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THE PSYCHOLOGY OF THE SELF AND PATHOLOGICAL OVEREATING

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THE PSYCHOLOGY OF THE SELF

AND

PATHOLOGICAL OVEREATING

by

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Chapter I

INTRODUCTION

It is well known that overeating and obesity are problems of epidemic proportions in this country. A particularly common form that overeating takes is referred to as a "binge," during which an individual compulsively eats large amounts of food, usually well beyond the point of satisfying hunger. In describing the feelings that stimulate these episodes, many people refer to vague sensations of emptiness and depletion. Often they describe this emptiness as more of a psychological hunger than a physical one. And though the feelings are nebulous, they are nevertheless quite powerful: once he begins eating, someone on a binge experiences himself as helpless and unable to stop.

In the following pages I propose to show that these vague feelings and the binges that are stimulated by them may be seen as an expression of self pathology as it has been described by Heinz Kohut (1971; 1977). I have often been impressed by the similarity of descriptions of binges to Kohut's vignettes of patients with pathology in the realm of narcissism and the self. Repeatedly, his case histories have presented individuals whose symptoms are feelings of emptiness, apathy, and depletion. They complain of an inability to derive satisfaction or lasting pleasure from their lives. Frequently, these patients attempt to stimulate themselves with enlivening activities pursued, at times, with compulsive urgency. These

activities take many different forms in addition to overeating: one finds self-pathology expressed in gambling, drug addiction, drinking, addictive promiscuity, and "thrill-seeking" behavior such as racing cars (1978b).

Kohut has expanded his original observations of pathology in narcissistic patients into a comprehensive theory which he calls "the psychology of the self." He contrasts it with classical drive psychology and assigns to the development of the self a separate, distinct, yet complementary path to libidinal development as it is traditionally described in psychoanalytic theory. The personification of the psychic disturbances and conflicts as conceptualized in mental apparatus psychology is what Kohut calls "Guilty Man" (1977, p. 243). In other words, this pathology is expressed in structural neurosis and guilty depression. The embodiment of Kohut's disturbed individual is represented by "Tragic Man":

> The psychology of the self is needed to explain the pathology of the fragmented . . . and of the depleted self (empty depression . . .)--in short, the psychic disturbances and struggles of Tragic Man. (1977, p. 243)

Addressing the topic of pathological overeating in particular, Kohut questions the usefulness of the classical position which asserts that this behavior represents a drive-fixation on the oral level as a flight from "castration fear and/or oral indulgence." He writes:

> it is not . . . [in the majority of these cases] . . . the child's wish for food that is the primal psychological configuration. Seen from the point of view of the psychology of the self, we will affirm instead that, from the beginning, the child asserts his need for a food-giving self-object . . . (In more behavioristic terms we might say the child needs empathically

> modulated food-giving, not food). If this need remains unfulfilled . . . then the broader psychological configuration - the joyful experience of being a whole, appropriately responded-to self - disintegrates and the child retreats to a fragment of the larger experiential unit, i.e., to pleasure-seeking oral stimulation . . . or, expressed clinically, to depressive eating. (1977, p. 80).

Thus, in Kohut's terms, the emptiness experienced by the compulsive eater can be seen as the fragmented self asserting its unfulfilled need for a nurturant selfobject.[1]

There is much in the eating disorders literature that supports Kohut's contention, although only one author (Goodsitt, 1977) has specifically addressed himself to his point of view as yet. Although there are few studies devoted to the particular phenomenon of pathological overeating, there is a voluminous literature on obesity which, obviously, is often the result of this behavior. However, it is not always the case that binges will lead to obesity. Many people correct for their periodic overeating by dieting scrupulously the rest of the time (Buchanan, 1973). Furthermore, binges are common in a subset of patients with anorexia nervosa, and "bulimarexics" are also known to engage in frequent binging followed by self-induced vomiting. Thus, overeating and binging behavior can be found in the four main categories of patients usually discussed in the literature: obese, normal-weight, anorexic, and bulimarexic.

Hilde Bruch, perhaps the leading authority on the psychology of eating disorders, has made extensive inquiries into the genetic determinants of the symptom of overeating. She asserts that the key

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[1]As of 1978, Kohut and others have spelled this as one word. In direct quotes from earlier papers, however, it will be spelled "self-object."

factor involved in this behavior is the individual's inability to recognize and respond appropriately to his own internal states. The overeater is not only unable to recognize whether or not he is hungry or satiated, he is often unable to discern if he is too warm or too cold, or tired or not. Schachter's classic studies (1968) support this notion in that they show that obese subjects respond to external cues in the environment such as time, rather than internal cues such as hunger in their eating patterns. Overeaters will eat because it is dinner-time; normal subjects eat when they are hungry. This finding is surprisingly consistent with Kohut's descriptions of patients with self pathology, who suffer many kinds of defects in the ability to regulate themselves.

Bruch's case histories are filled with examples of patients who report their binges as stimulated by an ill-defined emptiness, a vague "ache" inside of them. Furthermore, her studies on the mother-child interactions of families with obese children (1940; 1973), and the consequent psychological development of these children, are remarkably parallel to Kohut's descriptions of the origins of pathology in his patients. Both writers stress the paramount concept of a child who is inappropriately responded-to by the mother. This inappropriateness can be seen in responses that are either "too little" or "too much" to satisfy the infant's needs. In either case, the infant's need is <u>not</u> the primary focus of the response; in Kohut's terms, he is not empathically responded-to. Both Kohut and Bruch claim that this kind of interaction is often the result of a mother whose own narcissistic pathology causes her to view her child as her possession or as an extension of herself (Bruch, 1973; Kohut,

1971, 1977). Thus the child does not have the opportunity to internalize a significant other's well-modulated attention to his biological and emotional needs.

When a child is consistently denied this oportunity it often leads to a structural characterological defect which Kohut calls self pathology. The adult patient who has experienced such an interaction with his primary caretakers during infancy is unable to correctly identify and respond to his needs. Furthermore, Kohut asserts that the hunger drive is always accompanied by the equally powerful psychological need for the nurturant selfobject. Early, chronic frustration of this need produces fragmentation and disintegration of the self, which results in a hypercathexis of the original isolated drive--hunger--and hence compulsive and depressive eating. Indeed, an individual suffering from such a defect in the realm of the self will experience an empty depression in response to any kind of fragmenting event in which he is unable to feel he is a "whole, appropriately responded-to self."

Thus the psychology of the self can lend valid perspectives to the phenomenon of binge eating in at least two ways. In one light it offers a developmental explanation of the overeater's inability to respond to his internal cues, those cues that in normal people allow them to eat when hungry and to stop eating when they are full. Without that ability, a meal becomes a binge. Secondly, and perhaps more importantly, it points to what may be the origin of those painful feelings of emptiness that may stimulate the addictive eating in the first place.

Chapter II

A REVIEW OF THE LITERATURE OF THE PSYCHOLOGY OF THE SELF

"I've rocked the boat." - Heinz Kohut
(Quinn, 1980, p. 121)

Whatever the ultimate value of Kohut's contributions will turn out to be, he has created something of a sensation in the analytic community in recent years. Sharply criticized by some for what are considered heretical departures from classical theory, Kohut is deemed by others to be the most influential figure in psychoanalysis since Freud himself (Quinn, 1980), an ironic position for a man who writes about idealization. One disgruntled member of the New York Psychoanalytic Society, given the pseudonym "Aaron Green" in a recent article in The New Yorker (Malcolm, 1980), says that although Kohut's followers appear to be attempting to integrate the psychology of the self and classical psychoanalysis, "underneath you sense the revolutionary fervor, the belief in the New Messiah" (p. 140).

Yet many traditional analysts (e.g. Chessick, 1980; Friedman, 1980; Schwartz, 1978) have been accepting and even praiseworthy of Kohut's clinical contributions to the treatment of narcissistic personality disorders, what he calls (1977) the psychology of the self in "the narrow sense" (p. xv). It is his attempt to expand his observations into comprehensive metapsychological formulations, what he terms the psychology of the self in the "broad sense" (p. xv), that

has drawn him the most fire from classical theorists. They see it not as a "complementary" contribution to structural theory, as Kohut asserts, but as a "rival" theory (Chessick, 1980) that discards or diminishes some of the most crucial tenets of psychoanalysis. Some contend that his current popularity is "faddish" (Schwartz, 1978), and are doubtful that the fervor will persist (Malcolm, 1980). Indeed, it is difficult to discern how much of the controversy, both pro and con, is political; Kohut himself reminds us that even "Freud began that way" (Quinn, 1980, p. 131), that is, in the midst of controversy.

In the following pages I will follow the major thrust of Kohut's contributions, with particular emphasis, of course, on those that add a new perspective to the problem of pathological overeating. This discussion (hopefully undertaken without the spirit of "revolutionary fervor") will support the value of some of his metapsychological departures by demonstrating their applicability to this specific clinical problem.

The Classical Position on Narcissism and the Self

Before turning to Kohut's writings on narcissism and the self, a brief examination of the classical position is in order. These are considered to be among the most confusing and complex concepts in psychoanalysis (Pulver, 1970). The term "narcissism" was originally applied by Havelock Ellis in 1898 to describe a specific sexual perversion in which a person regards his own body as a sexual object. This definition remained predominant until Freud expanded the uses of the term in his classic 1914 paper "On Narcissism." Here he assigned

several new applications to the word, including "narcissistic object choice," "narcissistic object relation," and "self-esteem." However, it was prior to this famous paper--in a brief footnote to "Three Essays on the Theory of Sexuality" in 1905 and in his 1911 report of the Schreber case--that Freud introduced a meaning to the concept of narcissism as it will be most important to us here: narcissism as a developmental stage. Freud asserted that it is "a stage in the development of the libido which it passes through on the way from auto-eroticism to object-love" (1911, p. 60). The implication of this assertion is, of course, that narcissism and object love are part of the same developmental line, and thus that persistent narcissism represents a fixation or a regression. This is one of the issues from which Kohut makes a major departure, as he sees narcissism as having a separate line of development from that of object love and maintains that it can be considered not only healthy in many cases, but that it is also essential to mental health.

Jacobson (1964) takes issue with Freud's (1914) notion that narcissism is the libidinal cathexis of the ego and its functions and asserts instead that it is the libidinal cathexis of the self-representation, which is constituted in the course of ego development. Hartmann (1964), on the other hand, defines narcissism as the libidinal cathexis of the self, distinguishing all these murky concepts in the following manner: the ego is defined as a structural mental system; the self is the whole person of the individual, including his body and body parts as well as his psychic organization and its parts; and the self-representation is the unconscious, preconscious, and conscious

endo-psychic representations in the bodily and mental self in the system ego (p. 127).

Kohut (1971) applauds Hartmann's "conceptual separation of the self from the ego" (p. xiii), as well as his definition of narcissism, and in his earliest writing he too considers the self as a content of the mental apparatus, a psychic structure. However, Kohut later (1977) broadens his concept of the self and declares that it is "the center of the psychological universe" (p. xv), a "supraordinate configuration . . . with its own center of initiative and thus no longer a content of the mind" (Ornstein, 1978, p. 97). And thus Kohut makes his most fundamental move outside the classical position, for "as . . . [he] himself recognizes, this supraordinate self is beyond the laws of psychic determinism and outside the limits of traditional psychoanalysis" (Chessick, 1980, pp. 472-473).

Summary of Kohut's Major Contributions

The publication of the Analysis of the Self in 1971 represented Kohut's first attempt to present his ideas about narcissism and the self in a systematic manner, although he had been writing about these topics at least since 1966. It is in this monograph that he introduces, details, and begins to refine most of the key points that will later constitute "the psychology of the self." He achieves this through "the study of certain transference or transference-like phenomena in the psychoanalysis of narcissistic personalities, and of the analyst's reactions to them, including his countertransferences" (p. 1). He feels that the only completely valid way to distinguish

such patients from others is through the examination of the specific transference that develops, but he begins by presenting a schematic overview of the essential pathology involved.

Pathology

The dynamic-structural and genetic origins of the essential pathology are the fixations of these patients on "archaic objects cathected with narcissistic libido" (p. 3). These objects include the archaic "grandiose self" and the archaic "idealized parent imago," which are "not experienced as separate and independent from the self" (p. 3). As Kohut explains further:

> The fact that these archaic configurations have not become integrated with the rest of the personality has two major consequences: (a) the adult personality and its mature functions are impoverished because they are deprived of the energies that are invested in these ancient structures; and/or (b) the adult, realistic activities of these patients are hampered by the breakthrough and intrusion of the archaic structures and their archaic claims. (p. 3)

Despite the fact that this pathological fixation occurs quite early in psychic development, Kohut feels narcissistic patients can and must be distinguished from psychotic and borderline personalities because the "self" is cohesive even though it is constructed of archaic objects. He points out that there is no threat of "irreversible disintegration" of this unified self, and "in consequence of the attainment of these cohesive and stable psychic configurations these patients are able to establish specific, stable narcissistic transferences" (p. 4). It is through the study of these specific "selfobject" transferences, of course, that Kohut makes most of his points.

Symptomatology

According to Kohut, symptoms alone can never provide an adequate differential diagnosis in these cases. Nevertheless, he does provide an overview of the major clinical features that one encounters in narcissistic patients. He notes that the symptoms are usually ill-defined and speculates that "the vagueness of the patient's initial complaint may be related to the nearness of the pathologically disturbed structures (the self) to the seat of the self-observing functions of the ego" (p. 16). However, the analysand will frequently report the following: (a) pervasive, but subtle, feelings of emptiness and depression; (b) a feeling that he is not fully real, or that his emotions are dulled; and (c) that his approach to work lacks zest and initiative (pp. 16-17). These and similar symptoms are due to the depletion of the ego that is caused by the defenses against the archaic objects that the patient invests with so much narcissistic libido. They are usually alleviated by the establishment of the narcissistic (selfobject) transference; however, even small disruptions in the transference situation will cause the symptoms to recur. There exists in these patients:

> great narcissistic vulnerability which . . . is responsible for the fact that the patient's heightened pleasure in himself soon becomes submerged again and . . . the increased vitality of his actions cannot be maintained long. A rebuff, the absense of expected approval, the environment's lack of interest in the patient, and the like, will soon again bring about the former state of depletion. (p. 17)

Thus Kohut examines how these patients attempt to regulate their self-esteem through the use of the selfobject transferences. Their inability to do this, he says, is the "principle source of

discomfort" for narcissistic personalities, discomfort that ranges from "anxious grandiosity and excitement, on the one hand, to mild embarrassment and selfconsciousness, or severe shame, hypochondria, and depression, on the other" (p. 20).

The Grandiose Self and the Idealized Parent Imago

Kohut repeatedly emphasizes that "the crucial diagnostic criterion is to be based . . . on the nature of the spontaneously developing transference" (p. 23). The mechanism by which the narcissistic tranference is established is the activation of the archaic selfobjects: the grandiose self and the idealized parent imago. The illustration of how these archaic structures become fixated is accomplished by contrasting this process with that of normal development. The establishment of the grandiose self (the exhibitionistic image of the self, or "I am perfect"), and the idealized parent imago (the attributing of perfection to an admired, omnipotent object, or "you are perfect, but I am part of you"), occurs when the "equilibrium of primary narcissism is disturbed by the unavoidable shortcomings of maternal care" (p. 25). These two independent, coexisting archaic structures are, under favorable circumstances, gradually tamed by minor, occasional failures of the selfobject that "mirrors" the grandiose self and that which serves as the idealized parent and the normal result is that "the whole structure ultimately becomes integrated into the adult personality" (p. 27). Thus integrated, the grandiose self provides narcissistic libido for ambitions, goals, and self-esteem. Likewise, the idealized parent

imago is "introjected as our idealized superego" (p. 28) and provides psychic fuel for ideals.

Because Kohut postulates a separate line of development for narcissism and object love, he sees the energy that fuels these capacities as narcissistic libido. Object libido, from his viewpoint, comes from a separate source and fuels different activities. Thus, the idealized parent is a narcissistic object because "narcissism . . . is defined not by the target of the instinctual investment (i.e. whether it is the subject himself or other people) but by the nature or quality of the instinctual charge" (p. 26 [italics in original]).

The optimal development outlined above goes awry when the child suffers "severe narcissistic traumas" (in the case of the grandiose self), or "traumatic disappointments in the admired adult" (p. 28) (in the case of the idealized parent imago). In these instances, the archaic structure does not become integrated but instead "is retained in its unaltered form" (p. 28). The consequences of this pathological development are that the grandiose self continues to make its archaic, exhibitionistic claims, while the idealized parent imago "remains an archaic, transitional self-object that is required for the maintainance of narcissistic homeostasis" (p. 28).

Kohut makes the important point that when he speaks of "severe narcissistic traumas" or "traumatic disappointments in the admired adult," he is not referring to isolated incidents or even a series of incidents so much as a style of interaction between the parents (selfobjects) and the child. Vivid, dramatic memories "often turn out

to be no more than crystallization points" (1977, p. 187), for he states that "in the great majority of cases it is the specific pathogenic personality of the parent(s) and specific pathogenic features of the atmosphere in which the child grows up that account for the maldevelopments, fixations, and unsolvable inner conflicts characterizing the adult personality" (p. 187). Thus, for example, the narcissistically preoccupied mother who chronically fails to mirror the child's exhibitionistic strivings, or the narcissistically vulnerable father who consistently cannot tolerate the child's need to idealize him, are more relevant here that any specific, isolated psychic injuries. Only when these archaic, unfulfilled needs are remobilized in the selfobject tranference do they become available for scrutiny and ultimately, healthy integration into the personality.

The Selfobject Transferences

The idealizing transference. The idealizing transference occurs in treatment when the archaic idealized parent imago (the omnipotent object) is reactivated and revived. The essential aspect of this transference is that the analyst becomes an omnipotent, idealized selfobject and, because all ideals and power now reside with the selfobject, the analyst becomes necessary for the maintainance and homeostasis of the patient's self-esteem. The selfobject functions literally as if he were a part of the patient's psyche: the analysand "feels empty and powerless when he is separated from it and he attempts, therefore, to maintain a continuous union with it" (1971, p. 37). In the idealizing transference, a revival of the archaic idealized parent imago occurs from the point at which normal

development was interrupted. Unlike the analysis of transference neuroses, in which the idealization of the analyst plays an "auxiliary role" to the reactivation of oedipal conflicts, in the analysis of narcissistic personalities who establish an idealizing tranference the idealization plays a "specific, essential, and strategic role" (p. 77), for it is the crucial transference manifestation of the patient's central structural personality defect.

In Kohut's clinical experience, provided the analyst does not rebuff or reject the patient's first attempts at idealization, nor make premature interpretations, then the transference will proceed by means of "pathognomonic regression . . . [and] will establish itself spontaneously" (p. 88). The working-through of the idealizing transference occurs when the narcissistic homeostasis that the patient attempts to gain by use of the selfobject is disturbed. Kohut informs us that this usually is "caused by certain external circumstances," such as a separation for the summer vacation. "The analysand responds initially with rage and despondency . . . to any event that disrupts his narcissistic control over the archaic parent imago, the analyst" (p. 90). Even relatively minor events, such as changes in the schedule or "small signs of coolness from the therapist" (p. 91) can instigate a major disruption of the patient's narcissistic equilibrium: "anything that deprives . . . [him] of the idealized analyst creates a disturbance of his self-esteem" (p. 92).

These disturbances, which at first Kohut was at a loss to understand, provided him with his most crucial insights. Rather than view them as unproductive resistances (as Freud originally regarded

the transference neurosis), he realized that they were, in fact, the heart of the matter, and concluded that the "essential part of the working-through process concerns here the ego's reaction to the loss of the narcissistically experienced object" (p. 95).

Repeated interpretation by the analyst of the patient's reaction to this loss results in the reality ego's finally having access to the repressed and/or split-off narcissistically cathected selfobject:

> the essential working-through process, however, aims at the gradual withdrawal of the narcissistic libido from the narcissistically invested archaic object; it leads to the acquisition of new psychological structures and functions as the cathexes shift from the representation of the object and its activities to the psychic apparatus and its functions. In the specific case of the idealizing transference the working-through concerns . . . specifically the withdrawal of idealizing cathexes from the idealized parent imago and concomitantly, (a) the building up of drive-regulating structures in the ego, and (b) the increased idealization of the superego. (p. 96)

Kohut refers to the process through which these gradual gains are made as "transmuting internalization." In normal development, this gradual structure-building through transmuting internalization would have occurred in response to optimal frustrations and disappointments.

The analyst must repeatedly and consistently empathically reflect the patient's experience as he undergoes the following typical sequence that comprises a "regressive swing" in response to a "disappointment in the idealized analyst." The steps of this sequence include:

(1) the patient's loss of narcissistic union with the idealized self-object;
(2) the ensuing disturbance of the narcissistic balance;

(3) the subsequent hypercathexis of forms of either (a) the idealized parent imago, or (b) the grandiose self; and, fleetingly,
(4) the hypercathexis of the (autoerotic) fragmented body-mind-self. (pp. 97-98)

Step (4) is particularly noteworthy because it refers to the experience of fragmentation and disintegration that is so common among patients with narcissistic pathology. The disruption of the union with the selfobject initiates a process whereby "the cathexis is withdrawn from a cohesively experienced self and regressive (autoerotic) fragmentation and hypochondriacal tensions now threaten . . . [the patient]" (p. 99). He may turn to different kinds of regressive activities in a desperate attempt to alleviate the painful feelings of deadness and fragmentation of the self that he is now subject to. Citing just a few of the activities that Kohut mentions: self-applied stimuli such as looking in the mirror, eating, or masturbation; athletic feats to "reassure himself about the reality of his physical existence"; and/or voyeuristic or other perverse activities undertaken "in order to gain reassurance about being alive" (p. 99). In other words, these isolated activities are temporarily engaged in order to counteract the frightening sense of fragmentation that the self experiences when cohesiveness is suddenly lost.

The mirror transference. The "mirror transference" is the term that Kohut assigns (1971) to the therapeutic reactivation of the archaic grandiose self. He distinguishes between the three following forms of mirror transference. The first is the "merger" transference which occurs through the extension of the grandiose self. Kohut calls this the most "archaic" form of mirror transference because the

analyst is experienced most completely as part of the patient's own self. He regards the analyst as he would part of his own body or mind and, as such, "expects unquestioned dominance over him" (p. 115). Needless to say, "the analyst . . . experiences this relationship in general as oppressive" (p. 115). The "alter-ego" or "twinship" transference is less archaic in that "the patient assumes that the analyst is either like him or similar to him" (p. 115), and thus does not experience such a complete dissolution of boundaries as occurs in the merger type of transference. Less archaic still is what Kohut calls the "mirror" transference in the "narrower" sense. This form of the reactivation of the grandiose self is what he describes as "the therapeutic reinstatement of that normal phase of the development of the grandiose self in which the gleam in the mother's eye, which mirrors the child's exhibitionistic display, and other forms of maternal participation in and response to the child's narcissistic-exhibitionistic enjoyment, confirm the child's self-esteem and, by gradually increasing the selectivity of these responses, begin to channel it into realistic directions" (p. 116).

