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**Narcissistic
Psychosomatic
Disorders**

Psychology of the Self and the Treatment of Narcissism

Narcissistic Psychosomatic Disorders

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Narcissistic Psychosomatic Disorders

The psychosomatic approach may be defined as the study of the influence of emotional factors in any disease and the investigation of the coordination of somatic and psychological factors with each other. In the chain of causal events leading to certain illnesses, some of the links can only be described in psychological terms, and these are what we look for in psychosomatic studies. There are three types of influence of psychological processes on body functions, which constitute the three areas commonly studied in psychosomatic medicine: coordinated voluntary behavior, the motivational background of which can be described only in psychological terms; Darwin's (1965) "expressive innervations," the purpose of which are to bring about a discharge of emotional tension; and possibly adaptive responses which take place in the visceral organs, involving neither direct goals, conscious motivations, nor the immediate discharge of emotional tension. Cannon (1953) explained these responses as changes in the body economy under the influence of emotions and introduced the idea of an adaptive preparation for fight or flight.

For example, the wish to receive food, if sustained, has certain typical physiologic responses associated with it, such as the secretion of gastric juices. These responses become pathological only in situations of stored tension over a long period of time. Thus when no relief of the wish or from

the emotional problem or conflict by voluntary activity is possible, the organic difficulty begins to occur. When the voluntary behavior that would relieve the emotional tension never takes place—due, for example, to conflicts about this behavior—the perpetuation of the wish leads to organic pathology. This approach stresses the chronicity of the situation.

It is not necessary, however, to also postulate specific complex psychological drive-conflict constellations (Alexander 1950) in explaining each of the psychosomatic disorders. For example, narcissistic psychosomatic disorders may be defined as pathological, altered body conditions secondary to certain chronic narcissistic personality and behavior patterns. These patterns, like narcissistic personality and narcissistic behavior disorders, arise out of basic defects in the structure of the self which produce a state of chronic narcissistic disequilibrium superimposed on a faulty self-soothing apparatus. The patterns represent failed efforts at restoring narcissistic equilibrium, repetitive and chronic in nature, and accompanied by narcissistic rage secondary to the failures—which imposes an additional chronic burden on the already faulty drive-channeling and drive-controlling capacities and increases the disequilibrium, leading to a vicious pathological spiral and possible self-destruction.

Coronary Artery Disease

If we consider coronary artery disease as one example of a narcissistic psychosomatic disorder, we find a great deal of speculation in the literature but few hard facts. In reviewing a standard textbook such as Hurst et al. (1974), the consensus is that the arterial wall of the coronary artery reacts to a variety of stimuli and pathogenic influences; there are reversible elements in the atherosclerotic process. Thus the early fatty streaks and even the early uncomplicated atheromatous lesions have been shown to be reversible in animals and human beings. Coronary artery disease is a multifactorial disease involving genetic, environmental, and other factors, only some of which have been identified. The emotional factors at present are poorly identified and described in the standard textbooks as “minor risk factors.” Factors such as genetic familial history of premature coronary artery disease; elevated serum lipid levels; a diet rich in total calories, saturated fats, cholesterol, sugar, and salt; hypertension; diabetes mellitus; and cigarette smoking, are major risk factors which have been established by research. Obesity, sedentary living, personality type, and psychosocial tensions, are suggested but not established as risk factors.

The opposite point of view has been repeatedly expressed by Friedman and his co-workers in a series of publications. In the course of writing these works, Friedman et al. moved toward believing that personality type is the most important risk factor in coronary heart disease. In Friedman’s (1969) *Pathogenesis of Coronary Artery Disease*, a competitive behavior pattern is

seriously considered to be an additional risk factor: those individuals who have a highly competitive, aggressive, and hostile behavior pattern show a much greater incidence of coronary artery disease than less competitive individuals. Such theories were presented even by Osier in 1897, whom Friedman quotes on the worry and strain of modern life as a cause of early arterial degeneration. This view began to crystalize in Friedman's mind about 1955 when he began to observe the presence of certain traits in "almost every one" of our middle-aged and younger coronary patients.

The most salient description by Friedman (1969) of the "pattern A" is as follows: "a relatively *chronic struggle* to obtain an *unlimited* number of *poorly defined* things from their environment in *the shortest period of time* and, if necessary, against the opposing efforts of other things or persons in this same environment" (p. 84). This struggle is encouraged by the contemporary Western culture of narcissism; Friedman's emblem of such a person is "a clenched fist holding a stopwatch" (p. 85). It is important to differentiate this behavior type from the chronic or acute anxiety neurotic presenting with overt worry, fear, hysteria, or anxiety. The latter group of patients do not have an increased incidence of coronary artery disease, even though they perpetually worry about it.

This now named Type-A personality has been described so frequently (Hoffman 1984) that it is unnecessary to go into detail; furthermore, there is

no agreement—despite Friedman’s prodigious efforts—that Type-A personality is associated with increased coronary disease. For example, E. Friedman and Hellerstein (1973) disagree with the Type-A association and description and argue that their studies show that Type-A persons had a low incidence of coronary risk. Their coronary candidate is a phlegmatic or Type-B individual with low self-esteem! The subject is still surrounded by controversy, and more research is necessary (Moldofsky 1984).

The debate was brought to a fever pitch by Friedman and Rosenman (1974) and Friedman and Ulmer (1984), in which the theory is given as established fact: Type-A behavior is presented as the critical cause of coronary artery disease. The Friedman theory is not regarded by cardiologists as scientifically established.

