“OX HUNGER”: PSYCHOANALYTIC EXPLORATIONS OF BULIMIA NERVOSA

Lynda Chassler, Ph.D., B.C.D.

ABSTRACT: Bulimia, a term derived from Greek words meaning “ox” and “hunger,” is a food obsession characterized by repeated overeating binges followed by purges of forced vomiting, prolonged fasting, or abuse of laxatives, enemas, diuretics and amphetamines. It provides temporary relief to emotional pain. If untreated, bulimia causes serious medical and dental problems. In this paper, I first present an overview of the historical development of bulimia nervosa as a clinical entity and then explore the syndrome from a psychoanalytic perspective, focusing on the Freudian drive-conflict model, the pathology of early object relations, and attachment theory. A case is presented and treatment implications are discussed.

KEY WORDS: bulimia nervosa; psychoanalytic concepts; binge-eating; purging.

INTRODUCTION

Bulimia, a term derived from Greek words meaning “ox” and “hunger,” is a food obsession characterized by repeated overeating binges followed by purges of forced vomiting, prolonged fasting, or abuse of laxatives, enemas, diuretics and amphetamines (Merriam-Webster’s Medical Desk Dictionary, 1993), and “inappropriate compensatory methods to prevent weight gain, influenced by body shape and weight” (DSM IV, American Psychiatric Association, 1994).

In comparing bulimia nervosa to true anorexia nervosa, the basic psychopathology is similar; both display a morbid fear of fatness. The anorectic patient will starve and the bulimic patient, who can only maintain starving for a limited period, eat and purge. In both, the body weight is reduced below optimal level. In anorexia this is extreme, whereas in bulimia this is less extreme. The conditions differ in regard
to the frequency of amenorrhoea and the level of sexual activity and the preservation of fertility. In anorexia, menstruation and fertility are suspended, and most patients show a marked arrest or loss of sexual activity.

Bulimia nervosa begins when a person turns toward food for comfort, relaxation, and escape. It provides temporary relief to other problems such as fear, frustration, rage and emotional pain. The binge begins because a person feels low, often rejected, and turns to food almost as a narcotic. His or her mind is filled almost constantly with thoughts of food with resulting impairment of concentration. People with bulimia deal with the overwhelming guilt after the binge by purging. The purge means they are able to maintain their normal weight. Most patients describe the urge to overeat as different than hunger. As one bulimic patient stated, “Hunger is a void inside you, and you eat to put an end to that void. I keep on eating until I am stuffed so I can fill an emotional need.”

The frequency of binge eating can vary from 2–3 to as often as 10–14 times per day with a consumption of up to twenty thousand or more calories. The bulimic patient categorizes foods into two groups: (1) Those that don't produce weight gain and can be retained (e.g., fruits and vegetables, and (2) those foods that have to be thrown up (e.g., sugars, starch, fats, oils, cakes, bread, pasta, rice, beef, butter, and cheeses). The typical binge consists of a consumption of high caloric foods and vomiting begins as necessary unpleasantness which evolves into a sensual, addictive muscular convulsion.

Bulimia nervosa, if untreated, causes serious medical and dental problems. Chronic purging results in potassium depletion, causing fluid and electrolyte imbalances which can create life threatening conditions, such as cardiac arrest and kidney failure. Other medical complications include urinary infections, epileptic seizures, swollen salivary glands, and gastrointestinal problems, such as a ruptured stomach or esophagus. Dental complications include increased caries, gum recession, enamel breakdown, and general dental breakdown due to increased vulnerability to hydrochloric acid.

Bulimia typically begins in adolescence or the twenties, but its onset can occur at any age. The majority of bulimics are female who are affected at a rate of approximately 9–1 (Gordon, 1990, p. 41). Gordon (1990) stated that the prevalence of bulimia is closer to 10%–20% of the female population. As noted in DSM IV, 1%–3% of adolescents and young female adults have the bulimic disorder.