In the mirror transferences, as in the idealizing transference, the working-through is initiated by some failure on the part of the selfobject analyst. And, as in the idealizing transference, "when the mirror transference cannot be maintained . . . the patient feels threatened by the dissolution of the narcissistic unity of the self" (pp. 120-121) and once again he will experience a sense of fragmentation which produces the hypochondria and various other regressive activities outlined above, which constitute the patient's

attempt to counteract the disintegration. And, finally, as in the idealizing transference, such a disruption can occur in response to a separation from or empathic failure by the selfobject analyst, although the latter failures are most relevant in the analyses of mirror transferences.

It is during the working-through phase that the two major ways in which the ego defends itself against the claims of the grandiose self come to light. The first is through a horizontal split in the psyche (repression), depriving the ego of narcissistic libido and accounting for the ill-defined symtomatology of vague depressions, lack of zest and initiative, and poor self-esteem. More common, however, is the type of patient who has a vertical split in the ego and hence maintains two seemingly contradictory attitudes, both grandiosity and low self-regard, in consciousness. In either case, however, the remobilization of the archaic grandiosity through the mechanism of the mirror transference allows it to be systematically analyzed and worked-through. The desired therapeutic effect, as Kohut sees it, is that a condition he calls "ego dominance" will finally prevail over and direct the patient's grandiosity into "realistic channels." As Kohut points out, "the structures built up in response to the claims of the grandiose self appear in general to deal less with the curbing of narcissistic demands but with the channeling and modification of their expression" (p. 187).

Ultimately, the working-through of the mirror transference should facilitate the building of mature ambitions and goals from the former infantile grandiosity. A second therapeutic effect occurs

when the archaic narcissistic libido is freed from shame-provoking exhibitionism and made available to provide self-esteem and pleasure in these endeavors. And in all varieties of narcissistic transferences basic therapeutic progress is measured by the extent to which the patient has been able to build internal structures that perform the functions of maintaining a cohesive, vigorous self; functions that were previously given over to the selfobjects.

The Emergence of "the Psychology of the Self"

Up until this point, Kohut has introduced his concepts with an effort to stay within the major confines and language of traditional psychoanalytic theory. Furthermore, he has indicated that his ideas pertain to a small group of patients (although he says they are much more common than he previously realized) that can be classified as having narcissistic personality disorders. However, in his second book, The Restoration of the Self (1977), he takes a much bolder, broader approach in suggesting the need for "a psychology of the self" in which the "self is seen as the center of the psychological universe" (p. xv). In doing so he asserts that the vicissitudes of the cohesiveness of the self exert a decisive influence upon psychological adaptation in all levels of development and across a broad range of psychopathology. Thus far he has confined his formulations to the "self" in the narrow sense: as it functions in narcissistic patients--as a content of the mental apparatus. But now he also sees the self as a supraordinate structure and he declares that "the primary psychological configuration . . . is the experience of the relation between the self and the empathic self-object"

(p. 122). He introduces the terms "self pathology" and "self disorder" to refer to disruptions and disturbances in this realm, which he believes to be exceedingly common.

The bi-polar self. Kohut's conception of the self is further defined by his notion of "the bi-polar self." Here he asserts that either the establishment of a cohesive grandiose self or the establishment of a cohesive idealized parent imago can promote healthy narcissism in the adult personality. In other words, each child actually has "two chances as it moves towards the consolidation of the self--self disturbances of pathological degree result only from the failure of both of these developmental opportunities" (p. 185).

A "nuclear" core self is established quite early in infancy, according to Kohut. This process is shaped by the fact that the child's parents respond to him from the very beginning as if he already had a "self." However, in response to optimal frustrations from the primary caretakers, the infant begins to develop the two archaic structures, the grandiose self and the idealized parent imago, that compensate for the failures of the real objects. Further "selective" failures by the parents ultimately bring about the internalization of these structures and they become integrated into the personality as a whole, providing a basis for a vigorous, cohesive self. However, even if these two archaic structures are not adequately integrated, Kohut postulates that defensive structures in one can cover a primary defect while compensatory structures in the other can bolster insufficient cohesiveness. Either "pole" of the self can be secondarily reinforced in this way and hence can result in a more or

less stable self even though there may exist some fundamental defects of integration.

Theoretically, then, a child whose grandiose self was insufficiently mirrored by one selfobject (usually the mother, in this case), may still have an opportunity to develop a cohesive self through an idealized parent (the father, let's say) who can successfully tolerate the idealization while at the same time can gradually guide the child to a more realistic appraisal through optimal frustration and minor disappointments. "The strength of one constitutent," Kohut writes, "can offset the weakness of the other" (p. 186), and hence a potentially healthy self can essentially be developed in two different manners. These two distinct poles, however, whatever their relative strengths or weaknesses, provide the basis for a "specific energic tension arc (from nuclear ambitions via nuclear talents and skills to nuclear idealized goals) that persists throughout each person's lifetime" (p. 178). Kohut postulates that the nuclear ambitions are laid down in early childhood (ages 2-4) as the grandiose self consolidates, whereas nuclear idealized goal structures are formed later (ages 4-6) as the idealized parent imago is internalized as a cohesive structure. The image of a "tension arc" or "tension gradient" is provided, in any case, to evoke "the relationship in which the constituents of the self stand to each other," which is unique in each individual as he is "'driven' by his ambitions and 'led' by his ideals" (p. 180).

A classification of self pathology. At this point, Kohut offers a systematic outline of self pathology. He distinguishes

between "primary" and "secondary" disturbances of the self, defining the latter as "the acute and chronic reactions of a consolidated, firmly established self to the vicissitudes of the experiences of life" (p. 191). In these cases, the self is structurally undamaged yet still may experience reactive and temporary disturbances in self-esteem. Kohut asserts that "the psychologically healthy adult continues to need the mirroring of the self by self-objects . . . and he continues to need targets for his idealization. No implication of immaturity or psychopathology must, therefore, be derived from the fact that another person is used as a self-object" (p. 188n). Nevertheless, the vicissitudes of the fundamentally cohesive self are not as frequent or as severe as those that occur in primary disturbances of the self.

There are several different subgroups of psychopathology in which a primary disturbance of the self is prominent. In the psychoses, the nuclear self is non-cohesive and thus represents the most severe kind of self disorder. Less severe are the borderline states because although "the break-up, the enfeeblement, or the functional chaos of the nuclear self are also permanent or protracted . . . the experiential and behavioral manifestations of the central defect are covered over by complex defenses" (1978b, p. 415). Kohut also classifies schizoid and paranoid personalities as instances in which the use of defenses, in these cases defenses which help maintain a safe emotional distance from others, protects a seriously defective self from the danger of disintegration.

The only primary self disturbances that Kohut believes are analyzable are the narcissistic personality disorders and the

narcissistic behavior disorders, because in these syndromes there occur only temporary break-ups of the self. In the former, this is "manifested predominantly by autoplastic symptoms . . . such as hypersensitivity to slights, hypochrondria, or depression," and in the latter by "alloplastic symptoms . . . such as perversion, delinquency, or addiction" (1977, p. 193).

Kohut continues (1978b), however, by providing a more specific typology of self pathology and its developmental antecedents. For example, what he calls the "understimulated self . . . arises in consequence of prolonged lack of stimulating responsiveness from the side of selfobjects in childhood" (p. 418). In response to chronic, empty depression and painful feelings of deadness, these personalities attempt to stimulate themselves through various compulsively pursued activities: any addictive-like behavior, including our main focus, addictive eating, can be used to defend against a basic lack of vitality and painful emptiness present in the understimulated self.

A second type Kohut identifies as the "fragmenting self," which is the result of "the lack of integrating responses to the nascent self in its totality from the side of selfobjects in childhood" (p. 418). Such a personality is prone to occasional fragmentation states in response to an environment that does not acknowledge his "total" self. Often the parents of fragmentation-prone patients were preoccupied with details at the expense of recognizing the needs of a self that was attempting to achieve some unity and cohesion.

The "overstimulated self" was subject to "unempathically excessive or phase-inappropriate responses from the side of the

selfobjects of childhood" (p. 419). This can occur in one of two ways. Those who have been overstimulated in response to their early grandiose-exhibitionistic strivings are prone to easy stimulation of these archaic wishes, and hence shun situations that are likely to reinforce them, lest they be flooded with non-integrated grandiose fantasies. These people cannot tolerate being the center of attention, for example. Overstimulation of the need for an idealized parent, on the other hand, occurs in consequence of a childhood selfobject who had an excessive desire for admiration and thus did not allow the child to eventually reach a more realistic appraisal of him. Thus, the idealized parent imago did not become properly internalized and the need for idealized objects persists in such intense form that it must be avoided. In this type of overstimulated self, "the capacity for healthy enthusiasm will be lost" (p. 419).

A final subtype, the "overburdened self," has suffered "the trauma of unshared emotionality. The result of this specific empathic failure from the side of the selfobject is the absense of the self soothing capacity that protects the normal individual from being traumatized by the spreading of his emotions" (p. 420). Such a person experiences the world as a dangerous place and finds that he is unusually sensitive to stimuli. He frequently turns to self-applied soothing activities of different varieties (eating is certainly one form this takes) in an effort to diminish the anxiety that he does not possess the internal mechanisms to abate.

In addition to these subtypes, Kohut (1978b) describes a variety of personality styles "in the narcissistic realm . . . that

are frequently encountered in everyday life and . . . should, in general, not be considered as forms of psychopathology but rather as variants of the normal human personality, with its assets and defects" (p. 422). Briefly, these are "mirror-hungry" personalities, "ideal-hungry" personalities, and "alter-ego hungry" personalities, each of which attempts to bolster the area of greatest weakness in the self by the use of the respective selfobjects. Two additional character styles, "merger-hungry" personalities and "contact-shunning" personalities "must . . . be considered as lying within the spectrum of pathological narcissism" (p. 422), as the extent of the defect in the self is more severe in these cases.

The Psychology of the Self and Drives

It is evident by now that Kohut has come quite a ways from his original focus on narcissistic personalities and has attempted to describe the role of the self in a broad range of psychopathology as well as in normal behavior. However, the greatest measure of his distance from his starting point within the bounds of classical theory is his discussion of drives, which I have left for the end of my review because it is the most important issue in the context here of applying the psychology of the self to pathological overeating.

Aggression. Kohut (1977) flatly rejects the idea that aggression is a primary drive in man. What is primary, he says, is assertiveness, a "nondestructive aggression" which "develops under normal circumstances from primitive forms . . . to mature forms of assertiveness in which aggression is subordinated to the performance of tasks" (p. 121). Aggression, therefore, is but "a constituent

of the child's assertiveness," and destructive aggression in Kohut's view is always reactive and secondary. "It arises originally as a result of the failure of the self-object's environment to meet the child's need for optimal . . . empathic responses" (p. 116). In other words, the infant presents an assertive self, a self that asserts its need for empathic selfobjects. Only when that need fails to be met does aggression occur, reactively. Kohut goes on to say that "destructive rage, in particular, is always motivated by an injury to the self" (p. 116). Chronic narcissistic rage can only become established if the selfobjects of childhood have been consistently and traumatically frustrating. For Kohut believes that much more than the threat of castration or even the threat of physical destruction, the "bedrock" fear of human beings is "the threat of the destruction of the nuclear self" (p. 117). In a recent interview (Quinn, 1980) he summarized his position this way: "we are born as an assertive whole, as an affectionate whole, not as a bundle of isolated biological drives--pure aggression or pure sexual lust--that have to be gradually tamed" (p. 126). And from this view emerged Kohut's reevaluation of the central concept of psychoanalysis: the Oedipus complex.

The Oedipus complex. Kohut does not criticize the classical view of the Oedipus complex per se; he feels that it provides an adequate framework with which to understand the structural neuroses and that it describes a central sequence in human development. However, he states (1977) that "it falls short in providing an adequate framework for some of the most important experiences of man, those that relate to the development and vicissitudes of his self" (p. 223).

He proposes that the psychology of the self can offer a complementary theory to explain the problems of "Tragic Man," which are not encompassed in the theory of drives and complexes which he personifies as "Guilty Man." Kohut's stated aim is to "enrich classical theory by adding a self-psychological dimension" (p. 227). The following citation, however, indicates that he may, in fact, be saying even more:

> The presence of a firm self is a precondition for the experience of the Oedipus complex. Unless the child sees himself as a delimited, abiding, independent center of initiative, he is unable to experience the object-instinctual desires that lead to the conflicts and secondary adaptations of the oedipal period. Furthermore, if we acknowledge the presence of an active self during the oedipal period, then our conception of the oedipal strivings themselves . . . will reflect psychic reality more accurately. (p. 227)

In describing how he came to this point of view, Kohut offers his experience in the treatment of patients with self disorders. He claims that often during the last phases of these analyses, oedipal strivings would emerge, not as a regression, but as an entirely new developmental step, and, as such, were experienced by his patients not with castration anxiety but instead with joy--joy at the recognition of their achievement.

By the same token, Kohut (1977) proposes that in response to a child's oedipal desires "normally empathic" parents will also experience "joy and pride in their child's developmental achievement" (p. 230), along with the expected responses of sexual stimulation and counteraggression from the respective objects. Oedipal interaction can thus lend important support to the process of self-consolidation. However,

> if . . . this aspect of the parental echo is absent during the oedipal phase, the child's oedipal conflicts will, even in the absence of grossly distorted parental responses to the child's libidinal and aggressive strivings, take on a malignant quality. (p. 234)

Here, Kohut takes one more dramatic leap when he suggests that perhaps the Oedipus complex itself may be seen sometimes as a manifestation of pathological development that has occurred in consequence of a nonempathic selfobject milieu. "The dramatic desires and anxieties of the oedipal child" (p. 247), he explains, can be seen as the expression of isolated drive experiences which self psychology maintains only occur as a product of the disintegrating self. He asks could it not be "that . . . the dramatic, conflict-ridden Oedipus complex of classical analysis, with its perception of a child whose aspirations are crumbling under the impact of castration fear, is not a primary maturational necessity but only the frequent result of frequently occurring failures from the side of narcissistically disturbed parents?" (p. 247). Although he is only asking a question at this point, the implication is that the development of the self is more crucial and fundamental than any other psychological process. And judging by the massive waves of criticism questions such as this one have brought upon Kohut from classical analysts, it is clear that his discussion of the Oedipus complex is thought to be a radical departure from traditional psychoanalysis.

The oral drive. Kohut's discussion (1977) of drives in relation to self psychology also seriously questions the validity of the "oral fixation" hypothesis, not only in its conception of "oral-dependent" personalities, but also its power to make comprehensible

the phenomenon of pathological overeating. Instead, he believes that "in the majority of these cases" (p. 81) self pathology is the source of this behavior. He writes:

> It is the self of the child that, in consequence of the severely disturbed empathic responses of the parents, has not been securely established, and it is the enfeebled and fragmentation-prone self that (in the attempt to reassure itself that it is alive, even that it exists at all) turns defensively toward pleasure aims through the stimulation of erogenic zones, and then, secondarily brings about the oral (and anal) drive orientation and the ego's enslavement to the drive aims correlated to the stimulated body zones. (p. 74)

In explaining how developmental interaction influences this process with respect to the anal drive, Kohut points out that when the mother responds to the child's "fecal gift," she is responding to something offered by the child's total self, not just a drive. Indeed, it has been postulated that "the grandiose self is built around an anal core" (Bach & Schwartz, 1972, p. 467). How she responds, therefore, can have important consequences to the cohesiveness of a self that is in the early stages of formation and consolidation. "If her inability to respond to the child's total self leads her to a fragmentation-producing preoccupation with his feces . . . then the child's self will be depleted and he will . . . turn to the pleasures he can derive from fragments of his body self" (Kohut, 1977, p. 76).

It is easy to see how this example can translate to the oral drive. If we accept Kohut's assertion that "from the beginning, the drive experience is subordinated to the child's experience of the relation between the self and the self-objects" (p. 80), then it is possible to see how a nonempathic selfobject milieu can lead to what

has been called "oral fixation." Kohut explains that child's wish for food is secondary to his wish for "empathically modulated food-giving" (p. 81). This means that the mother must answer the child's total self, as in the above example from the anal period, and in doing so must not only respond appropriately to his need for food, but must first respond to his need for a selfobject. Kohut (1977) says that the

> importance of this two-step sequence--step one: empathic merger with the self-object's mature psychic organization and participation in the self-object's experience of an affect signal . . . (thus limiting) an affect spread; step two: need-satisfying actions performed by the self-object--cannot be overestimated; if optimally experienced during childhood, it remains one of the pillars of mental health throughout life. (p. 87)

But the mother who may recognize that the child is hungry but whose "food-giving" is not accompanied by the requisite emotional nurturance--the soothing merger with the selfobject--will be responding only to an isolated fragment of the child's self. Even more damaging is the mother whose own narcissistic defects make her unable to recognize and respond appropriately to the isolated need for food: the mother who, viewing the child as an extension of herself, cannot distinguish when he needs feeding and when he does not. As I pointed out in Chapter 1, the consequence of such an interaction can be the inability to recognize and respond appropriately to one's own internal states.

Lacking the experience of being responded-to as a total self, the child in such an interaction reacts to the disintegration of the self by retreating to the isolated drive, and attempts to reassure himself through oral stimulation. Left unfulfilled to a "traumatic

degree" (p. 81), the need for empathically modulated food-giving will later find expression in the behavior of pathological overeating. Kohut sees "the abnormalities of the drives and the ego . . . [as] the symptomatic consequences" (p. 82) of the unresponded-to, enfeebled self. As he succinctly sums it up: "man does not live by bread alone" (p. 87).

It is interesting to note that Kohut extends this paradigm to the sexual drive as well. What may appear to be straightforward drive hypercathexis can be seen from his viewpoint to be defensive promiscuity undertaken to counteract the disintegration of an understimulated self. Various perversions can also be understood in this manner. Indeed, Kohut (1977) sees the role of the self as fundamental in almost all kinds of addictive behavior:

> It is the structural void in the self that the addict tries to fill--whether by sexual activity or by oral ingestion. And the structural void cannot be filled any better by oral ingestion than by other forms of addictive behavior. It is the lack of self-esteem of the unmirrored self, the uncertainty about the very existence of the self, the dreadful feeling of fragmentation of the self that the addict tries to counteract by his addictive behavior. There is no pleasure in addictive eating and drinking--the stimulation of the erogenous zones does not satisfy. (p. 197n)

Thus, addictive eater's food binge, which has been described so often as an attempt "to fill a bottomless pit," does not satisfy because the need to satisfy hunger is not what "drives" this behavior. The binge, even while it is underway, never gives pleasure as Kohut says: it is usually experienced as noxious and painful. Such overeating provides self-stimulation or self-soothing to the fragmenting self--temporarily. Its only lasting effect is, in many cases, obesity. As Kohut puts it (1978a), "the calming or the

stimulating effect the addict obtains . . . is . . . impermanent" (p. 847). When the addict ingests food "he symbolically compels the mirroring selfobject to soothe him, to accept him. Or he symbolically compels the idealized selfobject to submit to his merging into it and thus to his partaking in its magical power. In either case, the ingestion . . . provides him with the self-esteem he does not possess . . . [But] it is the tragedy of all these attempts at self-cure that the solutions they provide are impermanent, that in essence they cannot succeed" (p. 846). They are doomed to failure because "no psychic structure is built" (p. 847) and it is the lack of this structure that drives the addict in the first place.

However, it is not necessarily a structural void that impels addictive behavior as a selfobject substitute. The processes outlined above can be seen in people whose selves are essentially intact--in response to some fleetingly fragmenting experience. "Addictive experiences," says Kohut, "occur on all levels and in all kinds of psychological circumstances--certainly there is no human being who has not grabbed food when he felt in need of selfobject sustenance under pressure" (1981, personal communication). Thus one can say that addictive or binge eating occurs in many cases because of selfobject pathology, and in those cases where such pathology is essentially absent, this behavior can often be seen in response to the temporary weakenings of the self that Kohut feels are an inevitable part of human life.

The psychology of the self can shed light on one further aspect of addictive eating behavior: the intense feelings of shame and

discomfort that usually follow a binge. These feelings, as well as the extreme preoccupation with the body and/or weight that often accompanies them, can be seen in the same way as Kohut views hypochondria: the intense preoccupation with isolated, fragmented parts of the self that is the inevitable result of a disintegrating experience.

Current Status and Criticism of the Psychology of the Self

Since the publication of Kohut's first two books the psychology of the self has developed quite a following, not only within the "Chicago School" (as it is sometimes called), but all over the analytic community, and several more books devoted to this topic have appeared. In addition to The Psychology of the Self: a Casebook (1978), and Advances in Self Psychology (1980), case histories and articles respectively (both edited by Goldberg), a two-volume edition of Kohut's writings, The Search for the Self (1978a) has been produced, edited by Paul Ornstein. And, of course, Kohut has continued his "search." One of his recent papers, "The Two Analyses of Mr. Z." (1979), is an attempt to demonstrate his theory through two separate analyses he conducted with the same patient. During the first, "pre-self psychology" analysis, Kohut interpreted this patient's compulsive, addictive masturbation as a pleasure-seeking, drive-motivated defense against castration anxiety. He contrasts this view with the one he reached during Mr. Z.'s second treatment, when Kohut came to understand that the patient's mother had used him as a self-object and had been intrusively overinvolved in his isolated physical

functions (bowel movements, skin blemishes, etc.). Kohut ultimately concluded that Mr. Z.'s addictive masturbation, which was often accompanied by masochistic fantasies, was "not drive-motivated. . . . It was his attempt . . . to obtain temporarily the reassurance of being alive, of existing" (p. 17).