Currently, there are *two* major approaches to the psychological aspects of the etiology of coronary artery disease. One approach stresses the nonspecific effects of intense psychosocial tensions, while the other claims there is statistical correlation between a certain type of personality and an increased incidence of coronary artery disease. A thorough review of the subject by Jenkins (1971) leads to some promising ideas. Jenkins hypothesizes that life dissatisfaction is a risk factor for coronary disease. Long-term struggle with persisting life problems, especially in a setting of fatigue, depression, emotional drain, is an equally suggestive etiologic factor;

the conceptual separation of “stress” and “dissatisfaction” is artificial. Jenkins regards the coronary-prone behavior pattern as an unsettled issue. He mentions that infarcts are often preceded by the loss of prestige (narcissistic wounding) which is reacted to by harder work. Angina patients are described as bursting with repressed resentment; Appels et al. (1979) stress that this aggression is turned inward when the narcissistically perceived environment cannot be controlled. Rimé and Bonami (1979) document a similar phenomenon, along with the disavowed exhibitionism of coronary patients.

The coronary-prone individual has been described by various investigators as a person who not only meets a challenge by putting out extra effort, but who takes little satisfaction from accomplishments. This young precoronary patient is restless during leisure hours and even somewhat guilty about relaxation. This individual rarely takes vacations and regiments leisure time with obligatory participation in assorted social, civic, or educational activities. Traditional psychoanalytic authors (Alexander 1950, pp. 72-75, Weiss and English 1957, p. 217) have viewed this pattern as a defense against deep regressive passivity. Their conception differs from Friedman’s concept of the Type-A personality. Alexander and Weiss and English stress unconscious guilt and counterphobic mechanisms in defining the coronary-prone individual.

Current studies emphasize the importance of hostility and point to the

stress of American-style contemporary urban life as major contributing factors in heart disease (Williams et al. 1980). Similar studies (Dembroski et al. 1985) suggest a somewhat more psychogenic rather than environmental etiology by documenting the depression, anxiety, tension, and repressed anger that coronary-prone individuals develop under stress. This is often associated with insomnia and a sense of being tired on awakening; we have here a person vulnerable to stress who is exhausted but not necessarily a Type-A personality.

Perhaps these two basic psychological points of view—nonspecific stress and personality type—could be combined by emphasizing the role of chronic stress. For a Type-A person, whose life is characterized by emotions of aggression, anger, and ambition, the usual stresses and strains of everyday life become highly magnified. A person who views these stresses from a narcissistic stance as constituting a never-ending flow of dissatisfactions and control battles to be won with a constant eye on the competition, will be coronary prone. At the same time, a person who is under tremendous chronic emotional stress for realistic reasons is similarly coronary prone. Both situations produce the state of emotional depletion in an overburdened self; exacerbate the tendency to drink excessive amounts of coffee and use other stimulants; and prompt the individual to use tension-relieving devices such as eating, smoking, and drinking with a corresponding inability to relax and enjoy unscheduled time, rest, and sleep. In all cases I am assuming that

genetic, dietary, and other etiologic factors are also implicated in this complex multifactorial disease.

A Self-Psychological Interpretation

The Type-A personality concept, utilizing conscious psychology, can be contrasted with a more psychoanalytic point of view based on the work of Kohut. Many of the characteristics of the coronary-prone individual are similar to Kohut's description of the narcissistic personality disorder. The lack of sense of satisfaction in accomplishments, vague and poorly defined goals, the sense of time urgency, and fierce competitiveness are typical of the individual with unresolved narcissistic problems and are explained by Kohut's formulations.

Friedman and Ulmer (1984) assert that, "insecurity of status (primarily arising from an inadequate or diminished sense of self-esteem), or hyperaggressiveness, or both, almost always serve as the initiating core causes for the development of Type A personality" (p. 43). This comes, they report, from "the failure of the Type A person in his infancy and very early childhood to receive *unconditional* love, affection, and encouragement from one or both of his parents" (p. 45). The lack of sense of satisfaction in accomplishments and the vague and poorly defined goals point in self-psychology to an unintegrated grandiose self and idealized parent imago with

resulting serious defects in the bipolar self. In such narcissistically damaged individuals, achievements can never match expectations—exactly as described by these authors (p. 78) for the Type-A personality.

Such individuals may suffer from profound narcissistic rage (Kohut 1978), which may become chronic. The demand for absolute control over a narcissistically experienced archaic environment and an unconscious boundless ambitious exhibitionism bring the individual into constant collision with the outside world and other people. Furthermore, since the aims and grandiose goals of the narcissistic personality are relentlessly motivated by the split-off grandiose self, there can never be any lasting satisfaction of these vague, endless, and boundless needs. (We all meet such individuals in clinical practice.)

The ego increasingly cedes its reasoning, modifying, and organizing capacity to the task of rationalizing the persistent insistence on exhibitionistic success. In extreme cases, failures and weaknesses are attributed to the malevolence and corruption of uncooperative individuals outside of the self, instead of acknowledging the inherent limitations of the individual. At worst this becomes a chronic quasi-paranoid condition. In most instances reality testing is preserved, but when narcissistic rage is blocked, Kohut suggests it may shift its focus and become directed either at the self, with the consequence of a self-destructive way of life and depression, or at the soma,

in which a psychosomatic disease can develop, or both.

Given the appropriate risk factors such as genetic predisposition, cigarette smoking, a high fat diet, and elevated blood pressure, which commonly accompany such ambitious driving activity, the life characterized by chronic narcissistic rage can produce coronary artery disease in the way that has been described in all the previous studies. The difference in the self-psychological point of view is that it contradicts the implied hopefulness of the outcome of the behavioral change methods suggested by Friedman and his co-workers (1974, 1984). If a person has a narcissistic personality disorder and is unconsciously fixed on unceasing efforts to achieve grandiose ambitions, attain omnipotence, and act out boundless exhibitionism, it is not possible to hold all this in check by common sense reasoning, self-control, and conscious mental exercises. Even if one deliberately curtails one's behavior, the chronic narcissistic rage continues unabated at an unconscious level. The conflict is driven underground by inhibiting the acting-out of the rage and the narcissistic aims that have produced the surface diagnostic manifestations labelled Type-A. Only the secondary effect on the body physiology, such as that from too much work and not enough rest could be eliminated in this conscious deliberate way, but the underlying narcissistic rage continues unabated with powerful unrelieved narcissistic tensions. Because it is important to eliminate the secondary effects also, nothing can be said *against* the behavioral approach of Friedman or of Carruthers (1974). It remains

questionable how effective this approach would be in the prevention of coronary artery disease.