Bulimia, as has anorexia, has increased throughout the western world and has been described not only in North America, but in England, France, Germany, and Japan. Evidence has been accumulating over the past ten years that bulimia nervosa is on the rise (Strangler &
Printz, 1980). In an inquiry specifically designed to determine the prevalence of bulimia nervosa using summer school students, Halmi, Falk, & Schwartz (1981) reported that 13% of a student population of 355 had experienced all of the symptoms of bulimia as defined by DSM-III (1980) criteria. Numerous studies suggest that bulimia is probably between five and ten times as prevalent as anorexia nervosa.

Bulimia nervosa is a complex illness, and the assumed causes reflect the interaction of biological predisposition (Johnson & Conners, 1987), intrapsychic conflict (Sperling, 1949, 1968), family (Humphrey & Stern, 1988; Igo-Gaifbaum, 1985), social factors (Bruch, 1986; Palazzoli, 1978), disturbed interpersonal relationships (Garfinkel, Moldofsky, & Garner, 1980), interpersonal sensitivity (Johnson, Stuckey, Lewis, & Schwartz, 1982), and social isolation (Johnson & Larson, 1982).

How biological factors affect the development of bulimia is unclear. Endocrine abnormalities observed among bulimic patients appear to be mostly side effects from behavior and are easily reversible. The relationship of bulimia to affective disorders has received the most attention. While several lines of evidence have been offered to support the idea that bulimia may be a symptom of a biologically mediated affective disorder (Johnson & Conners, 1987), this relationship remains controversial.

Bulimia began to manifest itself in the 1970's, concurrent with the increase in anorexia nervosa, and was associated with the same set of factors that were associated with the increase in anorexia; namely, an increasing obsession with thinness and appearance and the pervasive confusion associated with a changing female role. Authors (Bruch, 1986; Palazzoli, 1978) noted that women are becoming more competitive with men, when previously they were confined to the traditional "at home" role of wife and mother. Younger with severe personal self-doubt and uncertainty choose the fashionable edict to be slim as a way of proving themselves as deserving respect.

In recent years bulimia nervosa has also been considered from the angle of the family as a system. An unstable family environment of the bulimic patient is characterized as being disengaged, chaotic, and neglectful. Conflict and hostility are apparent, but open expression of this conflict is not encouraged. The families are detached and isolated with a de-emphasis on independent/assertive behavior. From an object relations perspective, integrating D.W. Winnicott's (1965) construct of the "Maternal holding environment" and M.Klein's (1975) formulation of ego deficits at the level of part-object relations to the entire family system, Humphrey & Stern (1988) suggested that families in which a member has been diagnosed with bulimia there are transgenerational developmental deficits and adaptations that determine the level and quality of
intrapsychic experience within individuals, as well as the interpersonal relationships and dynamic functioning of the larger family system. In these families there is a tension between unmet individual needs and equally or more powerful family system needs that require individual self-sacrifice. Igoin-Apfelbaum (1985) assessed family background characteristics in 25 bulimic patients. This author found the proportion of broken homes significantly higher than in a population of 25 overweight patients without bulimia also undergoing individual psychotherapy. Finding a sharp discrepancy between the actual family failings and the wish of patients to maintain their "family unit" fantasy, Igoin-Apfelbaum hypothesized that the occurrence of bulimia may be related to the combination of a history of violent separations or threats of violent separations.

The purpose of this paper is to assist the practicing clinical social worker who wants to understand and implement a psychoanalytic approach in the treatment of bulimia nervosa. First, I will present an overview of the historical development of bulimia nervosa as a clinical entity. I will then explore the bulimia nervosa syndrome from a psychoanalytic perspective, focusing on the Freudian drive-conflict model, the pathology of early object relations, and attachment theory.