In reference to "The Two Analyses of Mr. Z.," the anonymous analyst who was interviewed by The New Yorker (Malcolm, 1980) says that "the Kohutians rapturously hold up the paper as certification of the Second Coming," yet he claims that Mr. Z.'s initial analysis, as Kohut describes it, "just didn't make sense," and "in the second 'Kohutian' analysis, he finally did what any one of us 'classical' analysts would have done in the first place" (p. 140). This particular skeptic has the same objections to Kohut's work that have been voiced repeatedly by others: that while his clinical contributions are often valid, if not masterful, the theoretical underpinnings he suggests are not sound. As Ornstein puts it, the "criticism runs approximately as follows: Kohut's clinical understanding of narcissistic personality disorders and their treatment is innovative, significantly helpful, and rings true, but his metapsychology is all wrong!" (p. 65). Ornstein defends his colleague in this manner: "Just as Freud always considered his metapsychological formulations the most easily changeable and discardable layer . . . so has Kohut expressed a readiness to replace abstractions should they no longer prove useful" (p. 65).

Critics of self psychology also stress the point that Kohut's theory is not "complementary" to classical theory, as he suggests. Friedman (1980), for example, says that it is really "supplementary"

to drive-conflict theory and that it can be best seen as "an elaboration of an unstressed aspect of existing theory" (p. 409). In that same spirit, Rothstein (1980) makes "an attempt to integrate . . . [Kohut's valuable contributions] within the structural hypothesis" (p. 423). Most of these critical reviews emphasize the ways in which the psychology of the self is inimical to classical metapsychology. Chessick (1980) says that Kohut's work represents "a major philosophical change" in the restating of "the definition of the self from an experience-near abstraction from psychoanalytic data to an independent postulated center of initiative" (p. 470). He goes on to say:

> It seems to me virtually certain that Freud would not have accepted Kohut's theory of the psychology of the self in the broad sense as "complementary" but rather as a rival theory which uses a different treatment procedure from Freud's classical psychoanalysis. (p. 470)

A good summary of the major criticisms that are usually leveled against Kohut can be found in Hanly and Masson (1976). These authors contradict Kohut by reasserting the classical position from which they feel he has made a "radical departure." Their major points are: (a) narcissism is dynamically interdependent on object relations; (b) "higher" forms of narcissism mask libido fixated at or regressed to pre-oedipal stages of drives; and (c) narcissism necessarily reduces the quantity of libido available for object relations.

Further points of disagreement are offered by Kernberg (1975, 1976), who has written extensively about narcissistic disorders. He differs from Kohut in that he sees the grandiose self as a clearly pathological structure, rather than a fixation of an archaic "normal"

primitive self. Kernberg believes that "the study of normal and pathological narcissism cannot be separated from libidinal and aggressive drive derivatives and from the structural derivatives of internalized object relations," (Schwartz, 1973, p. 621). He stresses the role of aggression in narcissistic personalities, taking issue with Kohut's claim that narcissistic rage is always secondary and reactive to an injury to the self. In fact, Kernberg goes so far as to say that his colleague has a "total disregard" for the importance of aggression and that this "interferes with the systematic interpretation of the defensive functions of the grandiose self" (p. 622). As he sees it, analysis must focus on the interpretation of the grandiose self as a pathological structure and its gradual breakdown will uncover "a hungry, empty, primitive self" (p. 623) whose objects are dangerous and vengeful. In Kernberg's experience, these conflicts are on the oral level, and the extremely hostile negative transferences he encounters in the analyses of narcissistic patients are not reactions to nonempathic gestures from the therapist, but spring from internal, primitive oral rage.

In trying to explain some of these differences, Schwartz (1973) says that "Kohut and his co-workers seem to consider a larger group of patients of whom Kernberg's cases represent a sub-group" (p. 623). In another context (1974) this author goes further in indicating that it is "my impression that . . . [Kernberg and Kohut] write about significantly different patient groups" (p. 292). This has always been my impression as well, as Kernberg (1975) considers narcissistic personality structure to include "an integrated, although highly

pathological grandiose self" (p. 265) whose organization is "quite similar to borderline personality organization in general" (p. 229), whereas the kind of patients that Kohut discusses are quite distinct from borderlines.

Other Views of Narcissism

A final criticism that has sometimes been directed at Kohut is that he does not properly acknowledge the antecedents of his ideas in the work of others, nor does he make an effort to compare his views with those of other authors (e.g. Gediman, 1980). Kohut (1977) responds to this with a promise that such a task will be undertaken at a later date, when he has had more opportunity to gain distance and detachment from his work. Although he does not often make explicit mention of other views, it is clear that he is well aware of the roots of some of his ideas.

And it is fairly easy to hear the echos of other theorists in Kohut's work. Though we have already examined the important contributions of Freud, Jacobson, Hartmann, and Kernberg, a few others deserve mention here. A. Reich (1953, 1960), for example, frequently wrote about narcissism, and she defined two types of narcissistic object choice in women: one in which there is extreme submissiveness to a "great man" without whom the woman feels empty; and another, seen often in "as if" personalities, in which the woman "completely takes over the man's personality" (1953, p. 25). These types are quite similar to the "ideal hungry" and "merger hungry" personalities that Kohut has identified.

I believe it is also possible to see similarities to Kohut's ideas about overeating in Guntrip's work (1952). Guntrip postulated that the schizoid problem is one of "love made hungry" (p. 90), and indicates that "the entire problem if frequently worked out over food" (p. 92). He cites one patient who says that when her boyfriend is away, "I get desperately tired and feel empty inside and have to buy sweet biscuits and gobble them up" (p. 93). He goes on to say "she has the kind of relationship with this man . . . that compromises her stable existence as a separate person when she is not with him: she goes to bits" (p. 93). Kohut would, no doubt, contend that this is a selfobject relationship.

Finally, one can even see some aspects of Kohut's ideas in the experimental literature. The classic studies of infant monkeys and surrogates by Harlow (1958, 1966, 1970), for example, certainly support the notion that hunger is not necessarily the most basic of all needs. In these experiments, Harlow and his associates found that the infant monkeys usually preferred cloth surrogate mothers to wire mothers, regardless of which one provided food, because the cloth mother gave what Harlow calls "contact comfort." Harlow makes the point that if hunger were a more primary drive than the need for contact comfort, this would not be so. Nevertheless, deprived of a live mother with whom to interact, Harlow's monkeys were grossly abnormal psychologically as adults. Spitz's (1946) study, which showed that orphaned infants who were kept in nursuries where their physical needs were well provided-for but whose emotional needs for interaction with a caretaker were neglected were prone to develop an alarming

syndrome of "anaclitic depression," also provides support for Kohut's assertion that interaction between infant and caretaker is the most important need to be satisfied by feeding.

Clearly, Kohut has based many of his views on the existing literature. But, as he himself emphasizes, most of his ideas were fundamentally derived from his clinical observations. He likens his approach to that of Freud, who built his metapsychology on phenomena carefully examined and re-examined in his daily work with patients.

And if, as I mentioned before, Kohut regards his metapsychological formulations as his most "easily discardable layer," then perhaps he will reformulate some of his more controversial ideas in the future. For the time being, however, I believe he has given us an excellent basis for the examination of the developmental antecedents and genetic origins of the symptom of addictive, binge eating.

Chapter III

A REVIEW OF THE EATING DISORDERS LITERATURE

> For the compulsive eater, the urge to eat takes precedence over his family, work, social life and is without regard for consequential physical, mental, or emotional impairment. (Millman, 1980, p. 45)

> "I was eating steadily, doggedly, stubbornly, anything I could get. The war between my mother and myself was on in earnest; the disputed territory was my body." (Atwood, 1976, pp. 69-70)

There are many people who consider the regulation of eating patterns to be a simple matter of will power and self-control. Contemptuous of the overeater, they deplore him for his lack of "self-respect." Often, the overeater himself adopts such a viewpoint. And although social attitudes toward overeating and overweight have been known to fluctuate (Beller, 1977), certainly in this country the Protestant Ethic alone prohibits and decries the self-indulgence that these conditions imply.

Nevertheless, there is a vast body of literature, which will be partially reviewed in this chapter, that indicates that overeating is not just a simple matter of gluttony, but instead is the result of complex psychological forces. Those who remain unaware of these forces and attempt to deal with the problem as a moral issue alone are usually doomed to failure.

Curiously, the eating disorders literature rarely addresses itself to the behavior of overeating (or undereating for that matter)

as much as it does the physical manifestations of eating patterns. In other words, almost all studies have been aimed at groups who are divided on the basis of weight, the three main populations being obese, normal, and anorexic individuals. A fourth group, bulimarexics, have also recently been given some attention in the literature. However, overeating is a behavior that has been observed in all of these groups, even among anorexics, for as Crisp (1970) points out, there is a "high incidence of obesity or phase of overeating prior to the onset" (p. 3) of this illness. More importantly, many authors (Bruch, 1973; Palazzoli, 1974, etc.) have repeatedly emphasized that anorexia nervosa and obesity are two sides of the same psychological coin. "A better understanding of obesity," says Bruch, "has come from the study of its grotesque mirror image" (1973, p. 4).

Thus, this review will examine studies pertaining to all four populations, even though overeating is, naturally, most often associated with obesity. And although my main focus will be addictive eating, or binging, I believe it is possible to see the thread of self-psychological issues throughout the eating disorders literature in general. I have selected those studies from this extensive area of research that will best shed light on the interface between self psychology and eating disorders.

A Definition of Terms

Before turning to this task, however, I will briefly examine some of the most relevant terms that will be used. Neither the words obese nor normal need much introduction, although I would like to

mention that there are many people, relevant to my focus of interest here, who are considered by the standards set by the medical establishment to be of normal weight but who do not regard themselves as normal. Most often, this can be observed in women who are slightly overweight, but well within normal limits, who see themselves as "fat" and are greatly preoccupied by their weight and appearance in general. Some of this group even imagine themselves to be obese, although almost all authors restrict this term to those who are at least 10% or more above the normal weight for their height (Beller, 1977).

Anorexia Nervosa is considerably more complicated and it is a term that is often misused. Bruch (1973; 1978) distinguishes primary anorexia nervosa from secondary anorexia. Only the former is "genuine" anorexia nervosa: it is always a syndrome motivated by "underlying personality disturbances" and it has an "amazingly uniform" (1973, p. 251) constellation of symptoms. Briefly, in addition to rigid dieting, refusal to eat, and the subsequent massive weight loss, three major features are always present: (1) a delusional body image--the anorexic will insist that she[1] is normal even though her actual weight is dangerously low; (2) an inability to distinguish and properly interpret internal cues--this pertains not only to hunger, but also to emotional feelings and fatigue, and is related to the hyperactivity that is so charactersitic of anorexics; and (3) gross feelings of ineffectiveness which are largely responsible for the anorexic's intense need to control her eating habits and body weight.

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[1]In referring to both anorexics and bulimarexics I will use the pronoun "she" because the overwhelming majority of those who suffer from these syndromes are female.

Bulimarexia is considered to be closely related to anorexia nervosa (D. Brenner, 1980), but there is one important difference: these individuals regularly engage in binges which are followed by self-induced vomiting. Bruch (1978) says that this pattern develops gradually but "once the binge eating-vomiting cycle is established, it is exceedingly difficult to interrupt" (p. 10). In some women, this syndrome persists over a period of years and even decades, and it is in this type of eating disorder that the binge can be seen in its most extreme and bizarre form.

The term "binge" merits some further definition here as well. I believe that one can best view this behavior on a continuum that ranges from the minor compulsive eating that a great many people occasionally engage in, to the regular binges of some of the obese, to the even more compulsive and even "trance-like" binges that one often observes in bulimarexics. It is important to note here that not all obese people are binge eaters. As Buchanan (1973) points out, "like alcoholics who may be constant imbibers or binge drinkers, the obese may be nibblers or binge eaters" (pp. 32-33).

Stunkard (1959a), has identified a common binge pattern which he calls the "night-eating syndrome," that is characteristic of some obese persons when under stress. This pattern consists of anorexia in the morning followed by extreme hyperphagia in the evening, coupled with insomnia. Most eating binges occur at irregular intervals, however, and have been characterized as "my stomach doesn't need it--but my mouth wants it" (Bruch, 1973, p. 45). More severe binges, on the other hand, are almost orgiastic in their intensity. Describing

the binges of bulimarexics, Boskind-Lodahl (1976) says "one gives one's self to the food, to the moment completely. There is a complete loss of control (ego). It is an absolute here-and-now experience" (p. 352). Lindner (1959) reported a case of one woman who entered what approached a "fugue" state during her binges, in which she consumed incredible quantities of food. She described to him her experience during a binge:

> I think it begins with a feeling of emptiness inside. Something . . . starts to ache. . . . Soon I feel as if there's nothing to me but a vast yawning space surrounded by skin that grabs compulsively at nothingness. . . . The feeling of emptiness becomes agony . . . there's nothing of me . . . but an immense vacuum . . . so I start to eat. I eat and eat--everything, anything I can find to put in my mouth . . . it's a frenzy, a fit . . . something automatic and uncontrollable . . . I feel as if I'm going to become nothing, become the emptiness--get swallowed up by it. (p. 112, italics in original)

Extreme binging can include not only the consumption of every bite of food in the house, but can even extend to the eating of food from the garbage, or an endless journey from one fast-food place to another. And like the anorexic, the binger is overwhelmed by a feeling of helplessness--as if he is in the grip of something he is powerless to control. Bruch's summary (1973) is quite reminiscent of Kohut's thoughts on addictive eating:

> During eating binges they feel driven to eat against their wish . . . even to consume food they ordinarily dislike. They experience neither pleasure nor satiation during this kind of eating. They may find temporary relief from the anxious and depressed feelings that have been mistakenly experienced as "need to eat," but it is short-lived and the cycle of "not feeling right" and unsatisfying eating is endlessly repeated. (p. 45)

Thus the frequency and intensity of the binge may vary from individual to individual and from group to group, but I would like to

propose the following definition of this phenomenon as it will be examined here: a binge is any episode of compulsive or addictive eating that is carried on past the point at which hunger is normally satisfied and that is experienced as either undesirable and/or beyond the individual's control. By the use of this broad definition I will be including the range from minor, infrequent binging all the way to the most extreme and intense forms.

The Oral Fixation Hypothesis

Turning now to the literature on the psychological factors that influence overeating behavior, one finds that the earliest attempts to explain this symptom in other than moral or physiological terms suggested an "oral fixation" hypothesis. Abraham (1927), for example, one of the pioneers in this area of investigation, asserted that either frustration or overindulgence during the oral phase of development leads to an oral fixation, as well as an oral character trait whose hallmark is dependency. This provides the basis for prediliction to addictions, as well as a more direct expression in what Abraham calls "a morbidly intense appetite for food" (p. 404). Alexander (1934) expanded on this theme by pointing out that the wish to be fed has an unconscious meaning of a wish to be taken care of, nurtured, and loved as a small infant is by its mother during the oral phase.

The relationship between oral fixation and addiction was further explored by Fenichel (1945). He also sees food addiction as related to an oral fixation that occurs when the normal process of

psychosexual development is arrested. In these cases, he says, "no displacement has transformed the original object (food) of the strivings for simultaneous gratification of sexuality and self-esteem. . . . Later stages of development may have added other unconscious meanings to the pathologically craved food; it may represent feces, child (embryo), and penis" (p.381). It is interesting to note that Fenichel, like Kohut, considers a broad range of activities to have addictive potential, including reading and "love," in addition to eating.

The early investigators of the psychosomatic aspects of obesity continued to depend upon the oral fixation hypothesis to explain this condition. Schick (1947), in a review of the early literature, found almost unanimous agreement that food addiction represents a regression to a fixated wish for the experience of being fed at the mother's breast. Similarly, Kaplan and Kaplan (1957) state in no uncertain terms that "adult obesity is . . . a direct reflection of infantile orality" (p. 192).

Hamburger (1951) is yet another author who stresses the oral fixation hypothesis in relation to obesity. He points out that it is possible to see many different representations of this fixation in the behavior of the obese. These people, says Hamburger, are constantly involved in some kind of "mouth" activity: if they are not eating they are sucking their fingers, biting their nails, or gnashing their teeth.

However, Hamburger goes further in exploring the different meanings such a fixation might have for various individuals. He identifies four major symbolic meanings, stating that overeating can

represent: (1) a substitute gratification in intolerable life situations; (2) a response to nonspecific emotional tensions; (3) a symptom of an underlying emotional illness, especially either depression or hysteria (as a protection against sexual impulses or an expression of oral impregnation fantasies); and (4) an addiction, which can be likened to the behavior of alcoholics, "characterized by a compulsive craving for food" (p. 491). Yet despite Hamburger's attempt to define more specifically the psychological meanings of overeating, the oral fixation hypothesis reigned supreme in this field for decades until the theories of Hilde Bruch, the foremost investigator of eating disorders, gained prominence.

Developmental Aspects

Perhaps Bruch's greatest contribution has been the examination of the developmental aspects of eating disorders. As I noted in Chapter 1, she stresses, above all, the influence of the mother-child interaction in the development of these syndromes. Her earliest observations (Bruch & Touraine, 1940) revealed some very specific patterns in families with fat children. Specifically, she set out to discover the origins of the extreme passivity, dependency, and insecurity of these children. Bruch and her colleague found that these behaviors were directly related to the child's relationship with his mother, in which the mother had generally used the child as an extension of herself. In a later paper (1961), she writes that fat children are seen as a "personal possession" (p. 464) by their parents. Finding this pattern also common in the families of anorexics (1973;

1978), Bruch asserts that the hallmark of this interaction is the superimposition by the mother of her own concept of the child's needs without much effort to empathically reflect his real needs. In particular, the mother's response to the child's hunger is often "continuously inappropriate, be it neglectful, oversolicitous, inhibiting, or indiscriminately permissive" (1961, p. 470). In Kohut's terms, one can say that the child is used as a selfobject by his mother, and his need to internalize the regulatory functions of a selfobject of his own are frustrated by the lack of the necessary "just-rightness" of these interactions. Frustration is more often traumatic rather than optimal, and the result that Bruch finds is the same that Kohut would predict: "the individual is equipped with inadequate tools for self-orientation and identity, and the widening demands of self-expression and interpersonal experience" (1961, p. 479).

Rather than having a stable, continuous, and delimited sense of self, patients with eating disorders are often unable to feel that they "own" their own bodies or even their feelings. Bruch has found this to be almost universal: "In spite of the great differences in their clinical pictures . . . [patients with eating disorders] have an experience in common, which they express, explicitly or implicitly, as: '<u>my mother</u> always knew how <u>I</u> felt.' Implied is the corollary: '<u>I</u> do not know what I feel'" (1961, p. 465, italics in original).

Many other investigators have been able to validate and confirm Bruch's findings. Sours (1969), for example, stresses the fact that anorexic girls have had to subordinate their needs to the

"narcissistic ego-ideals of their mothers" (p. 252). The other side of the picture is the fat girl in Atwood's (1976) novel who resisted her mother's narcissistic claims on her body by continuing to binge and insisting "I wouldn't ever let her make me over in her image, thin and beautiful" (p. 88). Another investigator of anorexia nervosa, Goodsitt (1977) recalls an example of a patient who could not answer a question about her feelings but instead told the examiner to ask her mother. Goodsitt's is the first attempt that I know of to directly and specifically apply the psychology of the self to an eating disorder, maintaining that anorexia nervosa is primarily a disturbance of the self. He sees this illness as an expression of the hypochondriacal self-preoccupation that Kohut finds to be the product of a disintegrating self. Furthermore, he views the helplessness that Bruch says is a cardinal symptom of this disorder as an example of the deficiency in self-regulating psychic structures. The anorexic's hyperactivity is explained by Goodsitt as an attempt to enliven an empty depleted self like those attempts that Kohut has identified. And like both Bruch and Kohut, this author points to a disturbance in the mother-child interaction:

> Prior to the child's internalizing the regulating functions of the need-satisfying object, external factors loom large in the child's maintainance or narcissistic equilibrium. When there is a disruption in the dependent relationship with a nurturing object, the child or adult, arrested at this level of development, is liable to feel helpless, ineffective, overwhelmed, unworthy, unreal, incomplete, or empty. (p. 3)

The essential aspect that has been uncovered by most of these studies is the idea that these children <u>do not develop the structures</u>

and the capacity for internal self-regulation. They must depend on an external (self)object for the maintainance of narcissistic homeostasis. Applying this concept to obese patients, Buchanan (1973) writes that "in later situations where the child or adult has to rely on his own autonomy rather than on an external one he will experience a feeling of profound isolation, which he often calls 'emptiness.' He will attempt to deal with this feeling by invoking the original external regulator through performing the feeding ritual" (p. 35).

Development in Adolescence

In addition to the aforementioned developmental aspects in childhood, the pathology of eating disorders is often decisively influenced by the experiences of adolescence. Indeed, anorexia nervosa is almost exclusively an illness of adolescent-onset. Besides the physical maturation brought on by puberty, one of the major changes at adolescence is the required decathexis of parental objects. Blos (1962) maintains that this period is consequently characterized by marked "object hunger," and A. Freud has written (1937) that the developmental task of decathexis can bring on what is almost a period of "mourning." One recent author, Steele (1974), claims that this emotional hunger is often translated into physical hunger and the subsequent overeating that is so common during these years. Normal adolescents will ultimately fill the void created by parental decathexis by forming appropriate relationships with peers, including those of the opposite sex.

For the adolescent with an insecurely established, disintegration-prone self, however, the tasks of this developmental period are considerably more difficult. Ehrensing and Weitzman (1970) point out that the girl who has been her mother's narcissistic self-extension will find the demands of giving up this selfobject relationship exceedingly stressful, if not impossible: "the daughter . . . [who] proceeds through latency with a hungry yearning for mothering, a poor sense of self . . . [and] minimal self-esteem" will, upon adolescence, experience "intense craving for the primitive feeding experience of the mother" (p. 207).

The relinquishment of the external (self)object's regulatory functions necessarily results in the adolescent's need to find other means to achieve this regulation. In the anorexic, Goodsitt (1977) notes that this will be expressed in the all-consuming wish to establish control--not only of her eating habits and weight, but also of the general environment, by means of adhering to rigid schedules, routines, and codes to counteract the feelings of self-fragmentation. Obese adolescents, on the other hand, attempt to incorporate the functions of the selfobject in their overeating and binging (Buchanan, 1973), behaviors which are also attempts to counteract self-fragmentation. Obviously, these gestures do not achieve the desired result--adolescence represents a decided threat to self-cohesiveness even in relatively healthy individuals, as is evident in the wild and extreme fluctuations of self-esteem that are so characteristic of this phase for all adolescents.