Long-term life dissatisfaction and the inability to receive refreshment from social and leisure activities, as well as the frequent finding that coronary artery disease is preceded by a setback in work involving a loss of prestige (narcissistic wounding) and reacted to by even harder work, is explained by positing an underlying narcissistic personality disorder. This offers a much sharper dynamic explanation; chronic loss or failure of narcissistically perceived archaic self-objects has occurred, with the concomitant production of profound narcissistic rage. The rage also explains the obvious disregard of the Type-A individual for a self-destructive way of life. In reviewing a study comparing small samples of patients with angina and rheumatic heart disease, Jenkins (1971) reports that the authors judged the patients with angina to be profoundly angry but attempting to repress it or to use compulsive defenses; other authors also found “well-controlled aggression” to be correlated with coronary disease risk factors (Jenkins 1976).

The narcissistic personality disorder and subsequent narcissistic rage is common to a variety of ways of living that have been described as highly correlated with coronary artery disease. I (1976) have expanded and tried to dramatize this view in a recent book. Conscious efforts to change these ways of living and behaving will be most useful in reducing the secondary effects on

an unhealthy life style, but the basic disorder remains. The effect of chronic narcissistic rage, even if it is not acted out, on the development of coronary artery disease reduces our hopefulness that conscious change of life-style could somehow be a major factor in the prevention of this disorder or in the reduction of morbidity.

Further evidence corroborates this point of view, since it is common for victims of heart attacks to return to their previous way of life, gain weight, and often resume cigarette smoking. This is true despite efforts by the physician and the patient's family to prevent it, and indicates an unbearable underlying unconscious narcissistic disequilibrium, driving the patient to death.

Patients who go back to a self-destructive life-style after a myocardial infarction are urgently in need of intensive psychotherapy, just as much as patients with a severe narcissistic personality disorder. The internist or general physician who watches a postmyocardial infarction patient gain weight, resume smoking, and go on with the previous behavior has an obligation to confront the patient with the fact that the emotional disorder is life threatening, and to recommend intensive psychotherapy.

Adult Eating Disorders

I will now examine adult eating disorders as a second example of

narcissistic psychosomatic disorders. Goodsitt (1985) similarly has applied self-psychology to a study of classical anorexia nervosa. Narcissistic rage which stems from the failure of early self-objects produces a variety of the features of adult eating disorders, including migraine (Friedman and Ulmer 1984), adult temper tantrums, self-destructive activity, paranoid proclivities, body-image disturbances, and compulsive rituals. Such rage floods a defective self-soothing apparatus, and the patient regresses to eating disorders in order to gain temporary relief and to counteract threatened fragmentation of the self (Chessick 1985b). Psychoanalytic psychotherapy of these disorders requires a combination of modalities, but insight into what has happened and into the unconscious narcissistic fantasies, which differ in each individual case and determine the particular disorder pattern, is required consistently for lasting changes in the patient's lifestyle.

For example, a patient dreams that she, her husband, and her little girl plant a garden. The patient's parents visit and the garden grows nicely, but the mother will not go out to look at it. Father is a depressed man who after much coaxing does go out to the garden and take a look, and says rather indifferently, "That's nice." Then, however, father becomes happy and cheerful because the patient gets her little girl to eat a pizza. This is from the dream of an obese woman with a psychotic mother, who was saved from a totally depleted self by her usually depressed father who would brighten up substantially when the patient would eat. Neither the father nor the mother

had much interest in any of the natural developmental or growth experiences of the patient.

Weiss and English (1957) remind us that some families are quite “oral” in their orientation to life. A treat for such a family will be a good meal rather than creative work or play. Everything about the offering and receiving of food is endowed with a high emotional value.

Kolb and Brodie (1982) and Shainess (1979) point out that the development of obesity often occurs in a family setting in which the parents compensate for their own life frustrations and disappointments through the child; the mother is the dominant family member and holds the obese child by anxious overprotection, including pushing food. She frequently has high expectations for the child’s achievement in order to compensate for the failures of the parents. The obese child is one who has passively accepted the indulged role without rebellion, and has been taught to substitute food for love and satisfaction. This also produces the psychological situation Kohut (1971) labels the “vertical split” in the narcissistic personality disorder, as diagrammed by Kohut (1971, p. 185); openly displayed infantile grandiosity is related to mother’s narcissistic use of the child’s performance.

Hamburger (1951) described four different but closely related types of hyperphagia. One group of his patients overate in response to nonspecific

emotional tensions such as loneliness, anxiety, or boredom. Another group overate in chronic states of tension and frustration, using food as substitute gratification in unpleasant life situations over long periods. In a third group, overeating represented a symptom of underlying psychopathology, most frequently, an empty depression. The final group, in which overeating took on the proportions of an addiction, was characterized by a compulsive food craving unrelated to external events, and thus was driven by an unconscious chronic narcissistic disequilibrium.

Numerous descriptive typological reports on emotional disturbances among the obese have flooded the literature. The better the study, the less the evidence for distinctive psychological features. Stunkard (1980) described the negative body image in obese persons, who characteristically complain in psychotherapy that their bodies are grotesque and loathsome and that others view them with hostility and contempt. The obesity of persons who were obese in childhood (so-called “hyperplastic obesity,” “juvenile-onset obesity,” or “developmental obesity”) differs from that of persons who became obese as adults (“hypertrophic obesity”). The juvenile types tend to be more severe, more resistant to treatment, and more likely to be associated with emotional disturbances. However, Stunkard (1975) and others disagree with the common notion that “middle age obesity” develops slowly and gradually; actually it occurs in a series of weight spurts, as each stressful period in middle age is accompanied in predisposed persons by excess eating.