THE DEVELOPMENT OF BULIMIA NERVOSA AS A CLINICAL ENTITY

A review of the anorexia nervosa literature suggests that bulimia as a symptom has been known throughout the past century (Rahman, Richardson, & Ripley, 1939; Venables, 1930; Waller, Kaufman, & Deutsch, 1940). The case study of "Ellen West" (Binswanger, 1944) constitutes the first and the most carefully documented example in the literature of the bulimia nervosa syndrome in a partially remitted case of anorexia nervosa. Subsequently, other cases of bulimia nervosa have been documented (Bliss & Branch, 1960; Bond, 1949; Nemiah, 1950).

Boskind-Lodahl (1976) dubbed the term "bulimarexia," suggestive of the link between anorexia and bulimia. This phase was not widely adopted. It was condemned by Bruch as a "semantic monstrosity." Bruch had been aware of a non-anorexic obsession with thinness. However, she saw it as occurring in a formerly overweight person who shared the typical anorexic obsession with thinness. She adopted the phase thin-fat person. Russell (1979) published the first systematic investigation of bulimia as a distinct eating disorder which he labeled "bulimia nervosa" (p. 429) to indicate its kinship and yet its difference from anorexia nervosa. Russell noted that it would be premature to think of the disorder as a distinct syndrome. He saw bulimia as related to anorexia nervosa and
the majority of the patients he studied had experienced a previous typical episode of anorexia.

Because the symptoms of bulimia may appear in individuals with no history of weight disorder (Casper, Eckert, Halmi, Goldberg, & Davis, 1980; Russell, 1979) and in the obese (Stunkard, 1959), the question arises about whether it should be regarded as a distinct diagnostic entity. Lacy (1982) suggested that the bulimic syndrome at normal body weight is heterogeneous and that at least three clinical forms exist, although the underlying pathogenesis is similar. The syndrome seems to be rooted in the psychological, social, and biological concepts of female sexuality.

A PSYCHOANALYTIC PERSPECTIVE

The Freudian Point of View

Freud (1899) wrote on psychogenic vomiting in his letters to Fliess, describing the underlying fantasy as oral impregnation. Freud delineated the self-punishing aspects of vomiting along with its function as a drive-defense compromise formation. He wrote:

Do you know, for instance, why X.Y suffers from hysterical vomiting? Because in phantasy she is pregnant, because she is so insatiable that she cannot put up with not having a baby by her last phantasy-lover as well. But she must vomit too, because in that case she will be starved and emaciated, and will lose her beauty and no longer be attractive to anyone. Thus the sense of the symptom is a contradictory pair of wish-fulfilments (p. 278).

The image in childhood thinking from which this symptom elaborates, wrote Freud (1908), is that through eating and through a kiss one gets a baby. Eating has become erotically appealing. The blending of current oral incorporative mechanisms with active oedipal-genital wishes reflects (Freud, 1905) the child's wish to eat and thereby conceive father's baby. From a Freudian or classical perspective, the bulimia nervosa syndrome is interpreted as representing a displacement and regression from genital wishes. The symbolic significance of the binge eating is noted and the activity of bulimia is viewed as a "compromise product of conflict and stresses the role of the genitalization of the oral cavity" (Schwartz, 1986, p. 446). Schwartz further noted that to the child and to the unconscious, food is the paternal phallus; ingestions conceives the oedipal baby. The incorporative act of eating/gorging contains the desire for abdominal distention and impregnation. The expulsive act of vomiting desexualizes the receptive wish.
The Pathology of Early Object Relations

Psychoanalytic views of gorging as an attempt to merge with the engulfing maternal object and of purging as a rejection of this "bad" object have been extrapolated from theories of anorexia and applied to the syndrome of bulimia. Bulimia is interpreted as the simultaneous enactment of conflicting wishes for merger and autonomy. Sperling (1949, 1968) saw food as the semi-symbolic equivalent of the oral mother. Consequently, a number of psychoanalytic writers have viewed the bingeing-purging syndrome of bulimia nervosa as a concrete expression of the introjection-projection struggles of early infancy. Jessner & Absne (1960) using the pre-representational imagery of pathological splitting, saw the adult bulimic patient as longing for oral mothering while at the same time compelled to get rid of the introjected mother as it becomes poisoned by the rage of frustration.