It is also at this point in development that differences between the sexes with respect to eating discorders begin to be most

apparent. Anorexia nervosa and bulimarexia are almost the exclusive province of females, while binging and obesity in general are much more common in women than men after the landmark of adolescence as well (Millman, 1980). Furthermore, a general preoccupation with food, eating, and weight are more often seen in girls from this point on. Elliott (1981) feels that these phenomena are too widespread and consistent to be explained by sociological and cultural factors alone, and has proposed that they may be related to the reawakening of oedipal conflicts that have been dormant during latency. She cites the fact that almost all psychoanalytic writers have asserted that the tasks of the Oedipus complex are more complicated for girls than boys, in part because the decathexis of the original object, the mother, is required in favor of a new object, the father. Boys, on the other hand, are able to retain their original cathexis to a nurturant female throughout childhood and even into adulthood, since their primary sexual objects are women. Thus Elliott writes,

> while the young boy can feel some assurance that oral supplies will always be available, if not from his own mother, then from some other female, the young girl is confronted with the possibility that once the maternal source is unavailable she may be left with nowhere to turn for the symbolic gratification of oral needs; she has given up not only her own mother, but all mothers as libidinal objects. (pp. 4-5)

I believe, however, that it is possible to enrich this paradigm with a self-psychological dimension if one considers that the girl is required by this process to relinquish not only the mother as a libidinal object, but also as a nurturant selfobject at an earlier age than boys, and when she does, she must do so once and for all. Those girls who have not experienced the "just-rightness" of

interactions with the selfobject up until this point will have much more difficulty performing this task, and will continue to need greater than average selfobject sustenance from then on.

However, as Elliott points out, very few studies have attempted to investigate why overeating, obesity, and preoccupation with weight are more common in women than men. Feelings of inferiority and dissatisfaction with one's body in women has most often been ascribed by psychoanalysts to penis envy. In his classic 1925 paper "On the Anatomical Distinction Between the Sexes," Freud outlines his view that the discovery that little boys possess a "superior counterpart of their own small and inconspicuous organ" (p. 252) inspires both envy and a "narcissistic sense of humiliation" (p. 256) in the young girl. This further leads to a pervasive sense of incompleteness: "after a woman has become aware of the wound to her narcissism, she develops, like a scar, a sense of inferiority" and "she begins to share the contempt felt by men for a sex which is lesser in so important a respect" (p. 253).

Preoccupation with weight as an expression of feelings of inferiority about one's body can be seen as persistent and unresolved penis envy which, Freud asserted, is deeply felt by all young girls. This wish for a penis is replaced during the oedipal period by the wish for a child (by the father): penis envy sets in motion the sense of incompleteness and anger at the mother (who the girl imagines to be responsible for her castration) that makes oedipal strivings possible. The girl renounces that the mother as her primary love-object, in favor of the father, hoping he will give her the longed-for "penis-child" (p. 256).

However, Freud also noted that "the hope of some day obtaining a penis in spite of everything and so becoming like a man may persist to an incredibly late age and may become a motive for strange and otherwise unaccountable actions" (p. 253). Overeating can be conceived of as such an action: the displaced, unresolved wish for a penis, or the persistent wish for the "penis-child" as expressed via oral impregnation fantasies. An extension of this view is Erikson's (1950, 1951) notion that girls' awareness of an "inner space," corresponding to the vagina, is a profound and consistent psychological motivator, insofar as they feel the persistent need to "fill up" this inner space, a need which can also translate into overeating behavior.

Oral impregnation fantasies have been, in fact, the "one psychodynamic issue most consistently looked for" (p. 217) according to Bruch (1973), particularly in cases of anorexia nervosa. As Waller, Kaufman, and Deutsch (1940) describe it, "the wish to be impregnated through the mouth . . . results at times in compulsive eating, and at other times, in guilt and consequent rejection of food, the constipation symbolizing the child in the abdomen and amenorrhea as direct psychological repercussion of pregnancy fantasies" (p. 15).

Nevertheless, this view of eating disorders has been rejected by more modern investigators: both Bruch (1973, 1978) and Palazzoli (1974), for example, stress that anorexia is essentially a problem whose roots are pre-oedipal and lie "in the parent-child interaction from the beginning" (Bruch, 1973, p. 217). Palazzoli's (1978) extensive investigation of anorexics, which has earned her a world-wide reputation, asserts that:

> my own experience has convinced me that in anorexia nervosa . . . the sexual problem is not the basic one. All my women patients were fixated at pre-genital levels. Puberty and the sudden overwhelming physical developments it entails then trigger off traumatic, but in any case quite unexpected, situations that shake the apparent emotional equilibrium of these subjects. (p. 76)

Bruch concurs entirely with this view. It is not the disavowal of the wish for a penis and/or a child, nor, as some have suggested, the wish to be as "masculine" as possible by dieting away feminine curves and causing the cessation of menstruation that underlies this syndrome. Instead, Bruch says that in boys and girls alike it is the wish to bolster an insecure sense of identity, to assert a "specialness" by achieving perfection that motivates the rigid dieting and pursuit of thinness. In her study of male anorexics, she found (1973) that, like girls, these patients are haunted by an "acute sense of dissatisfaction with themselves . . . at a critical period in their lives" (p. 302). The quest for thinness is the mechanism by which they attempt to "provide the experience of self-confidence, self-respect, or self-directed identity" (p. 302). And, like anorexic girls, these boys suffer from an underlying sense of ineffectiveness and a lack of self-awareness that stems from distorted interactions with their mothers. As in the female cases she has treated, Bruch discovered that the mother of the anorexic male "superimposes upon the developing child her own concept of his needs and desires, disregarding the clues originating within himself" (p. 303). She suggests that one likely explanation for the rarity of anorexia nervosa in boys is that this kind of interaction is less frequent between mothers and sons than between mothers and daughters. "It is quite possible," she

says, "that the characteristic slave-like attachment of a child to the mother is more apt to develop in a girl" (p. 304). The obverse, of course, as Kohut would see it, is that a mother is more likely to use a female child as a narcissistic extension of herself, or as a selfobject, than a male child.

Bruch further points to the fact that anorexia nervosa in males usually occurs at an earlier age than it does in females. The vast majority of male anorexics are pre-pubescents, who have begun the process of separation and decathexis from the parental objects but who have yet to attain physical maturity. Pubescence may, she suggests, represent a different task for the young boy with an insecure sense of self than the young girl. "Male pubescence," she writes, "will flood a boy, even one who has . . . [a slave-like attachment to the mother] with such powerful new sensations of a more aggressive self-awareness that the event of puberty makes a new self-assertion possible, something he was not capable of in pre-puberty" (p. 304). Thus, the attainment of sexual maturity for the boy is accompanied by such a strong physical drive that it provides him with new opportunities to assert himself and hence a new opportunity for self-cohesion. For girls, on the other hand, puberty may be less of an identity-shaping experience than a confusing one: the demand for sexual activity in the newly mature body is not as strongly felt by girls as it is by boys of that age.

Yet many authors (e.g. Hamburger, 1951) have suggested that the prevalence of eating disorders during adolescence is due to the demands for sexual activity that are brought on by puberty. Both

obesity and anorexia nervosa have often been seen as attempts to defend against sexual impulses (Orbach, 1978). Again, it is possible to add a self-psychological perspective to this view. Goodsitt (1977) notes that the attainment of puberty, with its required integration of bodily changes into a new body-self concept, is extremely difficult for the adolescent girl with an unstable self and "the demands on the ego's synthetic function are extraordinary. Pubescence, with its associated sexuality is dangerous to these psychically impoverished children not because of threatened superego retaliation, but because it disturbs the previous relationships required for self-cohesion" (p. 8). And, although it may be belaboring the obvious, there is certainly no rejection more painful or potentially dangerous to the narcissistically vulnerable self than that of rejection by a member of the opposite sex. As M. Brenner writes (1980) about one bulimarexic woman, it was "not that she was afraid of men . . . what she was afraid of was being judged and rejected" (p. 58). Stunkard and Mendelson have found (1967) that obese subjects with body(self) image disturbances consistently exhibit great self-consciousness in relation to the opposite sex.

Thus, for an individual with a potentially fragmenting self, the major threat of adolescence is not the emergence of sexual impulses, but the loss of the regulatory functions provided by selfobjects. One need only think of the widespread prevalence of eating disorders of all varieties, from mild to extreme, among college girls to realize that college is yet another time at which further individuation, relinquishment of cathexes, and separation from parental objects is required.

Hunger Awareness

One of the more specific consequences of the distorted development of individuals with eating disorders is the pervasive inability to recognize internal cues. Because of the mother's consistently inappropriate, nonempathic responses to the infant's needs, Bruch (1961) says that the "outcome for the child will be perplexing confusion in his biological clues and . . . when he is older, he will not be able to recognize whether he is hungry or satiated, or suffering from some other discomfort" (p. 471). Bruch has concluded (1973) that both anorexia nervosa and obesity are directly related to this inability. As Buchanan (1973) describes it, the mother's intrusion of her own needs may force the child "to identify more with an outside regulation of his physiological needs than with his own internal clues" (p. 35). Calling for a "redefinition" of the oral fixation hypothesis, Bruch contends that this faulty hunger awareness, and the developmental patterns that lead to it, are the primary genetic factors in eating disorders (1973).

There has been a great deal of experimental research indicating that faulty hunger awareness is indeed central to eating disorders. For example, Stunkard (1959b) has found that obese subjects, in contrast to normals, deny hunger even in the presence of stomach contractions. The most famous of these experimental investigations, however, are a series of studies performed by Schachter (1968, 1971) which have consistently validated Bruch's notion that the obese are unresponsive to internal cues. Schachter showed that these individuals

rely instead on a variety of external clues to determine when and how much to eat. An obese subject will eat dinner because it is time to do so, even in the absence of epigastric emptiness. Many other external factors determine the eating habits of the obese: they will be stimulated by the sight or smell of enticing food rather than a sensation of hunger, for example. Of course, as Schachter points out, the environment is constantly offering such cues, and a person who relies upon them in order to know when to eat will find that he is eating too much. As an interesting corollary to this, he also found that the obese will choose not only the easiest method of eating, but also the fastest: in Chinese and Japanese restaurants, obese subjects are five times more likely than normals to eat with forks rather than chopsticks. Taken as a whole, Schachter's research seems to indicate that for the obese, eating is neither a matter of satisfying hunger nor the gourmet's savoring of a fine meal.

Spencer and Fremouw (1979) have also found that the behavior of overeaters is more often dominated by cognitive factors than hunger. Dividing groups into "nondieters" of normal weight and "chronic dieters," they gave a preliminary drink to both groups and then offered them ice cream. Half of each group was told that the initial drink was high in calories and the authors found that the dieters who were told this subsequently ate twice as much ice cream as the other subjects. It was concluded that this cognitive knowledge stimulated the overeating because the dieters who thought they had had a high-calorie drink said to themselves, "Well, as long as I've already broken my diet, it doesn't matter what I eat now."

Those dieters who were told their drink was low-calorie, on the other hand, ate no more ice cream than the nondieters.

In an ingenuous attempt to demonstrate that this lack of awareness of internal states would extend to other activities besides eating, Tsakonas (1976) predicted that obese subjects would be less successful at transcendental meditation than non-obese subjects. Although no clear differences were found in this study, several authors (e.g. Bruch, 1973; Buchanan, 1973; Palazzoli, 1974) have pointed to many different areas in which lack of awareness of bodily sensations is problematic to those with eating disorders. Palazzoli has repeatedly observed, for example, that anorexics have a "fakir-like insensitivity to painful sensations" (p. 20). She finds that these patients are immune to the cold and will often go outside inadequately dressed for freezing weather. They are similarly insensitive, says Palazzoli, to fatigue and commonly push themselves to the outer limits of physical exertion and exhaustion. This denial of physical sensation only disappears in the advanced stages of anorexia nervosa, when the patient is often so thin that she is gravely ill.

Body Image Disturbances

Closely related to these distrubances of self-awareness are the distortions and disorders of body image and sense of self that are so characteristic of eating disorders. Bruch (1973) has asserted that the inability to distinguish internal cues and the dependence on external ones leads to a "feeling of not being in control of . . . (one's) sensations or actions" (p. 155), as well as a "lack of

awareness of living one's own life" (p. 50). Repeatedly, she emphasizes the faulty interaction with the nurturant object as the source of these deficits and the subsequent dependence on external means of self-regulation.

In Kohut's terms, body image is a component of the self. Anorexia nervosa is perhaps the most striking example of distorted body image that can be found in the psychological literature. In this syndrome, the young girl sees herself as being at normal weight or even overweight when she is actually near starvation (and, in some cases, near death). Such victims will insist that they look "fine" when in reality their appearance is grotesque and horrifying to others. Bruch (1962) maintains that in cases of primary anorexia nervosa "disturbances in body image of delusional proportions . . . [are] present in all patients" (p. 194). On the other hand, Garfinkel, et al. (1978) were only able to detect body image disturbances in some patients. I believe that Bruch would maintain that these authors must have used an overly broad sample since she sees delusional body image as one of the cardinal distinguishing features of this illness. In another study, Garner and Garfinkel (1977) determined that those patients who do have detectable body-size disturbances have a poorer prognosis for recovery.

Body image disturbances can be seen in other eating disorders besides anorexia nervosa, however. In a particularly evocative study of ballerinas, all of whom displayed anorexic-like and bulimarexic-like symptoms, Druss and Silverman (1979) found that most of these women felt themselves to be "too heavy, in spite of all objective evidence to the contrary" (p. 119).

And, as I mentioned earlier, one can often observe what appears to be a disturbance of body image in normal-weight individuals who believe that they are "fat." Often this is mild in proportion, but in some it leads to an entire lifetime of rigorous dieting and self-denial (Orbach, 1978).

There is yet another group of people who have successfully reduced and achieved normal weight but who retain their former body image of themselves as fat (Buchanan, 1973). These "thin fat people," as Bruch (1973) calls them, continue to see themselves as heavy and have difficulty adapting to their new size and status. Often this will extend to such things as buying a size 16 dress even though an individual may have been size 10 for months or even years. The retaining of a "fat" body image is particularly prevalent in those who have been overweight as children and adolescents (Stunkard & Mendelson, 1967).

By the same token, some obese people who were thin as children retain a distorted body image of themselves as normal. This is especially true of those who have gained weight gradually in middle age (Bruch, 1973). Stunkard and Mendelson (1967) maintain, however, that "body image disturbances do not occur in emotionally healthy obese persons and . . . [they occur] only in a minority of neurotic obese persons" (p. 1296). It is important to note that "emotionally healthy obese persons" is a category that potentially includes those whose obesity is the result of constitutional factors or physical disorders, or who have successfully accepted and adapted to their condition regardless of its cause. Stunkard and Mendelson consider

this to be a sizeable percentage of the obese. But in those subjects who did exhibit body image disturbances, however, these investigators found that they were usually accompanied by disturbances in three related areas: (1) self-consciousness in relation to the opposite sex; (2) self-consciousness in general, including the conviction that "nothing ever happens to them except in some kind of (usually derogatory) relationship to their weight" (p. 1297); and (3) disturbed views of the self in general.

A disturbed view of the self would necessarily be a factor in those people who engage in compulsive or addictive eating in order to bolster a fragmenting self that includes a structural void or deficit. But if Kohut's assertion that even healthy individuals engage in this kind of eating as an occasional substitute for selfobject sustenance is correct, then Stunkard and Mendelson's findings are perfectly consistent with his outlook. However, I believe that the Kohutians would point to the delusional body image of anorexics, as well as the distorted body images of some obese, bulimarexic, and normal-weight people as expressions of a self disorder. One need only think of the long hours spent by anorexics, for example, examining their bodies and gazing at their reflections (Palazzoli, 1974) to imagine the lack of appropriate, responsive emotional "mirroring" that these girls must have suffered. But by the time the illness takes hold, they resemble "contact shunning" personalities who must deny their need for mirroring selfobjects because that need is so intense. At this point, even the appropriate mirroring of being told by others that they are dangerously thin is ineffective--it is too late. D. Brenner (1980) suggests that

this may indeed be a discernable personality characteristic, and she proposes that anorexics may move toward "keeping things and people 'out'" in contrast to overeaters who want to "take . . . [them] 'in'" (p. iv), while bulimarexics remain ambivalent.

Personality Factors

There have been, in fact, many studies conducted in the search for specific common personality features among people with eating disorders. The greatest success in this area has been in the study of anorexia nervosa (Bruch, 1978), which is quite logical since this illness is so rare and strikes in such an extremely narrow range of the population. The typical anorexic is a teenage girl from a middle or upper-middle class family who is of above average intelligence (Palazzoli, 1974; Sours, 1969). In contrast, there are no "typical" demographic features among the obese--obesity afflicts people of all ages and from all backgrounds, although it is somewhat more prevalent in the lower socioeconomic range of the population (Holland, Masling, & Copley, 1970). And unlike its uncommon mirror image, obesity is exceedingly common--figures cited recently in The New York Times indicate that as many as 80 million people in the United States today are significantly overweight (Feb. 24, 1981).

Not only are the backgrounds and symptoms of anorexics "amazingly uniform," as Bruch has discovered, but most investigators have also found that their "pre-illness" personalities are usually very similar (e.g. Palazzoli, 1974; Bruch, 1973, 1978; Bliss & Branch, 1960). Dismayed parents repeatedly emphasize that their child

was "always such a good girl! She never gave anyone any trouble--she was the perfect child!" Usually this record of "good behavior" is matched by outstanding school grades--the pre-anorexic girl is a diligent and cooperative student. Bruch (1973) maintains that underneath this ideal and compliant facade are deep feelings of insecurity and unworthiness. Most of these girls feel compelled to live up to their parents' high expectations of them, playing the role of the "all-round girl" who is "perfectly balanced" (p. 263). Often they have been the object of much praise and admiration from their parents--one could speculate that the admiration was too great and that they did not experience the phase-appropriate, gradual frustration of their exhibitionistic strivings which Kohut claims is so important to the internalization of realistic self-esteem. Once the illness becomes apparent, the anorexic girl often transforms from the compliant, insecure creature of her pre-illness personality to the grandiose and controlling dictator that personifies anorexia nervosa.

Those who have sought to find general personality features among the obese have had much less success, the stereotype of the "jolly fat man" notwithstanding. Weinberg, Mendelson, and Stunkard (1961), for example, were unable to find a common personality profile of their obese subjects and advocated caution in the attribution of specific features to the population as a whole. Similarly, Sash (1977) speaks out against the popular notion that obesity is a manifestation of neuroticism and writes that "it is important to note that the obese individual is only irrational and incompetent when it comes to eating" (p. 247). Using the MacAndrew Addiction Scale and

the MMPI, Leon, Kolotkin, and Korgeski (1979) were likewise unable to find a hypothesized "common addictive personality."

Other authors (e.g. Kaplan & Kaplan, 1957) have indicated that personality disturbances are associated with obesity, but they may be of "any type or severity" (p. 199, italics in original). Holland, Masling, and Copley (1970) found that obesity may indicate more emotional conflict when it occurs in middle-class women rather than lower-class women. Because obesity is so common in lower-class women, the authors feel that it cannot be considered an "abnormal" condition. "A middle-class woman," on the other hand, "must have a strong emotional need in order to eat excessively, since doing so results in such strong social disfavor" (p. 355).

Bruch (1973) believes that a broad range of pathology may accompany obesity, and she maintains that in some cases obesity and overeating are used as a defense against severe emotional illness. Dieting can be very dangerous to such people, because the removal of this defense may result in decompensation. Because of this, Bruch concludes that some people are better off remaining obese, even at the risk of endangering their physical health.

In the search for common personality features among the obese, the results are usually less equivocal in those studies that distinguish between adult-onset obesity and juvenile-onset obesity. Those who have been fat since childhood usually have much more clear-cut disturbances associated with their obesity, which makes sense in light of the fact that the majority of psychological theorists maintain that personality structure is laid down in the childhood years.

Stunkard and Mendelson (1967) discovered that "among subjects with adult-onset obesity, a wide variety of diagnostic pictures . . . [could be] observed, few if any of which seemed related to their obesity. Among subjects with juvenile-onset obesity, on the other hand, a disturbance in body image was usually a central feature of any emotional disorder" (p. 1298). In another study, Mendelson (1966) observed that, like anorexics and "thin fat people," those whose obesity began in childhood have a "high incidence of body image problems and of disturbances in the perceptual and conceptual organization of certain physiological states, feelings, preferences, and opinions" (p. 610).

Kohut would see these disturbances as expressions of self pathology, no doubt. One can certainly speculate that those who begin to gain weight in childhood, like the middle-class women in Holland's study, must have strong emotional motivations since juvenile obesity is such a particularly painful social handicap. Also, as Bruch (1973) points out, it is very difficult for children to get fat; considering the metabolic rate and amount of exercise that is usual in childhood, one must eat a great deal in order to gain weight under these circumstances. Although there are no studies I am aware of to support this notion, I believe that most childhood overeaters are probably not the "nibbler" type but instead are those depressive or addictive eaters who are attempting to fill an emotional void.

Furthermore, it seems to me that one of the problems that has handicapped those researchers looking for personality disturbances associated with obesity has been that they have misidentified the

problem, for as Rau and Green (1975) point out, obesity is only the physical manifestation of the disorder--compulsive eating is the problem. Those few investigations that have been limited to the study of binge eating have found more distinctive patterns than those that have included a generally "obese" group, many of whom may have been "nibblers" rather than bingers. Mendelson (1966), for example, finds that "most of the binge-eaters . . . belong to . . . [the more emotionally unstable] . . . range of the spectrum" (p. 605). He was also able to observe several common personality features among obese bingers: "(1) self-accusations concerning gluttony; (2) extreme self-consciousness about physical appearance to the point of self-loathing; and (3) fantasies of grandeur and massiveness and strength" (p. 606)--strikingly self-psychological features.

The general failure to find a common obese or overeater "personality" therefore, does not necessarily detract from my suggestion that there may be a common self-psychological defect among binge eaters. Furthermore, self psychology does not attempt to describe a certain "personality" type so much as it does the dynamics of the self--a structure that Kohut asserts influences the development and mental health of <u>all personality types</u>. In both neurotic and normal individuals, in fact, the relative strength of the self is usually quite independent from whatever structural pathology may be present. Weakness or temporary fragmentation, Kohut says, can occur in anyone, and hence all different kinds of people can engage in addictive eating in order to recover cohesiveness of the self. Only in the most severe eating disorders, anorexia nervosa,

bulimarexia, and chronic bingers from any category, is a self defect probably central to personality structure, as I shall describe in the next section.

Other Self-psychological Features of Eating Disorders

Although I agree with Kohut that a self-psychological dimension is probably present in all forms of addictive eating, this aspect can be discerned most clearly in the extreme forms of eating disorders. Specifically, there are several narcissistic features that are central to these disorders in addition to the disturbances of body image that I discussed earlier, including the need to enliven or soothe a fragmenting self, self-preoccupation and grandiosity, and narcissistic vulnerability and low self-esteem. Essential to all these traits is the need for selfobjects to perform the functions that the enfeebled self cannot.