Although many obese persons report that they overeat and gain weight when they are emotionally upset, Stunkard (1975) explains that it has “proved singularly difficult to proceed from this provocative observation to an understanding of the precise relationship between emotional factors and obesity” (p. 777). Obesity at a later stage often becomes a rationalization for failure and the attitudes of overweight persons toward themselves are complicated by the current Western cultural distaste for obesity, especially in women (Wooley and Wooley 1980).

Numerous authors have reported that the obese child becomes filled with grandiose daydreams as daily defeats in major aspirations are suffered. These fantasies are either conscious or disavowed and they differ from the psychotic because the obese person is aware that they are unreasonable. In the psychoanalytic treatment of adult obese patients, Ingram (1976) reports how these expansive and narcissistic features emerge coincident with weight reduction. In some cases, overeating appears protective against an incipient psychosis; such patients may develop a psychosis when they undertake to lose weight by vigorous dieting.

OBESITY AS AN ADDICTION

Stunkard (1975, 1980) describes about 10 percent of obese persons, most commonly women, as manifesting a “night-eating syndrome,”

characterized by morning anorexia and evening hyperphagia with insomnia. A “binge-eating syndrome” he says is found in about 5 percent of obese persons, characterized by sudden compulsive ingestion of large amounts of food in a short time, usually with great subsequent agitation and self-condemnation. In these two syndromes, a mere 15 percent of obese cases, it is allegedly easier to outline psychodynamics involving orality and ambivalence. Yet Bruch (1973) claims that in her experience such night-eaters are rare and binge-eaters are more common.

This leaves a large majority of obese persons in whom the disorder seems to be more subtle. In this large group that is described as “food addicts,” patients have used food as a substitute for defects in psychic structure. Overeating has become an indispensable part of their life pattern and vigorous weight reduction exposes them to unbearable tensions. Vigorous treatment aimed at weight reduction alone seldom is successful and even if successful is seldom maintained for very long. Frosch (1977) places these patients among the “character impulse disorders,” emphasizing their intolerance of tension or frustration based on developmental interference with their capacity for “anticipation” and confidence.

Psychoanalytic recognition of food addiction goes back to Rado (1926), who also coined the important concept of “alimentary orgasm”; the arguments for obesity as representing an addiction to food are updated and

reviewed by Leon (1982). Common observations and reports of obese patients about eating show that Rado's notion of the relatively slower and longer lasting "alimentary orgasm," a diffuse feeling of well-being that extends throughout the organism, complete with a sense of repose and a faraway look in the eyes, can indeed serve as a short circuit for avoiding sexual and more complex adult interpersonal intimacies. Clinical experience also confirms his contention that "a long series of foods and delicacies can be worked out, forming a regular gradation from ordinary foods up to pure intoxicants" (Rado 1926, p. 37n). I (1960) have investigated the drug end of this gradation and the "pharmacogenic orgasm". Woollcott (1981) presents a more recent discussion of this, emphasizing the "basic fault" which leads to a "fusion-individuation conflict," in some ways similar to the pathology of the borderline patient.

A SELF-PSYCHOLOGICAL EXPLANATION

In discussing the addict Kohut (1971) writes:

His psyche remains fixated on an archaic self-object, and the personality will throughout life be dependent on certain objects in what seems to be an intense form of object hunger. The intensity of the search for and of the dependency on these objects is due to the fact that they are striven for as a substitute for the missing segments for the psychic structure. . . . [The mother of the addict] because of her defective empathy with the child's needs . . . did not appropriately fulfill the functions . . . which the mature psychic apparatus should later be able to perform (or initiate) predominantly on its own. Traumatic disappointments suffered during

these archaic stages . . . deprive the child of the gradual internalization of early experiences of being optimally soothed, or being aided in going to sleep, (pp. 45-46)

In his last book, Kohut (1984) called attention to the obese Bismarck, who was enabled to reduce his “cravings” for food, wine, and tobacco by a Dr. Schweniger, who for 15 years functioned as a substitute self-object. Kohut bases this on a report by Pflanze (1972); this report does not indicate whether Bismarck actually lost weight after Schweniger entered his life. At any rate, Schweniger was at the same time an intuitive therapist and a medical charlatan who had been dismissed on a morals charge from the medical faculty at Munich—but as a therapist he did know what to do for Bismarck.

In the language of the psychology of the self, self-object failures of a traumatic degree during the day lead to increasing disintegration of certain sections of the self, which were experienced by Bismarck especially at bedtime as “oral cravings” that took on the character of a drive. Kohut argues that such an individual, giving up on self-objects, turns to stimulation of body zones for inner cohesion and a sense of being alive. The addictionlike intensity however is not due to a drive, says Kohut, but due to the intense need to fill a structural defect. It only succeeds for a moment and builds no structure, so it is like eating with a gastric fistula. Schweniger was able to replace the food, wine, and cigars, and to function as a sustaining self-object

for Bismarck, sitting with him as Bismarck went to sleep, much in the manner a parent sits with a child. When he had succeeded in achieving this self-object transference, Schweniger found himself indispensable to the Bismarck household for 15 years.

Bruch (1973) described “reactive obesity,” in which overeating serves as a defense against deeper depression. A variety of authors such as Cantwell et al. (1977) have linked the eating disorders to depression; some hopeful reports (Pope et al. 1983) on the treatment of these disorders with antidepressant medication have recently appeared. Overeating in these patients represents a self-soothing effort to prevent disintegration to more profound archaic experiences that are repressed and associated with the current depressive affectual situation.

In Krystal’s (1982) view these archaic experiences were often actual infantile disasters such as “colic, eczema, feeding, or sleeping difficulties” which are “covered over by a conspiracy of silence, related to the shared wish to undo the common misfortune” (p. 598). Thus overeating protects the patient against basic, disintegrating, massive affect states of a primitive archaic nature that threaten to develop if the current stress situation continues unabated. In self-psychology, overeating would be said to protect against fragmentation of the sense of self.