In describing the psychodynamics underlying anorexia nervosa, Palazzoli (1978) has hypothesized that, in an attempt to separate and individuate from a sadistic "bad introject" which becomes fused with the body self, the adolescent ruthlessly controls her own body to the point of self-starvation. Palazzoli (1978) wrote, "The body is experienced as having all the features of the primary object as it was perceived in a situation of oral helplessness: all-powerful, indestructible, self-sufficient, growing and threatening" (pp. 86–87). From this perspective, the anorectic patient experiences an intrapersonal paranoia and experiences the body as a persecutory object that must be controlled.

Elaborating on the theme of Palazzoli, Sugarman and Kurash (1982) view bulimia as a "primitive ego boundary disturbance" and have offered a developmental model which emphasizes object relations and cognitive dimensions. The essential premise of Sugarman & Kurash is that in bulimia, the body becomes a transitional object, a vehicle for the representing of the maternal object and then the repudiation of her. These authors have traced the bulimic problem to developmental arrest of the practicing subphase of the separation-individuation period when the infant begins to physically and cognitively separate from the maternal object. This leads to a narcissistic fixation on one's own body at the expense of the use of external transitional objects. Specifically, bulimia reflects an arrest at the earliest stage of transitional object development which has profound consequences as regards self-other boundary differentiation, individuation, and the capacity for symbolization. To regain the experience of the needed object, the person with bulimia needs concrete bodily action to evoke a representation of self and mother. In the bingeing of the bulimic patient, the bodily action is to regain a momentary experience of the mother; food is not the issue. The terror of engulfment evokes vomiting, another bodily action.
Adolescence, for the bulimic patient, reactivates the important earlier practicing subphase issues of: (1) disturbances in body self; (2) disturbances in object representations; and (3) the lack of libidinal object constancy and the capacity for evocative memory. Therefore, the body becomes the playground for concrete play of separation because individuals with bulimia lack the ability to utilize transitional phenomena. Because of the preoperational nature of the bulimic patient's thinking, his and her body is not experienced like the mother's, but as the mother's body. For the person with bulimia, the function of the bingeing-purging is to maintain the tenuous self-other boundary. The majority of transitional objects gradually lose meaning. However, for the person suffering from bulimia nervosa, the body remains the central focus.

Similarly, Woodall (1987) argued that bulimia is a problem of separation-individuation, based on analysis of self-statements by bulimic and anorectic adolescents and older women. It is suggested that bulimic patients by their use and abuse of food are attempting to make food a reliable transitional object as a way to undo the mother's frightening unreliability. It is noted that the characteristics of transitional objects are also features of the bulimia nervosa syndrome. Barth (1988–89) argued that college women who have failed to resolve early conflicts over separation-individuation and who have not yet developed a stable sense of self, are not psychologically prepared to meet the demands of the college experience. They develop bulimia as a way of coping with problems of separation-individuation, self-esteem, and intimacy. The college years especially for traditional age students, present pressures to complete certain developmental tasks. Students from pathological families are unprepared to complete these tasks and develop bulimia as an effort to cope (Provost, 1989).

The personality functioning of people who have been diagnosed with bulimia has been looked at from divergent theoretical perspectives. While it has been difficult to connect personality disorder and eating disorders directly, several investigators have reported an increased prevalence of histrionic and borderline personality disorders (Levin & Hyler, 1986; Yates, Sieleni, Reich, & Brass, 1989). Johnson & Conners (1987) have successfully differentiated between eating-disordered patients who present borderline characteristics, false self/narcissistic characteristics, and neurotic characteristics. They found that the key feature for bulimic borderline patients is parental underinvolvement that is experienced as malevolent neglect. It has an intentional or aggressive quality that contributes to the sadomasochistic tendencies of these patients who tend to internalize the detachment of the caretaker as a sign that they are unlovable, worthless, and deserving of punishment. They tend to self-mutilate, to punish themselves, using their bodies as the concrete representation of their selves. Self-mutilation also serves to
avoid depersonalization. This group of bulimic patients attempt to use the paranoid defense of the anorectic restrictor but over time they have to take things in from the outside, such as food, to relieve the chaos.