The "Understimulated Self" and the "Overburdened Self"

The hallmark of the understimulated self is the empty depression, boredom, and feelings of deadness and depletion that flood the individual when the cohesiveness of the self is threatened. Psychic feelings of emptiness have long been associated with binge eating, as can be seen in the case of a bulimarexic girl called "Ellen West" who was treated by Binswanger (1958). He reports that even after an enormous binge, this patient would feel "empty and dead, completely hollow" (p. 262). Citing "Ellen West's" own words, she asks,

> What is the meaning of this terrible emptiness--the horrible feeling of dissatisfaction which takes hold . . ? My heart sinks, I feel it bodily, it is an indescribably miserable feeling . . . [I have a] horrible fear of this feeling. I have nothing that can dull this feeling! (p. 253)

Yet to dull this feeling--to banish the emptiness, is precisely the need that causes the individual to binge again and again. Reporting on their observations of patients during the recovery phase of anorexia nervosa, Blackwell and Rollins (1968) write that the "wish to gorge represents a wish to fill up an empty inside . . . [to fill] its intolerable loneliness, longing, and sadness" (p. 297). They explain that "overeating expressed clinging to fullness and avoiding the feeling of emptiness at any cost because longing was felt as emptiness" (p. 299). Similarly, Bruch reports (1973) that obese "patients often complain about feeling 'empty' and behave as if their center of gravity were not within themselves" (p. 155).

One team of researchers, Burdon and Paul (1951), reviewing the early obesity literature, concluded that a "nagging sensation of epigastric emptiness is symbolic of an emotional void which the obese person is trying to fill" (p. 576). M. Brenner (1980) describes one case of a bulimarexic, who, in spite of the fact that she was an attractive and successful businesswoman, was constantly driven to binge by vague emotional dissatisfactions: "She dealt with everything by binging . . . anything could start her toward food" (p. 56). This woman described herself as having "no bona fide self," (p. 57) and any minor disruption in her selfobject relationships would instigate the pathological syndrome of binge-vomiting.

Sometimes these feelings are described more as "boredom" than emptiness. Abramson and Stinson (1977) were able to demonstrate that boredom significantly increases food consumption. Goodsitt (1977) has hypothesized that the self defects of anorexics are what compel them to enage in strenuous exercise, not in an effort to lose weight, but in order to relieve painful feelings of boredom. One patient in particular said she kept to a rigid schedule of vigorous activity for the purpose of "just having something to do, anything to relieve feelings" (p. 6). This same patient "described her future as going into empty space" (p. 6). Druss and Silverman (1979) have similarly described the compulsive repetitive practicing of ballerinas with eating disorders, in which the "dancers can achieve a state that each of the girls described as 'beyond boredom'" (p. 119).

Other authors (e.g. Kaplan & Kaplan, 1951; Sjoberg & Persson, 1979) have described how addictive eating can be used to diminish anxiety. Just as the understimulated self needs to enliven a feeling of deadness, boredom, or depletion, the overburdened self requires soothing that must be obtained from external sources because the self has not internalized mechanisms to do this independently. However, I believe that the self-soothing attempts of the overburdened self are more readily seen in addictions to alcohol and drugs, for the obvious reason that these substances contain agents that relieve anxiety quite directly and physically. Yet food can also be used to achieve this result, particularly when consumed in quantities large enough to produce a kind of stupor, as sometimes happens in binge eating (Lindner, 1959).

Fluctuations of Self-esteem

Another indication of the prominence of self-psychological disturbances in eating disorders are the widespread and far-reaching fluctuations in self-esteem that have been observed in these individuals. As I mentioned earlier, the pre-anorexic girl is often haunted by feelings of worthlessness, and similarly, the obese person often suffers from low self-esteem, even self-loathing at times (Bruch, 1973; Mendelson, 1966). Both groups seem to suffer from great narcissistic vulnerability--the vulnerability that stems from depending on external objects as regulators for self-esteem. Druss and Silverman (1979), for example, report the ballerinas in their sample were extremely dependent on their idealized instructor for narcissistic sustenance and they were only able to feel "up when complimented by . . . [the] teacher" (p. 118). Boskind-Lodahl (1976) also found bulimarexics to exhibit a "reliance on others to validate their sense of worth" (p. 347), and says that they see "achievement mainly in terms of what it . . . [can] provoke from others; . . . Achievement . . . [is] not seen in terms of intrinsic rewards to the self" (p. 348). In a study of obese women, on the other hand, Stunkard, Grace, and Wolff (1955) commented that they "were for the most part remarkably immature characters who relied inordinately on praise and tokens of love for the control of anxiety and the regulation of self-esteem" (p. 85).

After a binge, self-esteem usually plummets to its lowest point (Mendelson, 1966). Because such binges are undertaken in an effort to bolster the insecure self, in the aftermath the individual must face

not only the addictive eating's failure to do this, but he has the added problem of feeling sick and huge. Often this is accompanied by shame--the shame that follows the intense body-self preoccupation produced by a disintegrating experience.

Indeed, many binge eaters are excessivly preoccupied with their bodies and their weight. Some will weigh themselves after a binge and then again immediately after vomiting (Bruch, 1973). Anorexics, of course, carry this preoccupation to the extreme, and often think of nothing else (Palazzoli, 1974). Some have been known to weigh themselves hourly and to look in the mirror constantly to see if they have lost any more weight.

Indeed, this self-preoccupation is closely related to the other extreme of the fluctuations in self-esteem that one finds in eating disorders: narcissistic grandiosity and exhibitionism. The anorexic's assertion that "I do not need to eat" reflects the enormous grandiosity that is initially hidden by her feelings of worthlessness. There are also grandiose strivings behind the relentless dieting in an effort to achieve "perfection." As Sours (1969) puts it, "the narcissistic pleasure of attaining supreme thinness blurs the realistic ugliness of cachexia and the growing food desire" (p. 5). In self-psychological terms, this perfectionism represents the grandiose ideals and goals of a self that is not cohesive and has not integrated realistic goals. Other writers (Boskind-Lodahl, 1976; M. Brenner, 1980) have pointed to the presence of unrealistic ideals in bulimarexics as well. In the case of one patient, there "was no room in her picture of herself to admit flaws" (M. Brenner, p. 56).

Grandiose fantasies are also quite common among the obese. Millman (1980) says that many overweight people have been heard to make statements like, "I needed to lose not only weight but my size 44 ego" (p. 36). Bruch (1973) as indicated that for some the obesity itself serves as a defense against fantasies of omnipotence. Many overweight people believe that although their "present self-in-the-world may be fat, ugly, despised, or disregarded . . . inside, carefully nurtured is a private future self that is beautiful, powerful, and lovely" (Millman, 1980, p. 220). One obese adolescent who was treated by Bruch (1973) believed that she had "gigantic power. It was her duty, more than anyone else's, to correct the ills of the world because she had this gigantic power" (pp. 168-169). Contending that many obese persons have been used as selfobjects by their parents, who expected them to compensate for their own "unfulfilled ambitions," Bruch says that they often exhibit "a fantastic misrepresentation of their importance in the world" (p. 169). Often they believe that the only thing standing between them and greatness is their fatness. It is because of these fantasies, of course, that many obese individuals find the idea of losing weight threatening, and why some who do become thin suffer shattering disappointment that their specialness does not become magically apparent to everyone as they become thin (Buchanan, 1973).

In fact, obesity is the only potentially lasting effect that addictive eating can produce. Those who attempt to fill the void of a defective self in this manner find that it is ineffective and, moreover, that its consequences can be devastating. As Orbach puts

it, "compulsive eating is a very, very painful activity" (p. 37). And for those who become obese because of it, this pain is sustained by the humiliation of being fat, as one woman interviewed by Millman (1980) so poignantly attests:

> One day I was in the supermarket and a four-year-old kid was marching around and around me in circles, screaming at the top of his lungs, "You are fat. You are fat. You are fat."--over and over again. (p. 9, italics in original).

Far from being a matter of pure gluttony, overeating for many is as uncontrollable and as physically, emotionally, and socially self-destructive as any addiction can be.

Chapter IV

METHODOLOGY AND RATIONALE

In order to further illuminate the complex, depth-psychological phenomena described in the preceding chapters, clinical data will be offered in the form of a case history of a patient whom the author treated in twice weekly, psychoanalytically-oriented psychotherapy for approximately two years. I will also provide brief excerpts of reports of overeaters which give experiential descriptions of binges. It is my opinion that it would be extremely difficult, if not impossible, to measure and delineate adequately, with an experimental procedure, the vague and subtle vicissitudes that the self experiences. Indeed, I believe that clinical material is not only more relevant, but may also be a more fruitful source of data for the particular topic under consideration here.

Kohut would, no doubt, agree. He advocates "a return to concentrated, unprejudiced clinical observation" (1977, p. 142). However, he warns that "clinical descriptions . . . can never by themselves supply sufficient evidence in support of the claim that one viewpoint is more adequate, more encompassing, more accurately discerning than another. The enormous number of variables in the psychological field dooms a purely cognitive approach to failure" (p. 142). This approach must be supplemented, in Kohut's view, with "the refined empathy of the trained human observer," which is

"the irreplaceable step that leads to the meaningful grasp--understanding--of the psychological field" (pp. 142-143). He asserts that theorizing is always a two step process of understanding-explaining. Clinical data that are truly "evocative" must include the observer's introspective-empathic responses to such data.

Kohut has demonstrated this approach in his own numerous case histories in which he presents not only the patient's material but also the analyst's responses. Many of these clinical descriptions include data that could easily be interpreted along classical lines, as in "The Two Analyses of Mr. Z." (1979). But it was only by examining the total context that Kohut was able to arrive at the conclusions that illuminated this patient's pathology in self-psychological terms. Kohut (1977) reminds us, "an analysand can give fifty well-fitting associations whose ideational content would lead to a specific interpretation of the material - yet his tone of voice, the message emanating from the mood portrayed by his gestures and bodily posture will tell the analyst that the significance of the material lay elsewhere" (p. 143).

Of course, there is a long tradition of analysts, dating all the way back to Fenichel (1941; 1945), who have advocated the use of countertransference in understanding their patients. "Counter-transference" in this sense refers to the broader definition of the concept that includes all of the analyst's responses to the patient rather than the narrower meaning of "the analyst's own transference to the patient for whatever reasons arising from his own unresolved conflict" (Orr, 1954, p. 648). Searles (1965) is certainly one

prominent clinician who has advocated the examination of the analyst's responses, an endeavor which he has approached with candid, if not intrepid, dedication. And there are many others (Fromm-Reichmann, 1950; Heiman, 1950; Singer, 1970; Tower, 1956, etc.) who have made this concept, far from being unique to Kohut's approach, an almost universally employed tool of psychoanalysis and psychotherapy.

Nevertheless, Kohut is particularly committed to the introspective-empathic approach. He advocates what he calls "the Emperor's-New-Clothes" principle: "fact-finding in psychoanalysis requires at times the naive courage of the observer rather than a very highly developed cognitive apparatus" (1977, p. 144).

Ideally, of course, one applies both skills to this task. As Wachtel (1980) reminds us, "to do really good research in psychology . . . is exceedingly difficult" (p. 403). He questions the usefulness of the attitude that such reseach must be experimental in order to be worthwhile. An argument can be made, he maintains, against the popular notion that dissertations that do not employ an empirical component "do not merit a degree in psychology, since such work belongs in the realm of philosophy" (p. 401). On the contrary, Wachtel suggests that not only is theoretical inquiry acceptable, it is also necessary in the pursuit of scientific progress. An unquestioned emphasis on empirical research, in his opinion, has resulted in too many theses and publications of dubious quality.

Obviously, psychologists have had a long and difficult history in their attempt to be accepted as "real" scientists. But as Wachtel

puts it, "we need . . . to take into account far more than we do the variations in talent and temperament of individuals who are in a position to contribute to progress in our field" (p. 400). In any case, whether it be a matter of temperament, or, as Kohut believes, the necessary and appropriate approach to the understanding of depth-psychological issues, I will illustrate the relationship between self-psychology and binge eating with the clinical material presented in the following chapter.

Chapter V

ILLUSTRATIVE DATA

In an effort to illustrate the role of self-psychological issues in eating disorders, in this chapter I will offer a case history of a patient whose presenting complaint was compulsive eating as well as an extremely negative body image. By examining in detail the treatment of this patient, who I believe represents an example of a narcissistic behavior disorder, the central role of the self in the phenomenon of pathological overeating will be illuminated.

As an addendum to this case history I will also present excerpts from the written reports of bulimarexics and binge-eaters who were asked to describe their feelings during a typical binge experience. Hopefully, these self-reports will provide a more experiential description of the phenomenon of addictive eating, as well as illustrate how pathology of the self may operate in a broader range of subjects, rather than just those diagnosed as narcissistic personality or behavior disorders.

Case History

Presenting Problem and History

The patient, "Jane Vega,"[1] was 23 years old when she was seen in October of 1977 for her initial intake interview. She was

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[1]All names in this chapter are pseudonyms.

accepted for psychoanalytically oriented psychotherapy, and we met twice weekly thereafter until June of 1979, when I left the clinic to pursue further training. A college senior majoring in nursing, Jane was to graduate in three months, and she hoped to get a job as an R.N. at a hospital and move into her own apartment. She had always lived in New York City with her family, including her father (age 52), a seaman of Hispanic extraction, her mother (age 43), a dental assistant who was born and raised in a Scandinavian country, a brother, Freddie (age 18), and a sister (age 16), Linda, both high school students. For many years, her father's mother, Rita, had also lived with the family, but recently she had lived in the apartment next door to theirs. Jane indicated on her intake form that her mother had had two miscarriages ("she lost two little boys") between her birth and Freddie's five years later.

Jane described the problems that led her to seek therapy in the following words: "I am always depressed, tired, and irritable. I overeat continually. I can't concentrate or enjoy myself at anything. I have a very poor body image because I feel my body is ugly and abnormal." In particular, she was distressed about her legs, ankles, and feet, which she thought were hideously fat and swollen-looking. As a result, she always wore pants, and because she felt generally ashamed of her body, she never removed her coat unless it was absolutely necessary. To the observer, Jane appeared to be only mildly overweight, and her legs and feet, although concealed, seemed somewhat heavy but well within normal range. Blond and blue-eyed like her mother, Jane wore her straight hair shoulder-length, and she was

generally well-groomed in a casual way. She appeared to be both bright and well-informed, and she usually spoke rather rapidly, with a pronounced "New York" accent.

Saying that she had "always been a sad child," Jane reported that her depression had been "worse since adolescence when people my age were expected to have boyfriends." At that time, she became even more withdrawn and unhappy than she had been before, having no interest in either dating or developing friendships with other girls. She said that she "uses people" for what she "can get from them," and she felt she was "incapable of loving anyone." Around the time that Jane began college, she started going to discotheques and bars where she would pick up men for "one-night stands." She stated that she had no interest in developing a relationship with any of these men, nor did she derive any sexual satisfaction from these encounters. "I just like to be caressed and told I'm pretty," she said, "but when it's over I just feel a sense of relief." Jane was curiously unconcerned about this pattern, however; she stated her primary goal for therapy as the wish to "work on my hate for my body and my overeating . . . I am most miserable when I'm fat but I continue to overeat."

Portraying her family life in bleak terms, she described her mother as a sad and self-centered person who had had "a miserable life." Jane blamed her mother's unhappiness on her father. As the child of a warm middle-class Scandinavian family, Mrs. Vega met her future husband when she was 18 and returned to the United States with him as his wife. According to Jane, the marriage was never a happy one, and had in recent years deteriorated to the point where her

parents hardly spoke and slept in separate rooms. Describing her father as a "stupid, lazy, and disgusting person," Jane said she found him unbearably irritating, and when he was at home (which was not often, since he "shipped out" for many months at a time), she avoided him as much as possible. She also blamed much of the family's unhappiness on Rita, her paternal grandmother, who she saw as a constant pest and burden to her mother.

Jane was considerably more positive in her attitudes towards her younger siblings, both of whom had a kind of "independence" that she admired. For example, her sister, Linda, had the ability to "tell people off," particularly Rita, when they annoyed her. Jane felt incapable of doing this, and she envied Linda's "assertiveness." Furthermore, Jane had great admiration for Linda's eating habits. Although she was quite thin, the younger girl was always on a diet, and, in fact, she tyrannized the entire household by "controlling" the kitchen. Linda insisted on doing all the cooking, preparing special low-calorie meals for herself, and complained incessantly about the fattening foods that Jane and others brought into the house. She also did strenuous exercises, sometimes all evening long, according to Jane. Because of these patterns, and because Linda had not menstruated in over a year, an aunt, Carmen, suggested that she might be anorexic and should see a doctor. This angered Jane greatly, who declared that "Linda is the only person in this whole stupid family who has healthy eating habits and now they're calling her crazy! At least she has some control."

The particular independence that her brother, Freddie, had established which Jane so admired was a steady relationship with a

girlfriend, Sue, which had been going on for about three years. Although Mrs. Vega essentially disapproved of this girl, Freddie spent every free moment with her, often away at Sue's family's house in Long Island. Eventually, he even managed to earn enough money from after-school and summer jobs to buy a used car, making his independence all the more possible. Jane did not envy her brother's relationship per se, but she admired his independence, and she was pleased for him that he had gained some measure of emancipation from her "horrible family."

Although she claimed that she did not care about Linda or Freddie ("I don't even buy them Christmas presents!"), she did seem to show some concern for their well-being, and she even suggested to Linda, who had a habit of shoplifting "just for kicks," that she should go into therapy. Jane herself had had two previous therapists, both male psychiatric residents at a major medical center near her home. She described her first therapist, "Dr. Talbert," in glowing terms. Finding him to be handsome, warm, and understanding, she said she developed a "crush" on him, and as a result she was reluctant to disclose "unflattering" information about herself to him. This treatment lasted only three months, however, because Dr. Talbert was on a rotation, and although he had warned her of this, she was surprised and disappointed when she was transferred to another therapist. Even though her treatment with the second psychiatrist lasted a year, she found him to be silent and unresponsive, and she was never able to feel that he understood her as well as Dr. Talbert had. Her termination of this treatment was precipitated by a

particularly traumatic incident in which her therapist brought her to a case conference during which Jane sat on one side of the table and "the doctors sat on the other side like a row of judges." At the end of this meeting her therapist's supervisor told her that she was a "passive-aggressive personality" and that she must change the way she "thinks." Jane experienced this public confrontation as a humiliation and she expressed her anger and hurt by withdrawing in the treatment, finding she had little to say in her sessions. Finally, she suggested that she should terminate, and when her therapist neither attempted to persuade her to stay nor offered to transfer her to another doctor, she came away with the feeling "he didn't give a damn!" She had the fantasy that perhaps this psychiatrist let her go because his supervisor thought that she was "too sick to be helped."

It was 10 months after this termination that Jane decided to try therapy once again, but she remained quite bitter about this experience, saying, "I spent so much money working as a cashier to pay for my therapy because I felt I was really sick!" Despite this, she was eager to begin treatment anew, and on her intake form she wrote, "I don't want to live the rest of my life this way . . . I'll take anything and everything you're willing to give me."

Treatment Summary

Not surprisingly, once therapy began Jane revealed herself to be a very needy person, indeed. From the beginning she spoke about her difficulties with considerable opennesss, her speech often rapid and even somewhat pressured. Describing herself in the first session as a "zombie," Jane said that her depression had been fairly constant

since adolescence and it centered around her problem of overeating and her hatred for her body. Within moments, she was in tears, and referring to her previous therapy she cried, "they say I have to change the way I think but I don't know how to do that!" She said she had always had difficulties getting along with other people and that she was essentially not interested in having friends or boyfriends. Again, this problem emerged most clearly at adolescence: Jane said that it was then that she began to feel different from other girls and used to think that "either they had something I didn't or I had something they didn't."

She described herself as a "basically worthless" person who was unable to care about anyone. During the second session she said "I'm not human. I just take from others what I need and when they start making demands on me I don't want to have anything to do with them anymore." She gave as an example of her "difference" from others her reaction to the recent death of a childhood playmate: "I didn't care that he was dead; I just felt annoyance that now I would have to go to the funeral and act like I was sad." She claimed that her brief sexual encounters with men were also entirely exploitative: "I take what I can get from them and then I dump them." Saying that she was unable to tolerate the "burden" of caring about people, Jane declared that she had no interest in getting married or having a family, and that she only indulged in these relationships in order to "get flattered" but that she became bored very quickly. At certain times she would go out every night, meeting someone different at each new bar or discotheque. "Going with strangers," Jane said, "is

exciting--it makes me feel more alive." Indeed, she claimed that she was "exhausted all the time," and explained that "for short periods I can pretend to people that I'm alive and a normal human being, but I can't do it all the time."

These essential themes, related in the first few hours of treatment, remained dominant throughout our work together. Jane seemed to react to the therapeutic situation right from the beginning insofar as she reported great relief from "just talking to someone." Always arriving at least 20 minutes early, Jane cancelled only one session in the entire first year of treatment (and very few thereafter). Yet transference manifestations were quite indirect. Exhibiting no curiosity nor fantasies about me, Jane never asked any questions about my reactions or my personal life. As the therapst, I was initially puzzled by this and also distressed by my countertransference reaction of feeling drained and depleted by this patient. Only gradually did it become clear that I was probably reacting to a mirror transference of the merger variety (which, as I said earlier, is always experienced as a burden by the therapist), in which Jane was psychically unaware of my existing as a separate person. She conceived of relationships in terms of "parasites and hosts" (she described the mother-child relationship in these words, for example) and that was precisely the kind of transference relationship that spontaneously developed in the treatment.

As Jane began to talk about her parents and her early life, the probable origins of her difficulties emerged more clearly. At first, whenever she would talk about her mother she would weep, and

she seemed to identify with her quite strongly as the victim of a "horrible fate." Jane had an idealized image of her mother's childhood in Scandinavia: "she was never sick until she was 18. She had such a happy, healthy childhood!" According to Jane, it was after her mother's marriage to Mr. Vega that her entire life took a dramatic turn for the worse, and she began to suffer from frequent illnesses (most recently, a gum disease) and constant depression. Jane said that her mother had been "sad and unhappy" as long as she could remember, and that she was the kind of person who always felt "very sorry for herself." One can speculate that the two miscarriages that Mrs. Vega had after Jane's birth played a role in her depression, although it is difficult to know for sure.