BULIMAREXIA

The syndrome of bulimarexia, a binge-purge cycle, has become popular (Casper 1983) among patients mostly in the teens and twenties. The syndrome can appear at any age and approximately 5 percent of those who suffer from it are male. During the binge there is a sense of loss of control and guilt; during the purge, a restitution, catharsis, and reinforcement of the sense of control. Underneath all of these eating disorders there lies, in the language of self-psychology, a nameless preverbal depression, apathy, a sense of deadness in an empty depleted self, and diffuse chronic narcissistic rage. In my clinical experience the massive rage generates either paranoid fears or self-hatred with a distorted hateful self-image, migraine, temper tantrums, or any combination of these, similar to the pattern in the borderline patient. It may also appear as a curious relentless compulsive ritual, devoid of pleasure, in which the patient eats up everything in sight.

In all these patients, Bruch (1973, p. 100) points out, the fatness is only an externalization of the conviction of ugliness on the inside. A patient reported:

I eat to feel, to get some sensation as opposed to no sensation. When you have done you are uncomfortable, but that is a feeling. Also I make myself fat, I think, to mirror how I feel inside about myself—it broadcasts a message that says, "Love this ugly person as I am." It fits with my lack of trust in people and says, "I'll make it hard for you if you want to be nice to me."

We may regard this quotation in the light of Laing's comment (Chapter 6) about how projection represents an attempt at self-mirroring. From the psychology of the self point of view, projection in these cases, whether in fantasy or actualized, can be understood as giving up on the self-object and attempting to achieve the desperately needed mirroring, attention, and soothing. In our culture a fat person is indeed noticed, albeit in an unflattering manner. Becoming fat and thus making oneself the object of derogatory notice could be thought of as the actualization of a projective fantasy where individuals imagine that everyone is looking at them with hostile intent.

The dramatic eating disorder, whether through "alimentary orgasms," masochistic infliction of self-starvation or unpleasant compulsive stuffing, or the binge-purge guilt and restitution cycle, drains off the rage and paranoia and focuses the patient's attention from the empty depleted self and onto preoccupation with gastrointestinal tract sensations. In this manner some sort of sense of being alive is maintained. On top of the depleted and fragmented nuclear core, the patient has built various protective rituals and self-soothing activities which sometimes permit the patient to function in society.

NARCISSISTIC RAGE

At the same time, the patient must deal with the massive narcissistic

rage or (as it is traditionally called) the unconscious sadism. For example, Offenkrantz and Tobin (1974) discuss these patients as “depressive characters” and emphasize the great unconscious rage at important objects who are not providing the patient with what is unconsciously felt to be needed. Rage often is turned on the therapist. Under this lies an “anaclitic depression” characterized by depletion and a hopelessness that sufficient gratification will ever be possible.

Glover (1956) in a landmark study in 1932 also placed less emphasis on fixation in the oral stage and viewed addiction as a transition state between psychotic and neurotic phases, serving the function of controlling sadism and preventing a regression to psychosis, or fragmentation. Labelling the addictions “circumscribed narcissistic neuroses,” he writes that the patient’s rage

together with identifications with objects towards whom he is ambivalent, constitute a dangerous psychic state . . . symbolized as an internal concrete substance. The drug is then . . . an external counter-substance which cures by destruction. In this sense drug-addiction might be considered an improvement on paranoia; the paranoid element is limited to the drug-substance which is then used as a therapeutic agent to deal with intrapsychic conflict of a melancholic pattern, (p. 208)

In this form of “*localizing* paranoid anxiety” as Glover calls it, adaptation is enabled to proceed, and the differences in choice of substance from the more benign, like food, to dangerous chemicals are postulated by Glover to be

related to the degree of archaic sadism.

There is no reason for this postulate about choice of substance, because food can certainly be conceived of by the patient as destructive and totally noxious. This is best illustrated in a play by Innaurato (1977), *The Transfiguration of Benno Blimpie*, a nightmarish account of a grotesquely fat and lonely 25-year-old man, who relives the humiliating events of his life while preparing to end it by eating himself to death. Benno, who spent his childhood eating, daydreaming, and drawing, says, "Paintings, you see, aren't enough. When loneliness and emptiness and longing congeal like a jelly, nothing assuages the ache. Nothing, nothing, nothing." As the narcissistic rage erupts in the drama he depersonalizes and plans, "When I become so fat I cannot get into his clothes, and can barely move, I will nail the door shut. I will put his eyes out with a long nail and I will bite at himself until he dies" (Scene 8, pp. 16-17). At the end of the play, Benno prepares to mutilate his body with a meat cleaver.

ADULT ANOREXIA AND ANOREXIA NERVOSA

Patients suffering from anorexia have been separated by Dally (1969) into three subgroups; various authors (Wilson 1983) have stressed the heterogeneity of this syndrome as a "final common pathway" for many disorders. Anorexia, like obesity, can appear in clinical practice in a large

variety of ways. One group purges and induces vomiting; another group shows impulsive self-destructive behavior including suicide attempts, self-mutilation, and alcoholism; still another group achieves the desired end of thinness by dieting alone.

The psychodynamics of anorexia in young women have long been thought to include the impairment of development arising from an early unsuccessful mother-daughter relationship. The adolescent girl, faced with feminine individuation and threatened by the loss of dependency on the family, responds to the conflict in these cases by regression to an infantile maternal relationship with unconscious craving for blissful eating experiences. This is denied in the subsequent perpetual drama of an oscillation between eating and severe dieting; the pursuit of thinness usually represents an act of hostile and defiant compliance by the patient against the mother.

