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Sam VAKNIN*

Southern Federal University,
Rostov-on-Don, Russia

Eating Disorders and Personality Disorders

ABSTRACT

The Eating Disordered Patient

Eating disorders - notably Anorexia Nervosa and Bulimia Nervosa - are complex phenomena. The patient with eating disorder maintains a distorted view of her body as too fat or as somehow defective (she may have a body dysmorphic disorder). Many patients with eating disorders are found in professions where body form and image are emphasized (e.g., ballet students, fashion models, actors).

The Diagnostic and Statistical Manual (DSM) IV-TR (2000) (pp. 584-5):

“(Patients with eating disorders exhibit) feelings of ineffectiveness, a strong need to control one’s environment, inflexible thinking, limited social spontaneity, perfectionism, and overly restrained initiative and emotional expression ... (Bulimics show a greater tendency to have) impulse-control problems, abuse alcohol or other drugs, exhibit mood lability, (have) a greater frequency of suicide attempts”.

Eating Disorders and Self-control

The current view of orthodoxy is that the eating disordered patient is attempting to reassert control over her life by ritually regulating her food intake and her body weight. In this respect, eating disorders resemble obsessive-compulsive disorders.

One of the first scholars to have studied eating disorders, Bruch, described the patient’s state of mind as “a struggle for control, for a sense of identity and effectiveness” (1962, 1974).

In Bulimia Nervosa, protracted episodes of fasting and purging (induced vomiting and the abuse of laxatives and diuretics) are precipitated by stress (usually fear of social situations akin to Social Phobia) and the breakdown of self-imposed dietary rules. Thus, eating disorders seem to be life-long attempts to relieve anxiety. Ironically, bingeing and purging render the patient even more anxious and provoke in her overwhelming self-loathing and guilt.

Eating disorders involve masochism. The patient tortures herself and inflicts on her body great harm by ascetically abstaining from food or by purging. Many patients cook elaborate meals for others and then refrain from consuming the dishes they had just prepared, perhaps as a sort of “self-punishment” or “spiritual purging”.

The Diagnostic and Statistical Manual (DSM) IV-TR (2000) (p. 584) comments on the inner mental landscape of patients with eating disorders:

Corresponding Author:

Sam VAKNIN*

Southern Federal University, Rostov-on-Don,
Russia.

email: samvaknin@gmail.com

“Weight loss is viewed as an impressive achievement, a sign of extraordinary self-discipline, whereas weight gain is perceived as an unacceptable failure of self-control”.

But the “eating disorder as an exercise in self-control” hypothesis may be overstated. If it were true, we would have expected eating disorders to be prevalent among minorities and the lower classes - people whose lives are controlled by others. Yet, the clinical picture is reversed: the vast majority of patients with eating disorders (90-95%) are white, young (mostly adolescent) women from the middle and upper classes. Eating disorders are rare among the lower and working classes, and among minorities, and non-Western societies and cultures.

Refusing to Grow Up

Other scholars believe that the patient with eating disorder refuses to grow up. By changing her body and stopping her menstruation (a condition known as amenorrhea), the patient regresses to childhood and avoids the challenges of adulthood (loneliness, interpersonal relationships, sex, holding a job, and childrearing).

Similarities with Personality Disorders

Patients with eating disorders maintain great secrecy about their condition, not unlike narcissists or paranoids, for instance. When they do attend psychotherapy it is usually owing to tangential problems: having been caught stealing food and other forms of antisocial behavior, such as rage attacks. Clinicians who are not trained to diagnose the subtle and deceptive signs and symptoms of eating disorders often misdiagnose them as personality disorders or as mood or affective or anxiety disorders.

Patients with eating disorders are emotionally labile, frequently suffer from depression, are socially withdrawn, lack sexual interest, and are irritable. Their self-esteem is low, their sense of self-worth fluctuating, they are perfectionists. The patient with eating disorder derives **narcissistic supply** from the praise she garners for having gone down in weight and the way she looks post-dieting. Small wonder eating disorders are often misdiagnosed as personality disorders: Borderline, Schizoid, Avoidant, Antisocial or Narcissistic.

Patients with eating disorders also resemble subjects with personality disorders in that they have primitive **defense mechanisms**, most notably splitting.

The Review of General Psychiatry (p. 356):

“Individuals with Anorexia Nervosa tend to view themselves in terms of absolute and polar opposites. Behavior is either all good or all bad; a decision is either completely right or completely wrong; one is either absolutely in control or totally out of control”.

They are unable to differentiate their feelings and needs from those of others, adds the author.

To add confusion, both types of patients - with eating disorders and personality disorders - share an identically dysfunctional family background. Munchin et al. described it thus (1978): “enmeshment, over-protectiveness, rigidity, lack of conflict resolution”.

Both types of patients are reluctant to seek help.

The Diagnostic and Statistical Manual (DSM) IV-TR (2000) (pp. 584-5):

“Individuals with Anorexia Nervosa frequently lack insight into or have considerable denial of the problem ... A substantial portion of individuals with Anorexia Nervosa have a personality disturbance that meets criteria for at least one Personality Disorder”.