It appeared that Jane had yet to adequately separate from her mother. For example, although she spoke often about getting her own apartment, even after she had graduated and secured a well paying job in a prestigious hospital, she found herself unable to bring herself to move away from home. She worried that her life would consist of nothing more than working, eating, and sleeping, and that she would never have the energy to take the subway all the way uptown to see her mother. In the 15th session she said "I have this fantasy that I'll finally get my own apartment and then my mother will decide she can't take it anymore and will move in with me."

Jane further described her mother as being constantly preoccupied with her own problems and that she was always complaining about what a "horrible place" the world is. For example, Mrs. Vega felt that she was grossly mistreated by the dentist who was her

employer and every night she would come home from work with another tale of insult. As treatment progressed, however, interpretations about Jane's dependency on and identification with her mother led her to be more and more critical of certain aspects of her mother's behavior, particularly her complaining but "passive" attitude towards her problems such as her unhappy job situation.

Describing her mother's negative view of life, Jane recalled that Mrs. Vega had always had a preoccupation with "gruesome" stories. As a young child, Jane hated to hear these frightening tales about the "cruelty" of nature and man: how vultures eat "baby" turtles or how Eskimos torture polar bears by concealing knives in the meat they set out for them, etc. Mrs. Vega said she wanted the children to hear such stories so they would understand "the way the world really is," but at the same time, even as a child Jane realized that her mother's preoccupation with these things was extreme and a bit bizarre.

Indeed, as Kohut (1977) has pointed out, it is often possible to get a fairly clear idea of the parents' pathology not only from the patient's childhood recollections, but if they are still alive at the time of treatment, from the ongoing interaction between the patient and his parents (and even from the interaction between the parents and current children, such as a grandchild). Obviously, this was quite possible in the case of the Vegas, and so, for example, during treatment Jane would occasionally report that "last night my mother started in again" on the bizarre stories. More and more a portrait of Mrs. Vega as an extremely depressed, self-involved, and even somewhat "sadistic" woman emerged. Indeed, during the 12th session Jane

reported that a few days earlier a neighbor's child, Tony, had been over at her family's apartment and he had said to Mrs. Vega, "I don't think my mother cares about my feelings!" Jane said that her mother laughed and teased the little boy, responding, "Oh Tony! you sound just like an old man!" Jane went on to add that her mother "doesn't think that children have feelings. I remember once I said to her 'Mom, you hurt my feelings' and she got angry and just said 'tough!' So I knew never to say anything like that again." Amazed at how well Tony withstood this treatment, she contrasted his stoic reaction to her own sensitivity when responded-to by her mother in this way, and she marveled, "little Tony was so secure in himself! He didn't care!"

The report of this incident led Jane to a string of associations about her brother Freddie's childhood experiences with Mrs. Vega. Weeping, Jane recalled that

> my mother just can't tolerate children crying or anything. She was so awful to my brother. She used to beat him when he cried. . . . And later on he'd sit at the table--he was so sensitive, like me--and he'd start to cry. The tears would be streaming down his face, and you could see he was trying to hold them back.

In fact, Jane often used memories about Freddie's childhood as "crystallization points" for her recollections about her own relationship with Mrs. Vega. A few sessions later she described how her mother "is so concerned with external appearances and beauty. She's always criticizing my brother's girlfriend for her appearance . . . she's always talking about how she's not good enough 'cause she's not pretty. And my brother has such a complex about being too short! He's so worried about it. And my mother agrees with him . . .

she never says that it doesn't matter or that he's o.k. the way he is." When I commented that it sounded like her mother expected people to be "perfect" Jane responded, "Oh, yes! She always made me feel like she was ashamed of me."

A picture of Jane's early years gradually emerged in which it seemed that Mrs. Vega's own pathology had prevented her from providing adequate mirroring or even reliably empathic maternal responses. Kohut (1971) writes that it "can be regularly ascertained . . . that the essential genetic trauma is grounded in the parents' pathology, in particular in the parents' own narcissitic fixations" (p. 79). However, as I described in Chapter 2, the theory of the "bi-polar self" (1977) suggests that the child has two "chances" to develop an adequately secure and cohesive self. If the mother fails in the task of phase-appropriate mirroring of the grandiose self, the father can still provide the child with an opportunity for self-cohesion as an idealized selfobject.

In the case of Jane and her father, it appears that he had deeply disappointed her. Although she spoke much less about her father than she did about her mother, Jane's earliest recollections of him were surprisingly positive: she described how they used to go to the neighborhood swimming pool together (swimming remained one of her favorite activities although she had abandoned it in adolescence because she was too ashamed of her "fatness" to appear in a bathing suit in public), on walks, and on bike rides. He had a "pet" name for her, which he still used to this day. Yet whenever Jane referred to her father in a current context it was only with the most negative

affect. In the third session she said "he's like me, always in the kitchen eating!" Unlike her mother who was "slim and pretty," Jane described her father as "fat, lazy, and stupid. He's so stupid that sometimes I think he's mentally retarded! I guess because of the language barrier, my mother didn't realize it when she married him." In recent years, when her father was home Jane could not stand to be around him. She hated the sight of him "hanging around the house, drinking beer, always coming in to see what you're watching on t.v." Nevertheless, her descriptions of his stupidity were never entirely convincing (one example she offered was that he had "never even heard" of Studio 54, a discotheque that had often been in the news during the past few months when he had been away on a voyage). Furthermore, although he was treated like a pariah by both Jane and her mother, when he was away he regularly sent the family postcards and money. It seemed that Jane's reaction to her father, in contrast to her forgiving attitude towards her mother, did not adequately fit his "crimes."

I suggested to Jane that the "crime" for which she could not forgive him was his regular "abandonment" of her to go to sea at a time when she so needed him. She recalled how forlorn she felt as a little girl when he would leave. "He showed me a book once," she said, "about the Line where he worked and I pointed to a picture of the Captain and said, 'I don't like him because he makes you go.'"

A second reason for Jane's disappointment in her father was related to the family "myth" that her mother had married "beneath herself." It must have been very difficult for Jane to maintain an idealization of this man for whom her mother displayed such open

contempt. Indeed, Jane tended to idealize men whose backgrounds were radically different from her father's. Dr. Talbert is a good example, in fact: his real name was a rather uncommon one which happened to be the name of a very large corporation, and Jane fantasized that he was the son of the owner of this company, and as such, was fabulously wealthy. She was also obsessively preoccupied with a traumatic incident that had occurred with such a man shortly before our treatment had begun. Working over the summer at a metropolitan hospital as part of her training, she met a young doctor whom she greatly idealized. "He was a specialist," she said. "He must have been a genius or something because he was still in his twenties!" "He was so tall and tan," she said, and she was greatly enamored of his private school background and "preppie" clothes. After several weeks of tentative flirting, she finally received an invitation to come to this doctor's apartment. For Jane, it was a disastrous disappointment: although he made love to her she was crushed because "he seemed so bored and uninterested in me the whole time I was there, and when it was over, he practically kicked me out!" Immediately afterwards, she started to binge and reported that she gained 30 lbs. in a matter of weeks. In therapy, she frequently referred to "the doctor" and this incident, and when she graduated from college she refused a good job offer from a major hospital because she knew that "the doctor" was now working there. Her attitude was "now I have had the ultimate man and there's nowhere to go but down."

Thus it appeared in many ways as if Jane's father had failed her as her mother had before him. She agreed with this view when I

suggested it to her and recalled that she had once taken a sentence-completion test in which she had responded to the phrase "a father is just like . . ." with the words "a mother." Unable to internalize either a mirroring grandiose selfobject or an idealized selfobject then, Jane's self was depleted of narcissistic libido as these needs had never been properly responded-to or internalized, and this was apparent in her empty depressions, self-hatred, and feelings of not being "human." She constantly sought out both mirroring and idealized selfobjects in the men that she slept with, but the relief that this provided was only temporary and so she resorted to complusive eating in an effort to bolster her disintegration-prone self and to diminish the intense feelings of emptiness that she was subject to.

Throughout the treatment, Jane's sense of herself as an empty, hollow, not quite alive person whose neediness and lack of internal resources rendered her unable to have lasting or deep relationships was most elegantly expressed in her dreams. The very first one, reported during the 12th session, is a good example: "I dreamt that I went to see 'Close Encounters' and the middle rows were empty but I had to sit on the sides." However, Jane was consistently unable to associate to her dreams, and at first I was at a loss to understand this. Kohut (1977) has proposed that there are two kinds of dreams, and two kinds of dream analysis as well: "those expressing verbalizable latent content (drive wishes, conflicts, and attempted conflict solutions), and those attempting, with the aid of verbalizable dream-imagery, to bind the non-verbal tensions of traumatic states (the dread of overstimulation or disintegration of the self)"

(pp. 108-109). Whereas in the first kind of dream free associations lead to the latent content and subsequent understanding of the dream's meaning, Kohut says that "in the second type of dream . . . free associations do not lead to unconscious hidden layers of the mind; at best they provide us with further imagery which remains on the same level as the manifest content of the dream" (p. 109). Kohut calls these "self-state dreams" and he believes that they are the reactions of the psyche to the vicissitudes of self-cohesiveness. Thus Jane's dream can be made intelligible, even in the absence of free associations, as her sense of herself as someone whose central "emptiness" condemns her to sitting on the sidelines during the "close encounters" of her life.

A second dream which she reported during the 14th session is remarkably similar to one which Kohut (1971) says was dreamed almost identically by two of his patients. The dream that Kohut writes of is one in which

> the patient is in a rocket, circling the globe, far away from earth. He is, nevertheless, protected from an uncontrolled shooting off into space (psychosis) by the invisible, yet potently effective pull of the earth (the narcissistically cathected analyst, i.e. the narcissistic transference). (p. 5)

Jane's dream, on the other hand, was that

> there was this cannon and they were going to shoot me into space--sort of an experiment--but I had to be within the earth's atmosphere because I could look down and see trees and stuff. I wanted to come down but I was afraid that if I broke through the atmosphere I would get burnt.

I interpreted to her that she was afraid that if she became close or dependent on the world of people, including myself, she would get "burnt" the way she had with Dr. Talbert and "the doctor." She

responded, "also, if people were to get close to me all they would find is a corroded person."

Subsequent dreams were replete with similar images, including "clones" (33rd session), "mannequins" (42nd session), and one particularly expressive image of a "black cube of 'nothingness' that had the power to 'multiply' and take over" (58th session). Jane's dreams were generally of the type that Kohut says is so common among his narcissistic patients, who are expressing their fears of self-disintegration and the lifeless, hollow, and mechanical quality that existence has for them.

The fragility of Jane's self was further demonstrated in her need for external objects for the regulation of her self-esteem, which resulted in her extreme sensitivity to criticism and disapproval, real or imagined, from others. This was especially true, of course, in relation to idealized figures such as teachers, superiors at work, etc. "The smallest thing makes me fall apart," Jane said. She felt she always had to be accommodating to others because she was so frightened of being criticized. Speaking with amazement of a classmate who had been "picked on" by the teacher in class one day, Jane said that this woman told her "that she knew her work was good and she didn't care what he [the teacher] thought. And I asked her, 'do you really feel like that? Do you really have self-confidence like that?' . . . I don't know what it's like to feel like that."

Once she graduated and began to work at a hospital full-time, this became Jane's major work-related problem. Extremely dependent upon the reactions and approval of her supervisors (even the absence

of "enough" praise was narcissistically wounding to her), Jane's primary goal at work was to "stay out of trouble." This, in fact, led in one instance to some potentially serious consequences. Having given a patient the wrong medication, Jane's overriding concern was to avoid "getting caught" in her error, even though the hospital emphasized that mistakes are inevitable and must be reported at once because most can be counteracted or corrected. Her attitude was particularly striking because, according to Jane, the medication she had given this patient was not only the wrong kind, but it was also many times the normal dose, and for several days she quite expected this patient to die. But she said, "even if the patient had died I still would have only been worried that they'd find out it was me who did it. . . . I just can't stand people yelling at me. I would have been shattered." She said she had "always been this way" and told me that when she was 17 she had seen a man lying in the deserted lobby of her building, whose head was bleeding and who appeared to be having an epileptic fit. Even though Jane was the only person around she "just kept on walking. . . . I didn't want to get involved. I'm so self-conscious, I didn't want to draw attention to myself."

Jane's apparent lack of ethical ideals or guidelines in these situations, which is a frequent consequence of an improperly internalized idealized selfobject, was particularly curious in light of the fact that she ultimately chose to become a nurse. She said that this decision had nothing whatsoever to do with humanitarian ideals but was motivated by her sense that nursing was a secure profession. "Besides," Jane said, "I had always done fairly well in

sciences courses." She herself recognized, however, that the choice was somewhat curious and remarked that it seemed funny since "caring for other people is what I am least capable of doing." I suggested to her that she was attempting to learn "by rote" something that she could not find the internal resources to do naturally, and she seemed quite struck by this interpretation and she began to cry.

Of course, the crucial diagnostic criterion of a self disorder, as Kohut has repeatedly emphasized, is the nature of the transference that spontaneously develops, and in Jane's case, patterns slowly emerged that led my supervisor and me to conceive of hers as a "mirror" transference. Often such a transference will be silent and implicit until a disruption in the treatment occurs. The first such disruption in this case was the result of an error on my part to which Jane responded by feeling misunderstood and criticized. The error was specifically this: growing increasingly alarmed by Jane's apparent lack of appreciation of the risks involved in picking up strange men, I finally (after she had reported meeting someone in Times Square the night before) suggested to her that her need to have these encounters must be particularly intense since she seemed to be exposing herself to the risk of physical danger in doing so. The comment precipitated Jane to withdraw in the therapy hours and for several sessions she was increasingly silent until I inquired about this and she indicated how criticized this interpretation had made her feel.

According to Kohut, it is the working-through of such disruptions in the transference that is the "pay dirt" in the treatment of patients with self disorders, and the most predictable

and inevitable disruptions are due to separations from the analyst. Often separations as brief as a weekend are enough to incite a sense of self-disintegration in the patient, and in Jane's case such a pattern emerged quite clearly.

Although Jane was often able to control her eating (indeed, even to diet) and her impulses to meet new men during the week, at weekends this was not the case. Many a Monday morning she would come to therapy with a vivid and plaintive description of what "a horrible weekend" she had had. "If you could have seen me," she said to me one Monday, "walking down the street, going from place to place, stuffing all this food in my mouth, with the crumbs rolling down my chin and my fingers all sticky and the wind blowing my hair in my face, and me pushing it away so I could stuff more food in my face!" Often, these binges would be accompanied by compulsive masturbation, which she described as "a totally joyless experience." At other times she would compulsively search for a new man to have sex with: "when I'm not eating I get restless and I feel like going to a bar and meeting someone. Last night I walked all the way from the shuttle [42nd Street] to 116th Street, and it seems like I went into every bar I passed along the way." The desperation of these accounts, as well as the hollow emotional tone during the sessions in which she described these weekends, often led me to make interpretations such as this one: "it sounds as if this weekend you were really searching for ways to stimulate yourself--as if you were feeling some longing or emptiness and you were trying to fill yourself up with as much food and sex as you could."

Jane often responded to such interpretations but for a while we both remained perplexed as to why these feelings were so overwhelming on weekends, particularly since she was often required to work on Saturdays and Sundays and was usually quite busy. Eventually it became clear that they were connected to the transference and the threat to her self-cohesiveness that the absence from the therapist represented. This pattern was, predictably, even more striking in relation to longer separations such as the summer vacation. During the last session before the first summer break Jane reported that she had been eating so much lately that she had gained 20 lbs. "I've lost all shame about it--I've even started stealing food like candy and stuff from the patients' rooms while they're sleeping or at X-ray or something."

Finally, one of the most consistent and reliable guides to this patient's transference was the countertransference it inspired in me. As I mentioned before, my predominant reaction to Jane was to feel drained and depleted, almost what one might call an "empty depression," as a matter of fact. I was both confused and dismayed by the lack of other kinds of responses, particularly in sessions in which she would describe (often in very emotional if not histrionic terms) what sounded like very painful feelings and activities. Yet how they <u>sounded</u> was not how they <u>felt</u> to me. The tone was often hollow; there was a vague sense of some central aspect being missing, not only in Jane's experience, but also in the alliance between us. I did not have the feeling that a "collaborative effort" was going on. Indeed, I often came away feeling heavily "burdened" if not

"imprisoned" by this patient. In retrospect, I believe this sense of "imprisonment" was my response to being literally used as a part of someone else's psyche (Kohut, 1971).

The working-through in this case, that is, those issues that were repeatedly worked on and interpreted in various ways, revolved around two major themes: Jane's empty depressions and dependence on external objects for the maintenance of self-esteem, and secondly, the defensive nature of her feeling that she had no interest in or needs that could be satisfied by other people. Both issues were frequently related to the transference, the second one being seen in her denial that anything I said or did made any difference to her. Certain improvements were visible by the end of the first year of therapy. For example, although in actuality I rarely focused on this issue directly, Jane's preoccupation with the ugliness of her legs and feet, which I believe was an instance of the hypochondriacal tensions that haunt those who are experiencing disintegration anxiety, gradually diminished. After a while, she hardly ever mentioned this issue which had been so overwhelmingly important to her when she had started treatment. In fact, her self-consciousness about her body in general had abated to the point where, for the first time since childhood, she put on a bathing suit and went swimming. Indeed, during the second year of treatment Jane took a scuba-diving course which ultimately resulted in a scuba-vacation with her class in the Caribbean. She also took up jogging, which required her to wear shorts during the warmer months. And at the end of the first year she began to finally wonder if it was not strange that she had no friends, and she also

began to experience some depression about the brevity and emptiness of her relationships with men.

During the second year, further signs of progress were indicated. Tentatively, Jane began a few "dating" relationships, which although they were still largely exploitative, lasted several weeks, and in one case, several months at a time. Although she still denied caring for anyone, her descriptions of men were much more "real" and three-dimensional than they had been before. In addition, she began to develop "interests" that had been missing from her life for a long time. As well as swimming and scuba-diving, Jane took up photography, and two of her pictures won third prize in a contest at the hospital where she worked. She also started learning to drive, something she had "always meant to do, but never had the energy for."

Furthermore, Jane seemed more able to control her overeating, and she reported losing some weight. A month before we terminated she said "I no longer feel like I'm just a zombie or an eating machine." Nevertheless, predictably, termination precipitated a regression and she did have several binges.

It seemed clear, however, that despite these improvements the central defect in the self was far from decisively healed. Indeed, Jane expressed a desire to continue psychotherapy, and I suggested that although she could easily continue therapy with another graduate student, perhaps she could benefit even more from an analysis. Because Jane was still living at home but was earning a fairly good salary, it was quite possible for her to see an analyst in private practice. I supplied her with three referrals (that had been suggested by my

supervisor) and Jane determined that she would pursue the matter after her summer vacation.

Perhaps another measure of her improvement was that Jane was able to feel some sadness at my departure as well as some gratitude towards me at termination. She spent her last session describing the ways she felt she had changed: "I guess the most important thing is that I don't feel like killing myself anymore . . . there are too many things I want to do."

Summary and Comparison with Other Viewpoints

In summarizing this case history it is important to keep in mind that this was not an analysis or treatment conducted by an experienced analyst but a twice-weekly psychotherapy performed by a graduate student with no prior experience in long-term psychotherapy. This fact has several implications. First of all, the depth of the regression and the intensity of the transference were not as they might have been in an analysis. The meetings were not as frequent and the date of termination was not set by the patient as it would have been in an analysis. The transference relationship was not as carefully monitored nor as consistently interpreted as that of an analysand should be. And, of course, my inexperience as a therapist often dictated a rather "hit-and-miss" approach to the patient, reflecting what was often genuine confusion and lack of skill. Indeed, far from having a solid grasp of theoretical and technical issues, I was heavily dependent on the advice of my supervisors.

In retrospect, I am surprised at how "Kohutian" this case appears to be, considering I was only vaguely familiar with the

psychology of the self at the time. My reconstruction of the treatment is based on detailed, often verbatim process notes that I made immediately after each session, but now I can only guess at some of the thoughts that led me to make the interpretations that I did. One possibility is that as a "naive observer" I may have been even more dependent on the "empathic-introspective" method that Kohut recommends than a more experienced therapist might have been. In other words, as a result of my uninformed viewpoint I may have been forced to pay close attention to the mood and tone of the sessions and to my own responses to the patient, for lack of sophisticated techniques strongly grounded in theory.

However, taking a more "informed" Kohutian perspective at this time, I believe that the psychology of the self does indeed provide the most valid perspective to this case. Comparing it briefly to a more traditional psychoanalytic viewpoint, it is possible to see many of Jane's symptoms as expressions of an oedipal neurosis. For example, her preoccupation with her legs and her feet, as well as her sense of having an "unacceptably ugly" body could be seen as a castration complex in which she displaced her disappointment about lacking a penis onto other parts of her body. Both her compulsive eating and her compulsive promiscuity could be seen as an expression of penis envy, in which she attempted to make up for "the missing part" of her body. Furthermore, her hatred for her father could be viewed as either a reversal of unresolved oedipal desires or a possible expression of a negative Oedipus complex in which she never abandoned her mother as her primary libidinal object and hence saw her father as a rival.

For several reasons, however, I do not see these issues as especially relevant in this case. For one thing, the transference did not seem to have libidinal elements, either positive or competitive. Kohut writes (1971) that even a sexualized transference can mask a selfobject transference, which I believe was the case in the transference that Jane had towards Dr. Talbert. Secondly, occasional interpretations along these lines always failed to produce any associations. Nor were there any examples of such conflicts in her dreams. Furthermore, Jane appeared to improve despite the fact that the treatment did not really focus on any of these issues or potential aspects of pathology.

What did account for the improvement, in my opinion, was the selfobject relationship provided by the transference and the interpretations about the importance of both selfobject-like relationships and enlivening activities necessary to counteract her sense of depletion and emptiness. I believe that her central pathology was indeed a defect in the self. Both Jane's overeating and promiscuity had an oddly non-libidinal quality, and the two activities seemed to have virtually the same meaning to her. As Kohut has indicated in "The Two Analyses of Mr. Z." (1979), material that can easily be interpreted in a traditional manner takes on a different meaning when you closely examine the mood with which it is presented. In Jane's case, the lack of guilt and conflict as well as the sense of hollowness that accompanied her sessions were strong indicators that her pathology was not due to the deeply felt libidinal strivings of a vigorous self but instead the pathology of an empty self: "tragic man" rather than "guilty man" so to speak.