Bruch (1975) has repeatedly stated that anorexia nervosa is more akin to schizophrenic development or borderline states than to neuroses. She admits that depressive features deserve special evaluation and may indicate a true depression as the primary illness, but maintains that the disorder expresses “the underlying despair of a schizophrenic reaction” (p. 802) and recognition of the underlying potentially schizophrenic core is essential for effective treatment. In my clinical experience, an important difference

between classical anorexia nervosa, which appears suddenly in early adolescence, and the usually less lethal anorexia developing in adult patients is that in the latter, the core is depressive rather than schizophrenic and the clinical material points to Kohut's descriptions of the empty depleted self and narcissistic rage.

Most traditional psychodynamic formulations concerning the cause of anorexia have centered around the phobic response to food resulting from the sexual and social tensions generated by the physical changes associated with early puberty. But even in 1945 Fenichel (1945) stated that anorexias developing in adult life "may have a very different dynamic significance." He explained that anorexia may represent a simple hysterical conversion symptom expressing the fear of an orally perceived pregnancy, or of unconscious sadistic wishes. It may also be part of an ascetic reaction formation in a compulsion neurosis, may be an affect-equivalent in a depression (in which the symptom of refusal of food makes its appearance before other signs of the depression are developed), or may be a refusal of any contact with the objective world and thus point to an incipient schizophrenia.

Fenichel comes a long way from any simplistic formulation of anorexia, at least in adults. He mentions a case reported by Eissler which illustrates that anorexia is thought of as "only one symptom of a general disturbance of all

object relationships.” Fenichel writes that Eissler’s patient “had not gone beyond an extremely archaic stage of ego development. The mother ‘remained the most important part of the patient’s ego.’ The refusal of food represented the longing for the primary, still undifferentiated gratification by the mother and its sadistic distortion after frustration” (p. 177). The conceptualization here is closer to that of Kohut, but 25 years earlier.

A Self-Psychological Approach to Adult Eating Disorders

There are two general kinds of functional disturbances in the third area of psychosomatic medicine mentioned at the beginning of this chapter. One of them consists of unwanted physiological changes caused by the inappropriate use of the function in question, which Fenichel labels an organ neurosis. The other kind of disturbance has a specific unconscious meaning, is an expression of a fantasy in “body language,” and is directly accessible to psychoanalysis in the same way as a dream. The term “conversion neurosis” is usually reserved for this category. A certain percentage of organ neuroses actually are affect-equivalents; they represent the specific physical expression of a given affect without the corresponding conscious mental experience. For example, anorexia in some cases is an affect-equivalent of depression as recent studies (Cantwell et al. 1977, Casper and Davis 1977) demonstrate.

In most cases of adult eating disorders a pathological discomfort—

narcissistic disequilibrium—rooted in unconscious problems generates a certain behavior, which in turn causes somatic changes in the tissues. The person's behavior of dieting, overeating, or oscillation between the two was initially intended to relieve internal pressure stemming from this narcissistic disequilibrium; the somatic symptom forming the consequence of this effort usually was not originally sought by the person either consciously or unconsciously. Later, these body changes of fatness or thinness may be worked into the solution and become a central preoccupation.

Fenichel (1945) also mentions a paper by Wulff written in 1932, describing a “psychoneurosis” seen more in women and related “to hysteria, cyclothymia and addiction” and characterized by a fight against pregenital sexuality. Sexual satisfaction is conceived of as a “dirty meal.” Periods of depression in which the patients stuff themselves and feel “fat, bloated, dirty, untidy, or pregnant” alternate with “good” periods in which they behave ascetically, feel slim, and conduct themselves either normally or with some elation. The alternating feelings of ugliness and beauty and the oscillation in the body feelings seem to be similar to the feelings before and after menstrual periods, and also may have an exhibitionistic component. But Fenichel, like many traditional psychoanalytic authors, vacillates between conflict interpretations using traditional psychodynamics and his intuitive clinical knowledge that such interpretations are not sufficient to explain the compulsively addictive aspects of these cases.

Following Rado, Fenichel describes “an oral-erotic excitement” involved in eating; the food addictions are unsuccessful attempts to master guilt, depression, or anxiety by activity, but no explanation is given as to how this works. Eating disorders for Fenichel become what he calls “character defenses against anxiety,” in which certain basic infantile conflicts are mastered by working them out over and over again in terms of food.

Bruch (1973, 1974, 1975, 1979, 1982) developed her own therapeutic approach to eating disorders, but her concepts have the same sense of generalization about them as the old classical psychoanalytic formulations. She recognizes a problem involving self-esteem, narcissistic rage, depletion, and depression in these patients as well as a narcissistic power struggle with the parents, but she depends on interpersonal theory, using a Sullivanian approach.

Bruch (1979), in discussing anorexia nervosa, admits, “Relatively little is known how this changeover takes place, from what looks like ordinary dieting to this inflexible self-destructive but hotly defended fixation on weight and food” (p. 76). But Kohut (1971) described stages of fragmentation of the self in severe borderline and schizophrenic patients where there is a reconstitution of the self with certain parts of the body deattached and viewed as useless; such patients may indeed even cut off part of the body at this point. It is not hard to see how a fragmentation of the self in adolescents

and adults can lead to a similar reconstitution where the useless part of the body self is the body fat. Bruch (1979) points out from her vast clinical experience how many anorexics spend time looking in the mirror over and over again “taking pride in every pound they lose and every bone that shows. The more pride they take in it, the stronger the assertion that they look just fine” (p. 82).

Severe anorexia can be thought of as a pathological reconstitution of the fragmented self where a part of the self becomes split off and utterly divested of libido in order to permit a shallow reconstitution of the rest; this decathected part is represented by the body fat which is then viewed as useless, unwanted, and in need of being severed. Indeed, maintaining reconstitution of the self may require a continuing and dangerous severing of this useless body fat representing the unwanted part of the self, which would explain the persistence with which these patients starve themselves as well as their rigid negativism toward treatment. If they are force-fed, they may commit suicide.