In contrast to the borderline group, the caretakers’ detachment for bulimic false self/narcissistic patients is not experienced as intentional or malevolent. Their ego resources are more sophisticated so that regressions are not visibly manifested and they rely on defenses of avoidance, denial, isolation of affect, and intellectualization. This group of bulimic patients tend to adopt a pseudomature adaptation to the unavailability of the caretaker and have the ego resources to compensate by prematurely taking responsibility for their own and others’ self-regulation. They split off and isolate their own infantile needs and over time they feel as if they are two people: one who feels desperately needy, which they experience as out of control; the other who appears to be responsible. Their attachment is a dilemma: they wish someone would recognize and tend to their needs and at the same time are afraid of showing their neediness. Consequently, they maintain a distant closeness.

The neurotic group of eating-disordered patients have adequate intrapsychic structures and the onset of the eating disorder is seen as a developmental adjustment reaction. The condition of bulimia may then be a compensatory alternative to conflictual drives such as sexuality or aggression, or it may be a maladaptive behavior resulting from misinformation about dieting. The depression experienced is more over the shame and guilt rather than more anaclitic concerns. Cognitively, they are capable of abstract reasoning and they can interpret their behavior symbolically. Their interpersonal relationships are differentiated and appropriate.

Attachment Theory

Bowlby (1958) introduced the concept of attachment. Attachment theory, which combines ethology, cognitive psychology, and psychoanalytic thought, is defined as “a way to conceptualize the propensity of human beings to make strong affectional bonds to particular others, and of explaining the many forms of emotional distress and personality disturbance, including anxiety, anger, depression, and emotional detachment, to which unwilling separation and loss give rise” (Bowlby, 1979, p. 127). Within this framework, attachment is the bond that forms between a mother and child over time, and in response to familiarity and caretaking (Bowlby, 1969). The main variable to which Bowlby (1979) draws attention is the extent to which a child’s parents provide him or her with a secure base and encourage him or her to explore from it. If the attachment figure is available and responsive (Bowlby, 1979; McMillen, 1992)
and can provide protection, aid, and comfort when it is needed, the child is able to develop the emotional, psychological, and cognitive skills necessary to acquire mastery and a strong and pervasive sense of security. The child, then, has a secure base from which to move out and explore the world and to which he or she can return (Ainsworth & Bell, 1970; Bowlby, 1979). Thus, the capacity of the individual to make a bond with main attachment figures is fundamental to emotional security and provides the basis for all later attachments (Ainsworth, 1972).

Reformulating the concept of the “good” and the “bad” object, Bowlby postulated the existence of an internal psychological organization. Included are “representational” (Bowlby, 1979, p. 136) or “working models” (Bowlby, 1979, p. 117; Schneider, 1991) of the self and of the attachment figure who is either experienced as accessible and trustworthy, or inaccessible, untrustworthy, unwilling to respond, and hostile. Bowlby noted that whatever working models an individual forms out of the “real-life” (Bowlby, 1979, p. 142) experience of childhood and adolescence “tend to persist relatively unchanged into and throughout adult life” (Bowlby, 1979, pp. 141–2). Deviations or failures in the development of attachment behavior lead to many forms of personality disorders marked by a disturbed capacity for the making of affectional bonds, and often the bonds once made are repeatedly disrupted (Ainsworth, 1962; Bowlby, 1951).

Elsewhere (Chassler, 1994) I discussed the etiology of anorexia nervosa from an attachment perspective and viewed the anorectic syndrome as a disorder of disrupted early childhood attachments. I presented research (Chassler, 1993, 1997) which has empirically linked the onset of anorexia nervosa and bulimia nervosa to early problems of attachment with significant caretakers. Specifically, I discussed the anorectics in the study relative to controls who experienced their early attachment figures as significantly more unresponsive, unavailable, and untrustworthy. The anorectic subjects reported having been subjected to repeated threats of separation in the form of parental arguing, feeling responsible for their parents safety and/or happiness, and of being abandoned either by being sent away or of being left by their parents. Thus, anorectic patients in their early development have been faced with repeated threats of separation. This has caused uncertainty concerning their sense of security, which has resulted in constant feelings of abandonment, depression, and helplessness.