Reconstruction of Jane's early years also supports this view. Kohut (1977) maintains that the predominance of self disorders in the modern age may be due to the fact that family life today--unlike the intense overstimulating families of the Victorian era in which oedipal neuroses were so common--is characterized by fragmentation and understimulation. "The environment which used to be experienced as threateningly close," he writes, "is now experienced more and more as threateningly distant; . . . many children now seek the effect of erotic stimulation in order to relieve loneliness, in order to fill an emotional void" (p. 271). Jane's family certainly fits this description. With her mother consistently absent emotionally, and her father so often literally absent, there was little opportunity for overstimulation. Indeed, it appears that all the Vega children suffered from some understimulation or weakness of the self: Linda, as exhibited in her anorexic symptoms and thrill-seeking shop-lifting; Freddie, in his tortured insecurity and extreme reliance on his girlfriend; and, of course, Jane, in her constant search for both mirroring and targets for idealization as well as in her attempts to recover a state of self-cohesion through compulsive and addictive activities when selfobjects were not available.

Far from representing a valid "cure" however, this case history is only an example of some of the issues relevant to the psychology of the self and eating disorders. I think Kohut would agree that a complete analysis would be necessary to produce the real structural change, the integration through transmuting internalizations required for a healthy, vigorous self to predominate and for a truly rich and satisfying life to be possible for a patient like "Jane Vega."

Self-reports of Bulimarexics and Binge-eaters

What follows are the self-reports of bulimarexics and binge-eaters who are asked to describe their feelings during a typical binge experience. The individuals who provided this data, collected by Dr. Deborah Brenner, are all females, and all are members of the self-help group Overeaters Anonymous. It is possible to assume that, as members of this group, these subjects were distressed enough about their eating problems to seek help, and further that they had gained some insight into the nature of their difficulties through their participation in the program.

The excerpts that I will present will hopefully shed further light on these four aspects of the binge experience: (1) the feelings that initially stimulate a binge; (2) the details of what a binge can consist of; (3) the feelings experienced during a binge; and (4) the effects and aftereffects of a binge or a binge-vomit experience.

For some, the feelings that precipitate a binge are vague and difficult to describe. One woman writes, "the initial impulse to binge usually begins with some kind of overwhelming or panicking feeling." Others, while unable to specify precisely what their feelings are, report that they are frightened of them: "I feel I must eat because I want to be anesthetized . . . because I am frightened of what I'm feeling." Still others find their emotions are seemingly contradictory, as can be seen in the case of one woman who reports that "I usually feel very anxious and very bored." Another woman describes it this way: "I feel like I have to have something to fill in the space:

internal, of time, and of having something to do. I want and don't have so I'll eat . . . there is a knot in my stomach and food will make it go away."

For many of these subjects, the emotions that stimulate binging can include a broad range of negative affects: "I usually binge when I feel depressed or 'down' about something. If I feel sad, rejected, nervous, uncomfortable, angry or really any negative feeling, my first thought is to eating." Another woman writes that "when I binge, I feel (at the beginning) very fearful, anxious, almost unbalanced." Yet another provides a list of all the different precipitating factors she has experienced, including feeling "bored, lonely, rejected, depressed, unthinking, impulsive, unattractive, unloved, avoiding, anxious, compulsive, and angry."

These self-reports are very reminiscent of some of Bruch's patients. She describes (1973) the case of one girl whose "many episodes of compulsive eating were not due to hunger but what she called 'an unknown need--a feeling of being empty and panicky'" (p. 269). Not one of the subjects cited above list "hunger" as a motivation for binging, in fact. Indeed, I believe that the vagueness and variety of the emotions described can be attributed to the fact that, for someone with a fragmentation-prone self, almost any experience can set off what Kohut (1977) calls "disintegration anxiety." The emptiness, the boredom, the feelings of rejection or inferiority, on the one hand, represent the depletion of the self that is deprived of narcissistic libido; the anxiety, the fearfulness, the "panicky" feelings, on the other hand, correspond to the experience of

disintegration anxiety that occurs when the integrity of the self seems threatened.

Once the binge is set in motion, almost all subjects report that there is "no turning back." "At the moment when it 'clicks' in my brain, I feel that I am programmed to follow the ritual through to the end," says one bulimarexic. Often, a binge starts slowly (for some, binging can begin with a meal, such as dinner), but then gains momentum as it goes on, as can be seen in this lengthy report from a woman who says she binged and vomited daily for 14 years:

> When the urge to binge comes over me, it is totally irresistible. . . . I do try to resist for some time, but pain becomes so great that I finally give in, lately knowing full well that I must be pushing some devastating feelings down . . . I start small--always thinking/hoping it won't turn into a fullfledged gorging marathon. If and when it does, I find myself cooking up large potsful of things like rice, oatmeal, spaghetti . . . I start out trying to be neat . . . but the deeper I get into the binge, the more frantic a quality it takes on, and neatness is sacrificed . . . I binge at night, alone. The last time lasted about 5 hours, until 5 A.M. . . . Towards the end of the binge, it is mechanical. I've lost the desire to eat--but I am compelled to finish the entire pot of whatever I've cooked. . . . On this last binge I was exhausted, my jaws were actually aching from 5 hours of chewing, but I pressed on through the last of the oatmeal.

It is interesting to note the different kinds of foods that are consumed during binges. While some will literally eat anything they can find, it appears that most choose foods that have a distinctly "childish" appeal such as the woman cited above, who eats oatmeal and pasta. Many seem to concentrate on sweets and foods that have taken on a "forbidden" quality. Others develop preferences which can only be called bizarre, and as in the following case, are as preoccupied with the details of preparing the food as they are with eating it:

> I . . . eat chicken bones--pulling off the meat to discard, and orange rinds and a very limited amount of fruit cores. I prefer garbage to anything else by far. I want to spend unlimited time and energy with my food, making malteds with artificial sweetener and powdered milk--specifically weighed-out and used a tablespoonful at a time--creating an excruciating bloated feeling. I mix this hot concoction with frozen kool-aid or diet soda.

These activities, as we have seen, can often fill up many hours, and usually are so engrossing that there is no room for other thoughts, and especially, no feelings.

Indeed, it appears that for many, the binge produces a sense, as one woman put it, of being "blanked out." The feelings of emptiness and panic are usually diminished, and a kind of general numbing sets in. She continues, "there are really no coherent thoughts, or strong conscious feelings. I may try to read, but nothing registers. If T.V. is on, I can no longer follow the show." She writes that while the binge is "going on, I feel a sort of numbness--whatever was happening in my life is stopped, whatever I was feeling before the binge started has stopped." For some, the binge is initially the "ultimate form of fogging out, separating, and telling the universe to leave me alone so I can blot out and take a vacation." Another woman writes that while "when I begin the binge I feel relieved, . . . [but] as soon as I've gotten into it I get hateful of myself and others. I feel lost, demented, worthless, self-loathing, unattractive physically and as a person, not deserving to be alive, rebellious, defiant, revengeful, victimized, hopeless, helpless, and grandiose."

While for some the binge does soothe them and provide "a certain kind of security . . . a feeling of being safe, . . . none

of the comfortable, safe, secure feelings remain." In the words of another subject, "although I keep eating to try to satiate myself . . . (and I feel less lonely and somewhat comforted) . . . I am never able to reach a point of being totally sated." Indeed, almost all subjects report that the binge only temporarily wards off the painful feelings that precipitate it.

For some of the bulimarexics, the aftermath of a binge-vomit episode is worse than the prelude. Many feel most badly about the vomiting part of the sequence, knowing they are potentially damaging their bodies. Others, however, are relieved and even "proud" that they have the power to dispose of the hated calories they have consumed during a binge. "The vomiting is almost a cathartic release," says one bulimarexic. But as another writes, "when I'm all finished throwing up, I feel tremendously relieved, but not happy." Summing up her experience "following a binging/vomiting session," yet another woman writes that "I sometimes feel remorse and self-hatred, sometimes that I have gained strength to face the world from this, and sometimes relief that I was able to block the overwhelming feelings of inadequacy, self-hatred, and loneliness." It is probable, however, that most find, as another subject does, that "the bad feelings return the next day." Indeed, the binge-vomit cycle is one that bulimarexics tend to repeat endlessly (some many times in a single day), for although it has the power to temporarily relieve the negative feelings, it cannot provide real self-cohesion to an essentially fragile self.

Obviously, bulimarexics must differ from others who binge without vomiting. It seems likely that one difference is that these people attempt to counteract their helplessness in the face of their impulses to overeat by vomiting, and derive some false sense of control, not unlike anorexics do, from their ability to keep their weight down. Indeed, many authors (e.g. Bruch, 1973; Palazzoli, 1974; D. Brenner, 1980) feel that bulimarexia is almost a form of anorexia nervosa, or close to it. However Dr. Brenner found that bulimarexics more closely resembled obese subjects than they did anorexics, and I believe that the essential addictive experience for bulimarexics is not the vomiting but the binging. In fact, the vomiting affords one the option of continuing to binge while avoiding gaining huge amounts of weight, making overeating all the more possible. In any case, like all eating disorders, bulimarexia is an extremely powerful and insidious disease that can dominate one's whole life, making one feel totally helpless by its intensity. Many bulimarexics consider their binge-vomiting a horrible secret: "I . . . have occasionally not answered my phone because I was so ashamed of what I was doing." Most binging, in fact, isolates its victims, whose isolation and loneliness is often one of its primary precipitants. As this woman concludes, "When I binge, I feel very, very crazy--totally as if I can't control myself. It is one of the most painful experiences I can have."

Chapter VI

IMPLICATIONS FOR TREATMENT

"Emptiness is filled with love
by people who understand"

-1980 television commercial for
Overeaters Anonymous

If, as I have tried to show in this paper, pathological overeating represents an attempt to "fill in" a structural defect in the self, a defect that is often experienced as emptiness, then the logical implication is that the best psychotherapeutic approach to this problem is the kind of psychoanalytic treatment that Kohut advocates as being so effective in the treatment of disorders of the self. The basic technique of this form of treatment is the empathic relection of the patient's need for selfobjects as expressed in the mirroring and/or idealizing transferences. And, as we have seen, the working-through of the pathology occurs when the patient integrates, through transmuting internalizations, the functions that the selfobject provides into his own psychic structure, thereby making a healthy, vigorous self possible at last.

Obviously, I cannot make a recommendation so practically unfeasible as one that would suggest that all those people who suffer from addictive or binge eating seek out a "Kohutian" analysis. Nor are there any studies in the literature that I can cite to support the notion that this is the treatment of choice for eating disorders. However, what I propose to do in this chapter is both to explore

how the consistent failure of most treatment approaches as well as the rare success of a few may be related to the principles of the psychology of the self, and how Kohutian techniques are inadvertently applied in some of the successful therapeutic endeavors.

The Ubiquity of Failure

Perhaps one of the reasons why so many are contemptuous of overeaters and the obese is that the treatment could not be more obvious: eat less. As Bruch points out (1973), the energic principle that slimness requires that one expend more energy than one consumes has been well-understood since the age of the Greeks. Yet she writes that "this simple procedure often fails to be effective, so much so that doubt has been expressed about whether the laws of conservation of energy apply to obese people" (p. 310). Of course, these laws do apply to the obese, and the large percentage of those who suspect that their overweight has some physiological origin ("I have a slow metabolism") are almost always disappointed when they consult a physician (Bruch, 1973). Yet, overwhelmingly, the most commonly employed approach to the treatment of obesity has been one which stresses the mechanics of eating less and/or exercising more. New "diets" are being devised constantly, and, in fact, this has become a multi-million dollar industry (Time, February 21, 1972) which preys upon the vulnerability of the overweight. Surveying the literature of over 30 years, Stunkard and McLauren-Hume concluded that "the results of treatment for obesity are remarkably similar and remarkably poor" (1959c, p. 79).

Although most people who go on a diet will initially lose some weight, the vast majority will quickly regain it all (and sometimes more) (Bruch, 1952). There are several different explanations for this phenomenon. Schachter (1968) maintains that the "persistent findings that the obese are relatively insensitive to variations in the physiological correlates of food deprivation but highly sensitive to environmental, food-related cues, is, perhaps, one key to understanding the notorious long-run ineffectiveness of virtually all attempts to treat obesity" (p. 756). Bruch (1973) concurs with this viewpoint. Once the diet is over the environmental cues are still there, and a treatment procedure that does not address the distorted hunger awareness and eating habits that are common to almost all overweight persons is doomed to failure, in her opinion. Indeed, although she by no means asserts that all obese persons are neurotic, Bruch does see obesity in the majority of cases as a disorder whose origins are primarily psychological, and thus she is very skeptical about reducing programs that do not include some measure of psychological awareness. Because she views the basic problem of overeating as faulty self-awareness, Bruch recommends a second approach to its treatment, instead of the purely practical ones that advocate diet and exercise: a program which "attempts to effect a change in the person himself so that he no longer abuses the eating function in futile efforts to solve other problems of living" (p. 309).

Clearly, what Bruch advocates is a psychotherapeutic approach, but before I turn to an examination of the various forms of treatment this can entail, a brief comment about the treatment of anorexia

nervosa is in order. Bruch (1973) writes that "whatever the problems encountered during reducing of obese people they are insignificant in comparison to the panic and upheavals that surround the management of anorexia nervosa" (p. 327). Anorexia nervosa is an extremely grave, sometimes fatal, disorder, and its treatment almost always involves a lengthy stay in the hospital, according to Bruch, if only to regain physical health. Again, however, she insists that treatment programs that focus exclusively on getting the patient to eat and gain weight, without the benefit of understanding the underlying causes of the disease, are dangerously ineffective. And although she applauds the efforts and advances of investigators such as Palazzoli (1974) in the use of conjoint family therapy to treat this disorder, she believes that the essential defect in anorexia, like obesity, is one of self-awareness, and as such, requires individual treatment that focuses on the patient's denial and distortion of her internal experiences. Indeed, although Bruch sees family dynamics as extremely relevant to all eating disorders, she nevertheless concludes that the importance of internal dynamics is most crucial. She writes that, after all,

> [i]n anorexia nervosa the noneating is a very late step in an overall defective development. Some adolescents in the same predicament will resort to overeating as a defense against their sense of "emptiness" and "nothingness"; some will alternate between phases of bulimia and anorexia. The great majority adopt other ways and means that do not involve the eating function in their search for selfhood. (p. 376)

It is clear from this comment and many others, that although she may not realize it, Bruch is a "Kohutian," and the essential psychotherapeutic treatment she recommends is one that emphasizes the vicissitudes of the self.

Psychotherapeutic Approaches

There are many different treatment procedures that may fall under the heading of "psychotherapeutic approaches." Family therapy, mentioned above, has gained popularity in recent years, not only in the treatment of eating disorders (Palazzoli, 1974), but in general (Minuchin, 1974). Palazzoli has made an extensive investigation of the usefulness of family therapy with anorexics. She disagrees with Bliss and Branch (1960) who maintain that a psychotherapeutic approach is only necessary or effective in a minority of cases. On the contrary, like Bruch, she believes that it is crucial, and has reported very encouraging results with family treatment, but has rarely used this alone. Bruch is doubtful about the usefulness of family therapy in the treatment of severe eating disorders, however. She writes (1973), "I have not been able to convince myself that conjoint family therapy . . . offers advantages or is even feasible for these serious disorders" (p. 345). While the recent emphasis on families in the literature (Zakus & Solomon, 1973; Rosman, Minuchin, & Liebman, 1975) is consistent with Bruch's outlook that "intensive involvement with the parents, particularly with the mother, plays an outstanding role in obesity as well as in anorexia nervosa," she recommends that "therapeutic efforts . . . [should be] directed toward loosening these ties, with encouragement of the patient toward independence" (p. 344), a goal that family therapy can sometimes inadvertently undermine by continuing to encourage close involvement with the family. Bruch believes that family therapy is most important with younger patients who must continue to live at

home, but concludes that "[i]n severe eating disorders, the patient is not just 'a scapegoat' who could drop his symptoms when the patterns of family interaction change" (p. 345).

Another therapeutic technique that has been quite popular recently is behavior modification. Penick, Filion, and Stunkard (1971), for example, developed a program which involved encouraging the patient to take control over the various factors that influence his overeating. Thus, subjects were required to confine all meals to one specific place, and to count each mouthful during a meal, taking a break after every three bites. Once these techniques were mastered, then, weight loss became the specific goal of the treatment. The major emphasis appears to be on the development of awareness of bodily states and eating habits first, however, a recognition of the central importance of these defects in overeating behavior. While such training did result in more weight loss for the behavior modification group in contrast to a control group, no long-term follow-up figures were provided by these authors. As I said before, many can lose weight but few can maintain a weight loss. Bruch (1973) reports that she has used similar techniques, but the follow-up figures were very discouraging: "most had regained or surpassed their former weight. It was recognized that temporary control over food intake alone was not sufficient if there was not at the same time a valid change in personality structure and family interactions" (p. 319).

The most widely used procedure to effect personality change, of course, is individual psychotherapy. Most studies aimed at evaluating the effectiveness of psychotherapy have specified

psychoanalysis or a psychoanalytic approach, and Bruch's review (1973) concludes that "the literature on the value of psychoanalysis for the treatment of eating disorders is hopelessly inconclusive" (p. 336). While some maintain that psychoanalysis is totally useless (e.g. Kay & Leigh, 1952), others have reported surprising success (e.g. Rand & Stunkard, 1978). Rand and Stunkard (the latter having participated in the 1971 study advocating behavior modification, as cited above), said that they found "unexpectedly large weight losses reported by analysts for their obese patients, losses that compare favorably with the results of behavior therapy" (p. 550). Stunkard clearly differentiates between normal and neurotic obese individuals, however, and feels that psychoanalysis and psychotherapy are not necessary in cases where there is no disturbance of body image. He writes in another context (Stunkard & Mendelson, 1967) that only long-term psychotherapy can successfully improve a disturbed body image.

Buchanan (1973) also reports surprising success using psychoanalysis to treat obesity. His five-year study concluded that for most patients, "periods of compulsive eating become less frequent, more short-lived and tend to be corrected by periods of dieting so that the patient is able to stay much closer to his ideal weight than before therapy" (p. 37). Furthermore, he writes that "when many of these patients realized the extent of their personal problems, their obesity became much less important" (p. 37). Buchanan was also able to identify what he called a "narcissistic sub-type" among the patients in his study, and a pattern in which the weight loss alone does not

solve the underlying problem, but in which the patient then derives narcissistic gratification from some of the benefits of being a "dieter." So, for example,

> [t]he most successful Weight Watchers cures frequently become lecturers - a role which allows certain narcissistic needs to be gratified. The history of these patients may show a very ambivalent relationship with a mother who is thin, or attractive. . . . If one inquires about the girlfriends of such obese women one finds that they are usually slim and attractive, rather than obese. . . . Later in therapy when these patients become aware of their repressed narcissistic drives they fight with their former girlfriends and become openly competitive. (p. 36)

The author reports that "the 4 patients who made the greatest gains [from the treatment] . . . were those in whom the repressed narcissistic trends emerged and became sublimated" (p. 37).

Bruch's psychoanalytic treatment of patients with eating disorders began "in the optimistic expectation that 'insight' into unconscious conflicts and the symbolic meanings would lead to cure" (1973, p. 335). But she gradually began to feel that the classical psychoanalytic model, in which eating disorders are "conceived of as expressions of oral dependency, incorporative cannabalism, rejection of pregnancy, etc." (p. 335), was inadequate. She eventually developed a psychotherapeutic approach with an "emphasis on evoking a better functioning self-concept in the patient" which she likens to the methods that have become popular lately in the "treatment of schizophrenia, borderline states, or narcissistic disorders" (p. 335). Indeed, Bruch says that "I feel that obese and anorexic patients are singularly unresponsive to traditional psychoanalysis . . . psychotherapy must be modified to meet their personality problems . . . their lack of the sense of autonomy, . . . their disturbed self-concepts and self-awareness" (p. 336).

Bruch says that in spite of some of the insights her patients were able to gain when she used the traditional model, "some basic disturbance in their approach to life remained clouded and untouched, or was even reinforced in the traditional psychoanalytic setting where the patient expresses his secret thoughts and feelings and the analyst interprets their unconscious meanings. This represents in a painful way a repetition of the significant interaction between patient and parents, where 'mother always knew how I felt.' . . . 'Interpretation' to such a patient may mean the devastating reexperience of being told what he feels and thinks, confirming his sense of inadequacy" (p. 336). This viewpoint is very similar to Kohut's (1977) ideas on the development of self disorders in the children of psychoanalysts, whose parents always seem to know what they are feeling and thinking.

The kind of treatment that Bruch has found most successful in therapy of those with eating disorders is also very similar to what Kohut recommends for the treatment of disorders of the self. She advocates "the constructive use of ignorance" (p. 338, italics in original), not unlike Kohut's principle of "the naive courage of the observer," in which the patient takes the lead and the analyst attempts to communicate to the patient a feeling that he is being listened to, that "his own contributions are being treated as worthwhile" (p. 337). These patients are often literally unaware of themselves and their feelings; nor have they every experienced the sense that it was important that they know about these things. Patients with eating disorders, as we have seen, have often had their desires and needs subordinated to those of their parents, who have treated them as

narcissistic self-extensions. As a result, Bruch says the "therapeutic goal is to make it possible for the patient to uncover his own abilities, his resources and inner capacities for thinking, judging, and feeling" (pp. 338-339, italics in original), or as Kohut calls it, "the restoration of the self." Indeed, although she does not specifically refer to Kohut, Bruch herself recognizes the similarity of the form of therapy she has devised to treat patients with eating disorders to that of others: "the treatment approach I have described," she writes, "has been used effectively in many other conditions characterized by 'weak ego' or 'diffuse ego boundaries' or 'narcissistic character'" (p. 376). Through her method of listening and reflecting the patient's own internal state, she is essentially helping to build a cohesive self, the defect in which has led to what Bruch sees as "the fear of being influenced from without, or of being empty and ineffective" (p. 376), which is the hallmark of patients with both eating and self disorders.

Group Approaches to Treatment

In recent years, several group treatment organizations focusing on weight loss and overeating have gained prominence, the most famous of which is Weight Watchers. Essentially a self-help group, Weight Watchers is now a commercial institution, with centers all over the world, in which the members follow a prescribed diet plan and attend weekly meetings at which one is weighed, and applauded if weight has been lost (and sympathetically encouraged if it has not). However, because there is little emphasis on the psychological aspects of

eating disorders in this program, and because its members include people who are overweight for a wide variety of reasons, I will not focus on Weight Watchers here, but instead will examine another self-help organization, Overeaters Anonymous.