Severe pathological anorexia represents, as Bruch says, a grotesque mirror image of obesity. She maintains also that both are related to faulty hunger awareness. This leads to Bruch’s claim that the lack of awareness of living one’s own life is of fundamental significance to the development of severe eating disturbances. In my clinical experience, this curious sense of

being ineffective or being a child in an adult world is characteristic of patients with eating disorders.

A clinical feature I emphasize, as in the “case” of Benno Blimpie, is not given so much prominence by Bruch: that of the deep inner emptiness, chronic narcissistic rage, and consequent paranoid proclivities in such patients. Yet Bruch (1973) reports a case of a fat student nurse who was hospitalized for an acute schizophrenic episode and was observed to eat ravenously whenever she had an argument or felt threatened. Her explanation was that she was afraid that the hostility of others and their angry words would rattle around inside her and keep on wounding her. “By stuffing herself with food she would cover her sore inside, like with a poultice, and she would not feel the hurt so much” (p. 92). The deep intrapsychic dynamics involving cycles of introjection and projection or alternatively Kohut’s concept of the depleted nuclear self and its disintegration products are omitted in Bruch’s formulations.

The eating disorders protect the patient from unbearable affects which then appear if the eating disorder is stopped. The extremely negative self-image and self-hatred—or in Kohut’s terms the depleted self with the disintegration product of narcissistic rage—precede the development of obesity, as emphasized by Stunkard and Burt (1967), Powers (1980), and many others. This intrapsychic psychopathology forms the foundation of the

various adult eating disorders, which then develop when the narcissistic tension becomes unbearable and the faulty preoedipal self-soothing system becomes overwhelmed. The self then threatens to fragment or actually does so, as in *The Transfiguration of Benno Blimpie*.

As a clinical illustration, we may take Bruch's (1973) description of "thin fat people," borrowed from Heckel—who warned us already in 1911 that the loss of weight by a fat person does not represent a cure by itself. Indeed the patient may show much more serious psychopathology when the weight is lost, and the battle may shift to an attempt to keep from gaining weight by an obsessive preoccupation with maintaining a semistarved appearance that is so popular among fashion models in our culture. These dissatisfied people are still representatives of an eating disorder. Their compulsion with staying excessively slim is a common clinical sequel in cases of obesity treated with various forms of behavior modification or other symptom-focused therapies. These therapies have converted a miserable fat person into an even more miserable thin person, and in both cases the person is compulsively preoccupied with eating. Usually these adult patients do not progress to a malignant state of anorexia nervosa, but reach a certain miserable stability in their thinness.

The narcissistic aspects of adult compulsive eaters or dieters are especially striking along with their very low sense of self-esteem, conviction

of inadequacy, and compensatory fantasies and daydreams of “astounding grandiosity” (Bruch 1973). Obese patients often show a curious “all or nothing” attitude, so that when confronted with the fact that their unlimited aspirations are not obtainable, they are apt to give up, lay around at home, and grow fatter! In clinical work with such patients it is dangerous to allow the patient to assume that, if psychotherapy is successful and they achieve thinness, it will somehow lead to the realization of their grandiose expectations. This sort of attitude is greatly reinforced by advertising.

The inability of such patients to follow a diet acts as a safeguard against putting their narcissistic fantasies to the test of reality. As long as they are fat, they feel that they have it in their power now or in the future to set everything right by losing weight. Their basic psychological problems do not come into full awareness until they have lost weight. Remaining fat is an important defense against facing their own narcissistic psychopathology. Rigid dieting may precipitate a psychotic reaction or a profound depression. During the psychoanalytic treatment of schizophrenics, Federn (1947) observed that the psychosis was sometimes precipitated by intentional weight reduction.

In my clinical experience no patient has substantially reduced weight and maintained weight reduction without experiencing an extremely difficult and painful process. The inhibition of activity in obese persons is a more

fundamental aspect of the disorder than the overeating. Lack of activity expresses a disturbance in the total approach to life and manifests, as Bruch (1973) puts it, “a real lack of enjoyment in using one’s body, or a deep-seated mistrust of one’s ability of mastery” (pp. 314-315); in Kohut’s terms it is a representation of the empty depleted nuclear self. Thus the known value of exercise in weight reduction has to do with the reversal of a lifelong pattern of passivity, emptiness, daydreaming, and inactivity.

“COMPULSIVE” EATERS

The group of fat people who are compulsive eaters represent, as Hamburger (1951) pointed out, an important subgroup of eating disorders. These patients seem unable to let unfinished food alone; they must compulsively finish everything. They are acting out a ritual of pleasing somebody else, a ritual which hides a deep, narcissistic rage. Either the anxious, over-controlling parent insists that food is precious and sadistically demands the consumption of every bit of food that the parent provides, or the spouse—on whom the patient is pathologically dependent—has a deeply neurotic need to see the patient eat everything in sight. These patients are compulsively repeating a pattern that brought them mirroring approval from the vital self-object in the past in order to maintain a false self, which is less unbearable than fragmentation and rage. The role of compulsive rituals in controlling aggression is predominant. Other patients compulsively eat only

selected foods such as sweet rolls or ice cream, etc. In these patients there seems to be a combination of an organ neurosis and a conversion disorder; I have been able in some cases to trace the specific food to a vital association with the longed-for parental self-object.

Psychotherapy of Eating Disorders

Pernicious familial interference with reducing regimens can be expected. In the case of children and adolescents it is the parents who undermine the dietary regime, and in the case of married people it is frequently the spouse who has an unconscious vested interest in keeping the patient fat. This may come to the point where the therapist has to insist that other members of the family go into treatment if the case is to be successful. Every kind of ancillary support group such as Weight Watchers or TOPS, as well as medical supervision of diet and exercise, should be encouraged (Ingram 1976).