In clinical practice, co-morbidity of an eating disorder and a personality disorder is a common occurrence. About 20% of all Anorexia Nervosa patients are diagnosed with one or more personality disorders (mainly Cluster C - Avoidant, Dependent, and Compulsive-Obsessive - but also Cluster A - Schizoid and Paranoid).

A whopping 40% of Anorexia Nervosa/Bulimia Nervosa patients have co-morbid personality disorders (mostly Cluster B - Narcissistic, Histrionic, Antisocial, Borderline). Pure bulimics tend to have Borderline Personality Disorder. Binge eating is included in the impulsive behavior criterion for Borderline Personality Disorder.

Such rampant comorbidity raises the question whether eating disorders are not actually behavioral manifestations of underlying personality disorders.

Patients suffering from eating disorders either binge on food or refrain from eating and sometimes are both anorectic and bulimic. This is an **impulsive behaviour** as defined by the DSM and is sometimes comorbid with Cluster B personality disorder, particularly with the Borderline Personality Disorder.

Some patients develop eating disorders as the convergence and confluence of two pathological behaviours: self-mutilation

and an impulsive (rather, obsessive-compulsive or ritualistic) behaviour.

The key to improving the mental state of patients who have been diagnosed with both a personality disorder and an eating disorder lies in focusing at first upon their eating and sleeping disorders.

By controlling his eating disorder, the patient reasserts control over his life. This newfound power is bound to reduce depression, or even eliminate it altogether as a constant feature of his mental life. It is also likely to ameliorate other facets of his personality disorder.

It is a chain reaction: controlling one's eating disorders leads to a better regulation of one's sense of self-worth, self-confidence, and self-esteem. Successfully coping with one challenge - the eating disorder - generates a feeling of inner strength and results in better social functioning and an enhanced sense of well-being.

When a patient has a personality disorder and an eating disorder, the therapist would do well to first tackle the eating disorder. Personality disorders are intricate and intractable. They are rarely curable (though certain aspects, like obsessive-compulsive behaviours, or depression can be ameliorated with medication or modified). The treatment of personality disorders requires enormous, persistent and continuous investment of resources of every kind by everyone involved.

From the patient's point of view, the treatment of her personality disorder is not an efficient allocation of scarce mental resources. Neither are personality disorders the real threat. If one's personality disorder is cured but one's eating disorders are left untouched, one might die (though mentally healthy)...

An eating disorder is both a signal of distress ("I wish to die, I feel so bad, somebody help me") and a message: "I think I lost control. I am very afraid of losing control. I will control my food intake and discharge. This way I can control at least ONE aspect of my life."

This is where we can and should begin to help the patient - by letting her regain control of her life. The family or other supporting figures must think what they can do to make the patient feel that she is in control, that she is managing things her own way, that she is contributing, has her own schedules, her own agenda, and that she, her needs, preferences, and choices matter.

Eating disorders indicate the strong combined activity of an underlying sense of lack of personal autonomy and an underlying sense of lack of self-control. The patient feels inordinately, paralyzingly helpless and ineffective. His eating disorders are an effort to exert and reassert mastery over his own life.

At this early stage, the patient is unable to differentiate his own feelings and needs from those of others. His cognitive and perceptual distortions and deficits (for instance, regarding his body image - known as a somatoform disorder) only increase his feeling of personal ineffectualness and his need to exercise even more self-control (by way of his diet).

The patient does not trust himself in the slightest. He rightly considers himself to be his worst enemy, a mortal adversary. Therefore, any effort to collaborate with the patient against his own disorder is perceived by the patient as self-destructive. The patient is emotionally invested in his disorder - his vestigial mode of self-control.

The patient views the world in terms of black and white, of absolutes ("splitting"). Thus, he cannot let go even to a very small degree. He is constantly anxious. This is why he finds it impossible to form relationships: he mistrusts (himself and by extension others), he does not want to become an adult, he does not enjoy sex or love (which both entail a modicum of loss of control).

All this leads to a chronic absence of self-esteem. These patients like their disorder. Their eating disorder is their only achievement. Otherwise they are ashamed of themselves and disgusted by their shortcomings (expressed through the distaste with which they hold their body).

Eating disorders are amenable to treatment, though comorbidity with a personality disorder presages a poorer prognosis. The patient should be referred to talk therapy, medication, and enrol in online and offline support groups (such as Overeaters Anonymous).

Recovery prognosis is good after two years of treatment and support. The family must be heavily involved in the therapeutic process. Family dynamics usually contribute to the development of such disorders.

In short: medication, cognitive or behavioural therapy, psychodynamic therapy and family therapy ought to do it.

The change in the patient following a successful course of

treatment is VERY MARKED. His major depression disappears together with his sleeping disorders. He becomes socially active again and gets a life. His personality disorder might make it difficult for him – but, in isolation, without the exacerbating circumstances of his other disorders, he finds it much easier to cope with.

Patients with eating disorders may be in mortal danger. Their behaviour is ruining their bodies relentlessly and inexorably. They might attempt suicide. They might do drugs. It is only a question of time. The therapist's goal is to buy them that time. The older they get, the more experienced they become, the more their body chemistry changes with age – the better their chances to survive and thrive.

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