In contrast to Weight Watchers, Overeaters Anonymous groups are free, and their central focus is on the phenomenon of compulsive eating. Another difference is that psychological factors are considered central, and at meetings, instead of being weighed, members are encouraged to talk about their experiences. Nor is overeating considered to be the only problem by OA (as it is called); founded and based on the same principles as Alcoholics Anonymous, OA members essentially believe that compulsive eating is just a symptom of what is essentially a disordered life.

When a new member comes to OA, the first step is to admit that he or she (although mostly "she," for Millman [1980] suggests that over 90% of OA members are female) is powerless in the face of food and is a compulsive eater. OA members conceive of this problem as developmental and deteriorative, and like the AA attitude about alcoholism, this organization believes that the problem of compulsive eating can be arrested, but never cured. As in AA, a member of OA attempts to "abstain" from compulsive eating, "one day at a time."

Millman, a sociologist who has made a study of OA, says (1980) that it "delves into some of the psychological syndromes that many overweight individuals experience, particularly paradoxical feelings about personal control that are unrealistically excessive in some ways and markedly diminished in others" (p. 43). Most members

"come for the diet but stay for the program" (p. 33), as it attempts to do much more than help people lose weight. OA believes that the compulsive eater "preserves two mistaken ideas," according to Millman: "that she is capable of being perfect, and that she is in control" (p. 37). Like AA, OA has a list of "Twelve Steps" toward recovery, which are dependent on the idea that one must admit that one is not in control, but instead is dependent on "a Power greater than ourselves." Millman says that "OA repeatedly points out that the Higher Power is only what each member understands him to be" (p. 36). In addition, each new member (often called a "baby") is given a sponsor, to whom she must turn over a list of what she plans to eat the next day. It is understood, and in fact, repeatedly emphasized, that the sponsor is available to a member 24 hours a day. If one is having trouble abstaining, the sponsor is only a phone call away. In OA, "there is particular emphasis placed . . . on the importance of making sure a member is not left alone" (Millman, p. 45). During holiday times, which are considered particularly stressful, 24-hour marathon meetings are scheduled.

It seems to me that what OA accomplishes with these devices is the provision of "built-in" selfobjects to its members. Both the "Higher Power" and the sponsor are meant to function as external regulators of control--in fact, the members are encouraged to "surrender" to these external means of regulating themselves. Of course, for most compulsive eaters, this surrender fits the deep-seated need to fill in the structural self defect like a glove. Not only does their sponsor provide constant mirroring, but so do

one's fellow members, and there is an emphasis placed on "unconditional positive regard," the kind of acceptance that one ideally receives from the grandiose selfobject at a very early time in life. OA attempts to provide a kind of "corrective emotional experience" for those who have been deprived of this experience. Indeed, although I only attended one meeting (I quickly realized that the anonymity of the members, and the importance of everyone being equal as "confessed" compulsive eaters was sacred to OA), it was filled with the glow of mutual acceptance and warmth. As one member put it, "where else can someone look at two hundred or three hundred people they've never seen before and know there's not one stranger in the room?" (Millman, p. 44). Although most meetings are not nearly so large, the feeling of group solidarity is very important in OA, as it is in most self-help dieting groups (Allon, 1975).

I believe that the relative success of OA is due to this provision of "selfobject" sustenance to its members. Instead of turning to depressive, addictive eating in an effort to restore the integrity of the self, a member of OA can receive selfobject support by calling her sponsor, or attending a meeting (which are held at all hours, every day). During meetings, members often give testimonials on their progress (or failures, which are applauded just as much, if not more, since the person has exhibited strength and persistence by returning to a meeting). Often these women will tell their fellow members how their entire lives have changed, not just their eating habits. As one woman quoted by Millman said, "last year I was dead and today I am living" (p. 40). Do these changes represent real

structural change, as Kohut believes is necessary for those with self defects, or are they the result of the temporary bolstering that the self gets from this positive selfobject environment? As Millman says, "one might well ask whether the program isn't just exchanging different forms of compulsive behavior" (p. 35). Indeed, it is well known that some successful dieters can only maintain their weight loss at the cost of being constantly preoccupied with food and the details of their regimen. It is difficult to answer these questions, though I believe it is probable that in most cases, membership in OA does not provide structural change, and many "graduates" of the program feel the need to continue attending occasional meetings long after weight loss has been achieved and successfully maintained. However, I believe it is possible for some, whose compulsive eating may be the result of temporary, minor fluctuations in the strength of the self, to derive lasting benefits from a group like OA, particularly if one's sponsor is especially skillful and empathic. In any case, whether it provides lasting or only temporary results, it appears that OA is an organization that inadvertently, and in many cases quite successfully, applies the principles of the psychology of the self to the treatment of compulsive eating.

Acceptance: An Alternative to Treatment

As Bruch points out (1973), there are some people with severe eating disorders whose symptoms are used as a defense against psychological disintegration and psychosis, and for them, it is best not to encourage dieting. However, there is another group of

overeaters and obese people who are not necessarily neurotic and who have made a decision to accept their fatness and try to enjoy their lives in spite of it. Even though such people are not the main focus of this paper, I believe it is interesting to examine their position, because it appears that they have what most people with severe eating disorders lack: healthy self-acceptance and narcissism.

The idea that one might accept or even be proud of being overweight is a very new one to modern culture. For most of the twentieth century the only position on obesity was negative. Bruch (1973) believes, in fact, that "this hostile attack on weight as a shameful evil has contributed to overweight and obesity's becoming such serious health problems" (p. 386). Bemoaning the fact that there are hordes of young people who "waste their efforts and energies in trying to be thinner and slimmer than is natural for their body build or compatible with a healthy life" (p. 384), Bruch considers it "an amazing paradox that our society, with its emphasis on flexibility and liberal ideas, attempts to superimpose <u>one</u> form of body build" (p. 386, italics in original).

Lately, however, the obese have begun to fight back. Groups such as the National Association to Aid Fat Americans (NAAFA) attempt to reinforce their members' self-respect and dignity, as well as provide social opportunities (such as dances) that were once unavailable to them. Furthermore, fashionable clothes are now being produced by many designers in sizes that fit the obese, who in the past had to make do with matronly "tent-like" clothing, and overweight fashion models are in great demand. It seems that these

are very positive developments; as the "last" oppressed minority, some fat people have finally begun to assert themselves as never before. The existence of such groups and trends reinforces my observation that not all obesity stems from the compulsive eating precipitated by a self disorder. These people, who appear to have access to "healthy" narcissism, may have gained weight because they were nibblers, gourmets, or constitutionally pre-disposed to do so. In any case, they do not seem to suffer from the extremely painful syndrome which I have described, that denies one access to healthy, positive self-regard and a vigorous self enabling the individual to pursue a rich and active life.

Chapter VII

SUMMARY, CONCLUSIONS, AND RELATED TOPICS

Summary and Conclusions

In this paper I have endeavored to show that eating disorders and pathological overeating in particular are the symptoms of a structural defect in the self. The hypercathexis of the oral drive that is expressed in binge eating occurs when the cohesiveness of a fragile self is threatened by the loss of selfobject sustenance. In reaction to this threat, an individual experiences feelings of emptiness, depletion, and disintegration anxiety and he attempts to fill in the defect in the self, stimulating himself or soothing the anxiety through addictive eating.

To accomplish this task I have cited the relevant aspects of the literature of the psychology of the self and examined at length the support for Kohut's ideas that can be found in the eating disorders literature. Illustrating my hypotheses with a case history of a narcissistically disturbed patient, I explained the ways in which her compulsive eating and promiscuity were related to her central defect in the self. Also provided were excerpts from the written reports of bulimarexics and binge-eaters describing their emotional experiences during a typical binge, further illuminating the role of the self in this phenomenon. Finally, the implications for the treatment of eating disorders were explored, emphasizing the

the importance of understanding the role of the self and providing selfobject support to individuals who seek help for pathological overeating.

In examining whether or not I have succeeded in my task, the following question arises: why is the psychology of the self a more useful model in explaining this phenomenon than the classical psychoanalytic model? In other words, what is the evidence that suggests that the hypercathexis of the oral drive is motivated by disintegration anxiety, as Kohut suggests, rather than being a regression motivated by castration anxiety or a fixation based on the wish for a penis and/or child?

I believe that the bulk of the evidence is provided by the eating disorders literature itself, which taken as a whole, heavily emphasizes the role of the self (although not precisely in Kohut's language) in the pathological development of these disorders. Indeed, as the leading authority in the field, Bruch's central point is that both obesity and anorexia nervosa are based on faulty self-awareness and self-regulation, an inability to recognize and distinguish internal cues, and a sense of ineffectiveness. Her hypotheses have been consistently demonstrated by experimental procedures (e.g. Schachter, 1968). Furthermore, in describing the developmental aspects of eating disorders Bruch and others (e.g. Palazzoli, 1974; Goodsitt, 1977) repeatedly emphasize the fact that these children were not appropriately responded-to by their parents, a viewpoint that coincides exactly with Kohut's theory of the genetic origins of disorders of the self. Even though many of Kohut's metapsychological

formulations have been criticized by traditional analysts, most have accepted his ideas about the development of self pathology, as can be seen in this comment from Gediman's (1980) largely critical review: "when Kohut tells us that children who do not acquire internal structure because of sudden narcissistic trauma form a life-long object hunger and dependency, he is correct, clinically and developmentally" (pp. 508-509).

As we have seen, object hunger can translate into physical hunger (Burdon & Paul, 1951), a phenomenon that is particularly striking during adolescence (Steele, 1974). For those who develop eating disorders, the principle conflict is not a sexual one (Bruch, 1973). Kohut (1972) points out that "in certain adolescents the conflict about sex (the resurgence of incestuous sexuality) is paramount, while in others the danger of the dissolution of the self (the reactivation of earlier fragmentation fears) is the main problem" (p. 662). The latter group of adolescents are those who are in need of the self-stimulation or self-soothing that pathological overeating provides.

The question of how to explain the sex differences that emerge during adolescence remains, however. As I have said, the fact that eating disorders are so much more common in women than in men has largely been ignored in the literature. A classical analyst might suggest that penis envy is a likely unconscious motivation for some of the behaviors seen in eating disorders. But, if one views these disturbances in light of the psychology of the self, penis envy takes on a different position in our understanding of development, for Kohut writes (1975):

> I do not doubt the assertion that . . . it has an incidence of one hundred per cent. What I am questioning is that it is per se a significant factor in the major personality deformities encountered in women, that it accounts per se for disturbances of self-esteem encountered in women . . . or . . . that it is the essential motivating force that propels every girl towards womanhood. (p. 786)

According to Kohut, the girl's recognition that she lacks a penis is indeed an injury to her self-esteem, but it only takes on pathological proportions when it occurs in the context of an already insecure self: it grows "on a soil of broader and deeper narcissistic deprivations" (p. 791). Thus what may appear to be a central problem of penis envy may mask a much more central defect in the essential structure of the self.

It seems to me that the psychology of the self is also more relevant than classical theory to some of the more idiosyncratic aspects of eating disorders. For example, most binge-eating takes place in private, and is considered by the binger to be a shameful secret (see Chapter 5). Whereas Freud (1933) declares that in women "shame . . . has as its purpose . . . the concealment of genital deficiency" (p. 132), I believe Kohut's views on shame are much more helpful to the understanding of its meaning here. He asserts that shame accompanies the body-self preoccupation that is one of the effects of a "disintegrating" experience. Indeed, the well known self-consciousness of the obese about their bodies is understandable in Kohut's terms as one of the by-products of a self in which exhibitionistic libido is not well-integrated: "the shame of the adult . . . when a defective body part is looked at by others--indeed his conviction that others are staring at it!--is due to the pressure of

the unmodified, archaic, exhibitionistic libido with which the defective organ has remained cathected" (1972b, p. 632).

Another prominent feature of eating disorders that the psychology of the self is neatly able to account for is the extremely low activity level of the obese as well as the extremely vigorous activity of the anorexic. Indeed, Bruch (1973) says that in her experience the inactivity of the obese is an even more stubborn problem than their disturbed eating habits. This is not entirely due to large body mass, either; most overeaters, even if they are not obese, report persistent exhaustion and tiredness, despite the relatively low energy they are prone to expend. I believe that this is a by-product of the depletion of narcissistic libido in the self, just as Goodsitt (1977) has accounted for the compulsive activity of the anorexic as a defense against this depletion.

Indeed, chronic exhaustion was one of the main presenting complaints of the patient, Jane Vega, whose case history I provided in Chapter 5. This clinical data supplies many examples of the interface between overeating and self disorders. Depleted of narcissistic libido as a result of a central defect in the self, Jane compulsively pursued mirroring and stimulation in brief sexual encounters. When these failed to "fill in" the structural defect, she would typically turn to overeating. Developing and idealizing transference with her first therapist (Dr. Talbert) and subsequently a mirroring transference in her treatment with me (Kohut has pointed out that there is often a brief idealizing transference before the establishment of a mirroring one [1971]), Jane found her needs for mirroring and self-stimulation

were particularly intense when she was separated from the "selfobject" therapist, who functioned as part of her psyche as an external regulator of self-esteem.

Although many of Jane's symptoms may have appeared to be related to structural conflict there are several factors which mitigated against the diagnosis of this kind of pathology. Chief among them is the absence of guilt and conflict in her associations and dreams. Using an approach similar to the empathic-introspective method that Kohut recommends, I concluded from the "hollowness" in her sessions and my own countertransference responses that the central pathology was one of non-integrated grandiose-exhibitionistic fantasies, split-off and made unavailable by a repression barrier that was responsible for the emptiness and poor self-esteem that Jane experienced. This understanding was further aided by reconstructions of Jane's early family life which was characterized not by the overstimulation that produces oedipal neuroses, but by chronic understimulation, disappointments, and non-responsiveness on the part of parental selfobjects to Jane's developing selfobject needs.

The idea that traditional views of eating disorders are inadequate is further supported by the fact that the treatment of obesity has generally been such a dismal failure (Sash, 1977). Although originally a classical analyst, Bruch found through four decades of treatment experience that the interpretation of "unconscious" meanings of overeating and undereating was largely ineffective and unproductive (1973). Instead, she developed a method of therapy that is strikingly similar to Kohut's (1971) method of

treating narcissistic disorders: one that relies primarily on the empathic reflection of the patient's own internal state. Furthermore, I have suggested that the relative success of self-help groups like Overeaters Anonymous (whose members are all compulsive eaters, be they obese, anorexic, bulimarexic, or of normal weight) is due to an intuitive understanding of overeaters' needs for selfobject support and sustenance.

Naturally there may indeed be a type of overeater whose behavior is motivated by unconscious conflict and structural neurosis. However, I believe that the evidence I have cited here provides much support to Kohut's assertion that "in the majority of these cases . . . [pathological overeating] is . . . the depressive-disintegrative reaction to the unempathic selfobject milieu" (1977, p. 81).

The Question of Symptom Formation

Why do certain individuals with disorders of the self develop the symptom of pathological overeating and others do not? The fact that Kohut fails to provide a detailed theory of symptom formation (other than in his classification of such types as the under- and over-stimulated self) is one of the criticisms most often directed against him, and yet even Freud admitted he was somewhat baffled by the question of "choice of neurosis" (Bach, 1981, personal communication). And although Kohut suggests a comprehensive and eloquent explanation for the general formation of self disorders, he does not delve deeply into the examination of the specific symptoms (e.g. perversions and addictions) that often accompany them.

It is important to keep in mind, however, that self psychologists have not completely discarded Freud's sequence of libidinal development. Thus, for example, let me cite once again the elaborate account that Kohut gives of the interaction between drives and the self which is in statu nascendi during the anal phase:

> [i]f the mother rejects this self just as it begins to assert itself as a center of creative-productive initiative . . . or if her inability to the child's total self leads to a fragmentation-producing preoccupation with his feces . . . then the child's self will be depleted and he will abandon the attempt to obtain the joys of self-assertion, and will, for reassurance, turn to the pleasures he can derive from the fragments of his body-self. The adult's "anal character"--his penuriousness, for example--cannot therefore be adequately explained by references to his anal fixation or anal-retentive inclinations. (1977, p. 76)

He goes on to say that while there is an "anal fixation" it only becomes "fully meaningful" when seen as a function of the feelings that the self "was crumbling and/or empty" that were experienced during childhood, when he would try to "obtain reassuring pleasure from the stimulation of a fragment of his body-self" (p. 76).

As I mentioned in Chapter 2, this paradigm can easily be extended to the oral phase of development. During this time, when a rudimentary self is already in existence according to Kohut (1977), the interaction between the mother and the child often takes place around the feeding function. How the mother responds to the child's oral needs, and more importantly, how she responds to his need for a "food-giving selfobject" is crucially important. If she attends to the child's hunger to the exclusion of the needs of his "total" self, this too can lead to his turning to fragments of the body-self. The mother who is obsessively preoccupied with her child's diet and eating

habits is a familiar figure in our culture, as she is vividly personified in the character of Mrs. Portnoy in Philip Roth's novel Portnoy's Complaint (1969), which protrays a man whose compulsive masturbation and promiscuity lead him to seek analysis. While distorted responsiveness on the part of the selfobject during the oral phase in particular may result in an individual who resembles an "oral character," preoccupation with isolated functions during other phases may lead to different hypercathexes that are the reaction of a self that feels it is "crumbling and/or empty," as Kohut says.

Yet, one may ask, if Mrs. Portnoy was obsessed with the feeding function, why did her son develop symptoms that resemble those of a phallic-narcissistic character? For one thing, her distorted responsiveness may not have taken place during the oral phase. But inherent in this question is the essential difficulty in the problem of choice of neurosis. The best answer, in my opinion, is that any disturbance must be examined in light of the child's native capacities as well as the total selfobject milieu. So, for example, Portnoy tells his analyst that his father was obsessed with the anal function! Even a classical analyst would be at a loss to explain his symptoms unless he took into account the needs of an empty self for stimulation.

Whereas Portnoy is obsessed with sex, his sister overeats compulsively, and it may be that which body part or body function the self-disordered individual hypercathects may be different for men than women, regardless of the stage of development that was most traumatizing or inadequate to the building of a cohesive self. So, for example, Benedek (1936) writes that "female narcissism is always

retreating from the genitals, so its cathects the body as a whole. . . . In men, narcissism is concentrated far more on the genitals, specifically on the penis" (p. 53n). Perhaps, as Kohut suggests, when considered in the context of the psychology of the self, both penis envy and castration anxiety take on new meanings when viewed as "crystallization" points for a deeper and earlier narcissistic injury. There may be some women who develop the symptoms of eating disorders not because of selfobject failures during the oral phase but as secondary reactions to their general preoccupation with the adequacy of their bodies (especially their weight), which is the result of penis envy experienced in the context of an already fragile self, as we have seen. Mrs. Portnoy was not just an "orally overindulgent" mother; as a selfobject she was constantly overstimulating her son's narcissistic-exhibitionistic impulses while failing to mirror her daughter's.

Obviously, I do not mean to draw solid conclusions from a fictional case history written with a liberal dose of "poetic license." Nevertheless, this example illustrates the complexity of each individual case, which I believe is primarily responsible for the long-standing trouble that Kohut and many others have had in developing a detailed and specific theory of symptom formation that is easily generalizable to the incredible variation of the human experience.

Related Topics

As in the case of Jane Vega, a self defect can result in other addictions, in her case addictive promiscuity, besides overeating.

There are some people who seem to be addicted to love (Fenichel, 1945; A. Reich, 1953) and as Goldberg (ed. 1978) points out, an example of self pathology may be seen in the very common phenomenon of a woman who is only happy when she is "in love," or in the language of the psychology of the self, requires "a self-object relationship with an idealized man to maintain a feeling of inner stability and self-value" (p. 307). Indeed, the symptoms of self pathology are clearly visible in the most prominent addictions of our time: alcoholism and drug addiction (Wurmser, 1978). Ours has been called an "addictive" society, or more to the point, "the Culture of Narcissism" (Lasch, 1978). Kohut (1977) points to many signs of self-fragmentation in our culture, particularly in modern music and art. He believes all good artists are able to anticipate the dominant psychological themes of their society, and so artists such as Picasso began painting pictures filled with fragmentation, the feeling that would become so widespread in our time, decades ago. There are also expressions of self pathology in current artistic productions. The highly-praised novel Final Payments (Gordon, 1978), for example, portrays a woman in her thirties who suffers acute disintegration anxiety when the father she has lived with all her life finally dies. An empty depression ensues which propels her into an eating binge which lasts for several months, interrupted only by the intervention of an idealized priest. The film Ordinary People (1980) provides a splendid example of the interaction that Bruch describes in which an adolescent with an insecure sense of self has no awareness of her own internal states but says instead, "my mother always knew how I felt." In the scene I have in mind, a

teenage boy is sitting outside on a cold November afternoon, wearing no coat or sweater. His mother, portrayed as an extremely self-involved and narcissistic woman, suggests that he should put one on, and he responds, as if he really does not know, "do I need one?" The point that Bruch so often makes is that when one has been treated as a personal possession of a parent, one does not develop the capacity to know these things by oneself; the mother has to tell the child, because it is the mother who is imagined to own the child's body.

As another example of how the psychology of the self can illuminate social and cultural issues, Kohut has written (1976) about the power of charismatic figures as idealized selfobjects to lead large groups of people. One can speculate that Americans have been unable to find someone to serve this function since the death of John F. Kennedy, and perhaps it is because of this they have quickly disposed of every President since 1963 as a disappointing failure. The proliferation of different cults and organizations based on the power of a charismatic leader (Sun Myung Moon of the Unification Church, Werner Ehrhard of est, James Jones of the People's Temple, etc.) may also be an expression of an increase in the need for idealized selfobjects in a society that is progressively more fragmented. For those who turn to analysts and psychotherapists instead, more and more the complaint that they voice is the lack of zest, the absence of ideals, the chronic boredom that characterizes life for so many (Kernberg, 1975; Kohut, 1977).

Yet perhaps the greatest service that Kohut has performed with the development of the psychology of the self is that he has

taken narcissism "out of the closet." By asserting that narcissism is not only not pathological but that it is instead both healthy and desirable, he has made it more possible to understand that the self-centered person does not suffer from too much self-love but too little. Someone who is insecure about the cohesiveness of his self--indeed, not even certain that he exists, that he is fully alive--is necessarily unable to be a full and active participant in society, much less in his own life. By focusing on the needs of the self for an accessible fund of narcissistic energy and well-integrated ideals, Kohut has given us invaluable tools not only for the understanding of the prevalence of eating disorders, but also for the understanding of the general prevalence of emptiness in modern life.

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