Bulimia nervosa, too, can be understood in the context of Bowlby’s attachment theory. In comparing the bulimic to the anorectic subjects (Chassler, 1993, 1997), the bulimic subjects also reported experiences of early disrupted bonds. It has been suggested that, in dysfunctional families, an impoverished relationship exists between the bulimic subject and her family. This increases the likelihood that the bulimic patient,
like the anorectic, will face serious disturbances in the attachment system. Families of individuals with bulimia have been characterized as disorganized and conflict-ridden (Ordman & Kirschenbaum, 1986; Root, Fallon, & Friedrich, 1986). Existing evidence suggests that families of persons suffering from bulimia are higher in conflict, chaos, detachment, neglect, dependency, and contradictory communications than normal families (Humphrey, 1988).

TREATMENT

The primary psychological treatment for bulimia covers a variety of psychotherapeutic modalities—individual, group, family, cognitive, and behavioral. Secondary therapeutic agents that have been found to be helpful in some instances include self-help groups, support groups, and nutritional counseling. Even though secondary therapeutic agents can have beneficial effects, they are not a substitute for a primary form of therapy. Effective treatment not only depends on normalizing eating habits, but also on the therapist's capacity to understand the basic underlying psychological struggles of bulimics in order to help them bring about a change in their personality.

THE CASE OF BETTY

Betty is a thirty-four year old white, Jewish divorced female who lives in Long Beach with her thirteen-year-old daughter, Sue. Betty described herself as a loner who hates parties because she doesn't drink and feels awkward around people. She has been dating Tom for the past three months. Betty had been seen in supportive psychotherapy periodically for the past five years. Her psychotherapist felt that Betty could benefit from an analysis and referred her to me. I have been seeing her for one year.

Presenting Problem

Betty has suffered from anorexia and bulimia for the past fourteen years. She began bingeing and purging when she discovered she was pregnant with Sue and started to feel frightened about the changes her body was undergoing, her rounding hips and thickening thighs. She reported that she was terrified of motherhood and stated, "I was not more than a twenty-year-old baby myself."

Betty was anorectic three years ago for several months following the breakup of a ten year relationship with her boyfriend, Bill. She went on a six hundred calorie per day diet and her weight dropped from 115 to 90 pounds. She is 5' 6" tall. During that time she was training for a marathon, to the point of insanity. Betty came to her senses and started to eat when her periods stopped and she fractured her pelvic bone. She gained 20 pounds in two weeks and she again wishes she could be anorectic. It frightens her to think that it is more
normal to have bulimia. Betty lives with the fear of becoming fat even though she knows that she is not overweight and she is terrified to look at her stomach. As she states, "The slightest bulge means obesity." Betty perceives her body as "so heavy with inches and inches of excess skin and doesn't feel capable of being in control." She sees herself as having lots of light colored dimpled flesh. She perceives her thighs as broad and shaky but she knows that there is muscle underneath. Betty has stated that running takes away her frustration and she runs 7 miles a day and that binging numbs all of her feelings.

During the initial interviews Betty shared that she knows she has been depressed for a long time. She reported that "there is piece of her that should relinquish her need for total self-reliance and let somebody take care of her, but that's too frightening."

Background Information

Betty initially flooded the session with information about her past. I noted she felt a sense of pride in her ability to manage her life to this point in time. Betty's reported that her family is extremely wealthy. She was born in Seattle, Washington and spent her early years on an estate. She is the youngest of three siblings. Her older married brother, Rob, lives in the Boston area. He is described by Betty as an arrogant, demanding prince who always got his own way. Her middle sister, Susan, lives in the Los Angeles area. While she felt estranged from her siblings growing up, Betty said that she likes Susan and is struggling to define a relationship with her. Betty sees her sister, Susan, as confident, stylish, and socially outgoing, and while envious of her, feels she can learn from her.

