DOWNLOAD PDF PSYCHODYNAMIC TECHNIQUE IN THE TREATMENT OF THE EATING DISORDERS

Chapter 1 : Philosophy and Approaches to Treating Eating Disorders | HealthyPlace

Eating disorders are symptom complexes that occur in a variety of character disorders: hysterical, obsessive-compulsive, borderline, and--in some cases--psychotic conditions. The major problem for the psychotherapist is that these patients do not readily seek treatment, and if they do, they want a resolution of the symptom rather than a.

The approach is based upon theory rather than empirical data. Decades ago, when psychologists and psychiatrists first began treating eating disorders, psychodynamic therapy was the only tool they had. Science has come a long way since then. Why use theory-based practice when we have evidence-based practice? It confuses symptoms with causes. For example, one psychodynamic theory posits that girls develop anorexia nervosa due to their fear of growing up and their desire to remain child-like. In reality, the ammenorhea and boyishly-thin bodies of anorexic girls are symptoms of the illness. Insight and motivation are over-emphasized, especially early in treatment. Insight and motivation are crucial to sustaining wellness later in the recovery process. But patients with anorexia nervosa suffer from anosognosia, a brain-based inability to recognize that they are ill. Precious weeks, months, even years are wasted trying to form an alliance, cultivate motivation, and develop insight. There is no reliable scientific evidence to support these theories. Families of eating disorder patients do typically present for treatment with high levels of conflict and tension. The conflicted parent-child relationship, however, is most likely the result of the eating disorder rather than the cause. Having a child with any serious illness creates enormous strain on even the healthiest, most functional families. A great deal of time and money is wasted attempting to discern this deeper meaning. I advise patients and families: We still do not know the cause of many types of cancer, but we begin aggressive cancer treatment immediately upon diagnosis because the longer it goes untreated, the more grim the prognosis becomes. We can remove a tumor or give chemotherapy without knowing how the tumor originated. Too much attention is paid to early experiences, often at the expense of solving problems in the here and now. Psychodynamic theory presumes that psychiatric disorders stem from early childhood experiences. Too much value is placed on the relationship between therapist and patient. While I completely agree that the therapeutic relationship is very important to the healing process and there is solid research supporting this , I believe that this relationship must take a backseat to treating the eating disorder aggressively. In my experience, this often means that the patient translation: It undermines the relationship between the patient and his or her parents. The typical result of this type of therapy is that the patient begins to distrust and resent her parents for making her ill, and the parents back off even further out of fear of making problems worse. We now know, through research on family-based treatment, that empowering parents to help their children overcome eating disorders is actually the most effective way to help them recover. I believe that nurturing positive relationships between the patient and her family members is essential for full recovery and ongoing relapse prevention, as family members are usually the first to notice signs of struggle, and the first ones to intervene. It is extremely difficult to undo the damage done by psychodynamic treatment. A substantial amount of the trauma that patients and families endure is not the result of the eating disorder itself, but rather the result of bad treatment and protracted illness. Often, patients and their families come to me for family-based treatment after months or years of traditional therapy which has not been effective. Even a newly-diagnosed patient will struggle with re-feeding, but having a history of traditional treatment makes the process much more tumultuous. It does not bode well for relapse prevention. Unfortunately, eating disorders have a very high rate of relapse, in part because the underlying biological vulnerability stays with the patient for life. In order to maintain full recovery, it is extremely important for the patient to maintain his or her optimally healthy body weight, practice excellent self-care, manage stress adaptively, and eat a complete, well-balanced diet. They have built careers on these ideas; written books about them; conceptualized their own recovery through these lenses. But that does not make these theories correct, or evidence-based, or useful, or effective in treatment. This entry was posted on Sunday, May 29th, at You can follow any responses to this entry through the RSS 2. Both

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Chapter 2 : Psychodynamic Therapy

" Psychodynamic Technique in the Treatment of the Eating Disorders." American Journal of Psychiatry, (2), p. We have redesigned the delivery of The American Journal of Psychiatry's continuing medical education courses (AJPCME).