It does not follow from any of this however, that the eventual understanding of the unconscious meaning of the disorganized eating patterns through traditional methods is a mistake. But a traditional psychoanalysis based on drive psychology runs the risk of ignoring all that has been learned about such disorders. Self-psychology oriented psychotherapy, in an approach with which even Bruch (1974, 1979, 1982)

would agree, concentrates first on the building of structures: “an attempt to repair the conceptual defects and distortions, the deep-seated sense of dissatisfaction and isolation, and the conviction of incompetence” (Bruch 1979, p. 143). This type of therapy focuses secondarily on interpretation and is consistent with Fenichel’s characterization of most eating disorders as organ neuroses rather than conversion neuroses.

The most serious problem in intensive psychotherapy of the eating disorders is not that of a schizophrenic loss of reality testing, but of a deep empty depression in a defective nuclear self, often with core paranoid fragments, manifested clinically by a derogatory self-image, cynicism, and hopelessness. Profound narcissistic rage also begins to show itself as the eating disorder is corrected. Thus, a long and difficult intensive psychotherapy is to be expected because we are dealing with a deep preoedipal disorder characterized by severe early structural defects in the nuclear self. The best clinical measure of basic change in these patients is in the reduction of their derogatory body image distortion (Garner et al. 1976, Casper et al. 1979, 1981).

Paranoid distortions and fuzzy reality testing need to be corrected by careful attention to the current realistic situation. As Bruch (1973) writes, “They suffer from an abiding sense of loneliness, or the feeling of not being respected by others, or of being insulted or abused, though the realistic

situation may not contain these elements. The anticipation or recall of real or imagined insults may lead to withdrawal from the actual situation and flight into an eating binge” (p. 337). Even their confusion of body image is complicated (Powers 1980), combining inaccurate perception of actual size or shape with an unrealistic negative self-appraisal often consolidated in adolescence.

Such patients tolerate a silent psychoanalytic therapist poorly. The therapist, as Basch (1980) points out, must, at least at the beginning of treatment, be willing to participate with the patient in discussion of the details of the patient’s current situation. At the beginning of therapy the patient must experience the therapist as practically useful and helpful in getting the patient to explore the details of and the solutions to the problems of everyday living. Krystal and Raskin (1970) call this “facilitating the establishment of a benign introject,” in which the therapist is used “to create an object-representation which they can utilize for inspiration and achieving a major change in their identity and function” (p. 106). In other words, an idealizing transference must be allowed to form. If this early phase of psychotherapy is properly traversed, an addictive transference to the therapist forms, resembling the narcissistic self-object transferences described by Kohut, and the intensive psychotherapy shifts increasingly into an interpretive psychoanalytic mode.

COUNTERTRANSFERENCE PROBLEMS

The most serious countertransference problem encountered in the intensive psychotherapy of eating disorders is also understandable in self-psychological terms as described by Gunther (1976). The deep, empty depression in these patients produces a painful sensation of disequilibrium in the therapist, as the latter's normal liveliness, enthusiasm, and human investment in the patient are met repeatedly by a silent and depleted response or narcissistic self-preoccupation. This constitutes repeated narcissistic disappointment for the therapist over years; any therapist who works with eating disorders must have ample independent sources of emotional supply and empathy and be free of the temptation to turn to patients for gratification, soothing, or narcissistic massage. As the weight problem begins to correct itself patients become "worse" as the anger, despair, projective proclivities, and intolerance of any frustration or humiliation shows itself more and more in the interactions with the therapist (Ingram 1976).

Therapists may deal with their narcissistic disequilibrium and consequent narcissistic rage at these patients by a reaction formation, becoming a replica of the overanxious parent and shifting to a so-called supportive treatment due to excessive projective concerns about the patient's fragility. The patient thus gains control of the therapy and leads the therapist

on a merry chase by threats of suicide, psychosis, or extreme fluctuations in weight. Because of the typical projection fantasy of these patients, as reported by Offenkrantz and Tobin (1974), that “the therapist needs the patient to become abstinent in order to alleviate the therapist’s own sense of inner emptiness, lack of pleasure, and craving for relief,” careful, continuing self-analysis is required to prevent externalization (Chessick 1972a) of this fantasy. Consultation with colleagues is often helpful.

The therapist in the intensive psychotherapy of these disorders is often called upon to decide when recommendations of outside medical help, groups, and even anxiolytic drugs are necessary. Danger arises when these aids are advocated due to countertransference disappointment, anger, and frustration, rather than in the service of the patient’s need. If this occurs, the patient re-experiences empathic failure with the “food-stuffing mother.” Conversely, withholding these when they would be appropriate is also a destructive manifestation of countertransference; careful self-analytic investigation on each occasion is required.

When the patient must take realistic steps to change her or his life-style, the previously compliant and cooperative patient begins to show a tough capacity to engage the therapist in a bitter struggle. The willingness of the therapist to enter into this struggle and still maintain an empathic and analytic interpretive stance is probably the crucial factor that determines

whether the treatment will succeed. As Nacht (Chessick 1974) said, analogous to Kohut's (1984, pp. 15-16) statements about early parental self-objects, the therapist's comments are not as important as what kind of person the therapist actually is.

It is extremely difficult for the therapist to maintain empathic contact with and a deep inner sense of commitment to an extremely disturbed patient who is only very slowly responding to the treatment, and whose eating disorder seems fixed. At the same time, the therapist must resist the temptation to soothe himself or herself by adopting a supportive or messianic role. A test is made of the therapist's skills, capacities, training, and personal analysis, as demonstrated in the case of severe anorexia treated by Mintz (Wilson 1983).

In the narcissistic psychosomatic disorders, the defective self-soothing mechanisms must be repaired by appropriate self-object transferences and transmuting internalizations. The patient must be enlisted as a partner in order to develop better reality testing and a new life-style based on a stronger functioning ego, developed both through appropriate interpretations and the establishment of a more cohesive sense of self (Chessick 1985b).

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