In terms of her early attachment experiences, Betty described her household as chaotic—with "five lunatics running free in the huge mansion." There were constant battles between her parents and they separated and divorced seven times. She describes her father as being a violent man who would fly into rages and threatened Susan with a gun because he couldn't tolerate her open rebellion. Betty reported memories of being awakened during the night and taken by her mother to a neighbors when the fighting became too violent. Her parents first divorced while Betty was 13 and away at camp. She feels she must have cared because she wrote letters to her father to come home, and she feels responsible for reuniting them.

Betty stated that at a very early age she walled herself off from the family "crasies" because it was too dangerous being close. At some point she stopped fantasizing for change because it felt hopeless and so she locked her feelings tightly away inside her and wrote in her loneliness to an imaginary Mr. Owl. As a child she had no fantasies of growing up and having a useful life. She always drifted to things and she expressed fear to be thinking of a future because she may not attain it or she won't like it.

At 18 years of age, in her attempt to separate herself from her family, Betty attended an out-of-state college. Her sister, Susan, was at the University of Texas so she went there. In college they became close, and since then, Betty has felt a bond with her. Betty met her husband, Joe, at college and pressured him into marriage. She knew she didn't love him but thought he would be "a safe bet." To the contrary, Joe was mean and cruel. He insulted her and labeled her a "neurotic bird." Betty found out that Joe had been cheating on her so she divorced him when their daughter was two years old. She continued to have sex
with him for a while following the divorce because she was afraid he would cut off her child support.

**The First Year of Treatment**

The themes that have emerged during the first year of treatment have focused on Betty's wishes and her fears to find safety and security in relationships, at work, with family, with peers, and in her relationship with Tom. She has been in a constant struggle to find an equilibrium, a balance, and as she has stated, "a secure footing in life."

During the early months of treatment, in an effort to curb her bingeing, Betty exercised overcontrol in all areas of her life. She spoke of her need to control her pace. Initially, in the transference, Betty maintained a distant, cautious attachment (Chassler, 1994). Over time, however, she gradually began to examine her fears of getting close and involved and spoke about her fears of rejection in her search to feel a secure bond. She shared her enormous self-doubts that people would find her ugly inside and would stop caring. These fears were reflected in a dream Betty had the first month of treatment, "I had a dream last night—I didn't know at first if I was dreaming or if it really happened. Tom rejected me for being too needy." In her associations she stated, "I am afraid to get involved with Tom. I have no idea what he will be like for me in the long run. It scares me—it upsets me. I'm too scared to talk to him about it because I will scare him away."

I empathized with her concerns in her relationship with Tom and wondered also if she might not be frightened of beginning analysis and what this will be like for her in the long run. Betty replied that she had a fear of feeling optimistic that analysis could really help her and wondered what it would be like to be happy. She shared the difficulty she had in asking for an appointment because it felt as if she were asking for a favor. She has always been afraid of analysis and to look at herself inside and outside. She has always avoided looking at herself in the mirror out of fear of what she would see.

As Betty began to experience the analytic holding environment as a secure base, she more openly explored her fears and analyzed her concerns about her close affectional attachments. She felt doors slowly beginning to open and she very cautiously made tentative connections to her early traumas as the cause for her eating disorder. For the first time in her life, Betty shared with her family and with Tom that she had bulimia and that she had also suffered from anorexia. Betty's thoughts about analysis were changing and she began to express hope that I could point her in the right direction. As Betty reached out to the world, her needs began to surface and she shared her fears, her hopes, her vulnerabilities, and her hungers.

