes all that is necessary is a word or two to let a student know that the feelings are not taboo. It is also helpful for a therapist to explore situations in which an adolesent shares "too much" with her parents. Constant phone or email contact, and the sharing of too many intimate secrets with parents is not necessarily a sign of health in an older adolescent. The key word here—as it is throughout the college experience—is balance. Either too much or too little intimacy—with parents, friends, and even lovers—can interfere with the balance of individuation and attachment. The parent's capacity to survive not only anger and resentment, but also separation while maintaining a deeply caring connection to an adolescent is crucial to this developmental process. Unfortunately, many parents suffer major life crises at precisely the time that their children leave for college—divorce, loss of their own parents, death of a spouse, and serious illness are not unusual occurrences at this time of life. These crises may make parents less available to work through attachment-individuation issues. Furthermore, parental difficulties with their own emotions, and specifically with the dynamic of separation and attachment can make it particularly difficult for them to work with their children on the critical struggles of this developmental stage. One of the hardest tasks for therapists in this process is to manage a countertransferential desire to place all of the blame for a child's eating disorder on her parents. Recognition of the parents' struggles with painful emotions can help.

## ADULT EMOTIONS
## CLINICAL EXAMPLE: I DON'T WANT TO BOTHER MY PARENTS

Laurie was in graduate school when she came to me for help with bulimia that seemed to have spiraled out of control. Like many college students with eating disorders, Laurie had struggled with her weight for most of her life; but

after breaking up with her boyfriend, she became depressed and unhappy and started binge-eating. "I needed to control my weight," she said with shame, "but I couldn't stop eating." So she started throwing up. By the time she called me, Laurie could not keep any food in her stomach. "If I eat a spoonful of spinach, I have to throw up," she told me. Interestingly, Laurie's throwing up was not keeping her weight down. While this bothered her, it is actually not at all unusual.

Bingeing and purging over an extended period of time—like restrictive dieting—can throw off the body's metabolism so much that weight gain and loss seem to have nothing to do with amount eaten. I was more concerned that her constant purging was depleting her body of crucial vitamins and minerals and interfering with her electrolyte balance, which can cause fainting and eventually lead to serious physical problems. She often felt lightheaded and dizzy, and her energy was, not surprisingly, extremely low. It appeared that her physical symptoms, however, captured something about her psychological and emotional state in a way that she could not put into words. What she could talk about was her relationship with her ex-boyfriend.

Particularly important to her had been the cuddling that was a key part of their sex life. "I loved being held by him. I felt such a sense of comfort just lying in his arms, my head resting on his shoulder . . ." As she told me more of the details of this comforting connection, she also shared with me for the first time that her mother had had breast cancer while Laurie was in her senior year of college. "Max really helped me get through that time," she said softly. "We weren't sure Mom was going to survive. She had a double mastectomy, and chemo . . . it was bad. And Max hung in there with me the whole time." What only gradually emerged was Laurie's terror over her mother's illness. "What if she dies?" she whispered to me in one session after we had been working together for some time. "I don't know how I'll survive. I know I shouldn't need my mother so much at this time in my life . . . but I'm so afraid . . ." Max had comforted Laurie and helped her deal with her anxieties during the diagnosis and treatment stages of her mother's illness; but we began to suspect that he had had difficulties with her continuing neediness. Eventually, he had pulled away from Laurie—not all at once, but over time. "It didn't hurt so much," Laurie told me. "I mean, I was expecting it. We had just stopped spending so much time together . . ."

But Laurie felt lost, disconnected, alone and lonely—and fearful that her needs were overwhelming and unacceptable. Laurie felt that she could not turn to someone else for comfort. Her mother and father had their own troubles, and she was afraid of driving other men away as she unconsciously suspected she had done Max. She began to binge to cope with her terror and loneliness. She purged at first to keep from gaining weight, and then because the physical sensations that followed actually made her feel better. A large part of our work together was simply to help Laurie understand that her feelings were normal and acceptable. My own mother was quite ill during the time we worked together, and Laurie was amazed when one day I shared with her that I was feeling very sad about the illness.

"I wouldn't have thought a grown woman, with a family of her own, and a career and everything, would have that kind of feeling about her mother," she said. "I mean, I guess I would have thought it was sick or something to be that connected to your Mom at that point in your life." As Laurie explored the painful feelings related to her mother's cancer, she talked about her fear that it would hurt her mother if she said anything to her about her emotions. "I mean, she's got so much on her plate. I don't want to add to it. It must be awful thinking about your own possible death. You wouldn't want your daughter telling you she's afraid you're going to die. And that she's worried about her own death—which I am, you know—too!"

We discussed the very real possibility that Laurie's worries might add to her mother's pain. I asked, "Do you think she's not worrying about you anyway? Do you imagine she's never thought about any of these possibilities?" As Laurie began to open up with her mother, she found that indeed her mother was extremely worried about her—and also extremely uncomfortable talking about the feelings. "But you know what?" she asked me. "I feel better—closer to her—just having mentioned the fact that I'm scared. She held me. We both cried. It was awful. But it was good, too."

## CONCLUSION

Just as it takes time for an eating disorder to develop, it also takes time for one to be overcome. Some individuals who develop eating difficulties in adolescence may battle some aspects of the disorder for the rest of their lives. Others may use the symptoms to cope with a specific phase of life and never be bothered by it again. In either case, focusing on the link between an eating disorder and the struggle to find a balance between separation and connection, attachment and individuation can be extremely helpful in working with older adolescents with eating disorders. In many cases, the adolescent and her family may not realize that they are approaching the college separation experience as an "all or nothing" process. They may assume that everyone deals with this separation as they are trying to deal with it. Parents and adolescents are often surprised and relieved when they learn that I do not believe that parents should simply "let go" when a teenager goes off to college. Part of a therapist's job is to help parents and adolescents recognize that the need for connection is life long, and that the process of separating must make space for attachment as well as love, frustration, irritation, and anger. Sometimes even hate can be extremely powerful for these families. Such an acknowledgement will not, of course, make the eating disorder magically disappear. It will, however, be an invaluable aid to the healthy development of the college student.

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