**Discussion**

Betty's eating disorder can be viewed as a disorder of disrupted early attachments with her primary caretakers. Specifically, Betty experienced her early attachment figures as unresponsive, unavailable, and untrustworthy. They appeared to have failed to foster autonomy through their inability to provide an adequate and secure home base from which she could separate. Betty reported having been subjected to repeated threats of separation because of the continued parental battles and her father's violent outbursts. Betty said she always lived
in the fear of being sent away. This has caused uncertainty concerning her sense of security, which has resulted in constant feelings of abandonment, depression, and helplessness. As Igoi-Apelbaum (1985) has assessed, the occurrence of bulimia may be related to the combination of a history of violent separations (or threats of violent separations). Consequently, Betty failed to develop the necessary skills and sense of resilience (Bowlby, 1979) to deal effectively with the hazards and risks of the world.

Her peer relationships were significantly affected and she turned to an imaginary “Mr. Owl” to curb her loneliness. It is the contention of several writers (Ainsworth, Bell, & Stayton, 1971; Arend, Gove, & Sroufe, 1979; Pastor, 1981) as well as Bowlby (1969, 1977, 1979) that an early secure base facilitates the child’s capacity to explore the world and to develop satisfactory relationships with peers. A number of authors (Bruch, 1973; Mintz, 1983; Palazzoli, 1978) have noted that life long attachment and dependency conflicts within the family mitigates against the development of healthy interpersonal attachments in anorectic patients.

Betty’s attachment is a dilemma: She wishes to be close and to have her needs attended to, yet she is afraid of showing her needs. She needs to control her attachments to others by maintaining a distant closeness.

CONCLUDING COMMENTS

The separation and attachment difficulties that Betty and other bulimic patients have experienced, in terms of their fears of being abandoned, unwanted, and unloved, complicate the forging of a healthy therapeutic alliance with someone they trust will be caring and reliable. As noted, Chassler (1994) and Johnson and Connors (1987) described the primary transference themes revolving around “... whether the patient is capable of being loved and whether the therapist is committed, durable, and able to help her contain and organize her thoughts and behaviors” (p. 111). The author believes an effective way to develop the therapeutic alliance is for the therapist to create an environment that will enable the bulimic-eating-disordered patient to experience the therapeutic relationship first as a reliable, secure base. The concept of “holding environment” (Winnicott, 1965; Modell, 1976) describes how a therapist can best meet “the patient’s desire for a secure base” (Bowlby, 1979).

According to Modell (1976), “The holding environment provides an illusion of safety and protection, an illusion that depends upon the bond of affective communication between the caretaker and the child” (p. 290). Modell (1976) views the analytic setting as an object relationship containing some elements of the mother-child relationship which helps to foster a therapeutic alliance and to facilitate the necessary ego consolidation so that internal controls are developed and mutative interpretations may be eventually effective.

From a psychoanalytic perspective, the transference provides bulimic patients the opportunity to sort out their deviant patterns of
attachment (Chassler, 1994) and difficulties surrounding the separation-individuation process. Bowlby (1979) emphasized the genuine relationship between the therapist and the patient that must develop if progress is to be expected. Similarly, Chassler (1994, 1997) noted that the support of the therapeutic bond is central to change and the transference is perceived as providing an atmosphere in which to experience a temporary attachment relationship. The bulimic patient in the transference has a new object or attachment experience and over time, through the mechanism of introjection and identification, new intrapsychic structures form related to whole object relations (Sours, 1980). The therapist who listens empathically will be internalized as a constant, reliable attachment figure, one who has been experienced as accessible and responsive, having provided support, comfort, and protection (Chassler, 1994).

The analysis of the transference enables the bulimic patient to separate the therapist and other significant people in his and or her life from the early primary caretakers. This new attachment-object relationship becomes the foundation for people with bulimia to update their early developmental failures, in the long term replacing an old “model” by a new one (Bowlby, 1980), so that they can move out and explore the world with confidence and security.

REFERENCES


LYNDA CHASSLER


Lynda Chassler, Ph.D., B.C.D.
360 North Bedford Drive
Ste. #409
Beverly Hills, CA 90210