Petrocelli, Jean and Stuart, Catherine Publisher: Jason Aronson, Reviewed By: Carol Saturansky, Summer , pp. Compulsions, such as in obsessive-compulsive behavior, are not addressed here. A state of hunger usually requires or compels an action: The cover of this book piques our interest because all human beings, analysts included, have known hunger. Addictions and eating disorders are similar in that they involve ingesting or refusing to ingest, and thereby causing the same effect substances that alter the brain and body chemistry and result in intrapsychic, physiological and social consequences. These symptoms are highly dramatic and provocative. One cannot easily ignore, miss or minimize these behaviors. This is behavior that involves engulfing a part of the outside world: Eating disorders and addictions embody high drama because these symptoms are about actions that people take that affect them as well as others. But for the psychoanalytic therapist, the symptom is just one aspect of a person, and the contributors to this book all attempt to understand the symptom as part of the greater whole of that person. Still, the symptom is dramatic, discrete and more immediately distressing than say, a chronic depression. And, as we learn from the various writers, the treatment of an eating disorder or addiction regularly goes beyond understanding and usually involves more than the usual level of active participation from the therapist. The Introduction tells us that the book grew out of a conference given by the William Alanson White Institute. There is indeed a conference feel in many of the chapters, where it seems as though the author is speaking, not writing, and the reader is part of an actively listening audience. This format is fascinating as the authors write about the subject of addiction in personal, specific and concrete ways. In terms of theory and practice, we get a chance to look at how similar material is handled by clinicians of different theoretical persuasions. Yet, the sense is that this collection of essays is a collage of ideas, not always coherently related to one another. If you read the papers in the order presented, you initially find yourself reading almost exclusively about eating disorders. After more than half the pages are read, the material shifts, and the balance of the book contains sections devoted to other varieties of addictions. The breadth of topics presented here is impressive. There are theroretical, clinical and personal perspectives; literary, philosophical and historical references; case presentations, analyses of enactments and countertransferences, and transformative dramatic episodes for both patients and therapists. Thus, the anthology is really a sampler of ideas. The 26 chapters are divided into seven sections. These two papers suggest two seemingly opposing ways of conceptualizing the remaining material: Dissociation and the Eating-Disordered Patient. The writers here emphasize the need for the therapist to be more active, more real, and more reactive. Dramatic clinical examples are offered. There was a moment untouched in the room of stunned disbelief. I closer to yelled it. In her clinical example it was not until she, the analyst, disclosed the fact that she had broken a tooth in the middle of the previous session that the work with one very difficult patient began to progress. I understand her transference to me. Here she notes the necessity of distinguishing between two separate eating disorders: As for all symptoms looked at psychoanalytically, it is important to understand the specific meaning of the fatness. Interestingly, he defines compulsion as behavior meant to avoid danger, and drug taking as behavior meant to court danger. In clear language and with the use of clinical material, Ehrenberg describes how for a patient, what may seem like a masochistic kind of addiction to a very poor object choice is really a lifeline, to be understood as such and as a vehicle to escape from a much greater inner pain: Ehrenberg goes on to point out that the therapist can also become a substitute addictive object, rather than a working collaborator. The subtleties of these insights make for extremely valuable reading. The differences are not clearly addressed here. Is not nicotine addiction different from heroine? What about the sociological factors involved in both alcohol and drug addiction? These topics are not included in this volume, but they are questions that cannot be completely ignored, even when attempting a psychoanalytic

understanding of a symptom. Probably every therapist who has practiced for any length of time has had the opportunity to work with a patient with an eating disorder, whether or not they knew about the problem when they began work. The work involves a special challenge; the individuals with these symptoms can be incredibly difficult to help, and may even require a team-approach. In this book, we find comfort in the shared clinical vignettes and we learn from the therapeutic illuminations. These are the patients who seem to drive us the most crazy,â€”the eating-disordered, drug-addicted, alcoholic, passionately locked-in souls. These are people who live highly dramatic lives, and it is the nature of good drama to pull the audience in, to make you pay attention. This collection of essays emphasizes the liveliness of our work because of the active and dramatic nature of these symptoms, the strong pull for the clinician, and the final recognition that the tools best used for this work are the very same ones employed for all of our psychotherapeutic workâ€”only more so. Theory, clinical observation and empirical research. Readers therefore must apply the same principles of fair use to the works in this electronic archive that they would to a published, printed archive. These works may be read online, downloaded for personal or educational use, or the URL of a document from this server included in another electronic document. No other distribution or mirroring of the texts is allowed. The texts themselves may not be published commercially in print or electronic form , edited, or otherwise altered without the permission of the Division of Psychoanalysis. All other interest and rights in the works, including but not limited to the right to grant or deny permission for further reproduction of the works, the right to use material from the works in subsequent works, and the right to redistribute the works by electronic means, are retained by the Division of Psychoanalysis. Direct inquiries to the chair of the Publications Committee.

Chapter 3 : Psychodynamic Technique in the Treatment of the Eating Disorders - Raamatuvahetus

Psychodynamic Technique in the Treatment of the Eating Disorders. This volume is written by the most prominent contributors to the current understanding and treatment of anorexia, bulimia, and obesity.

However, two aspects of eating disorders known definitively are they do not discriminate due to gender, religion, ethnicity, or socio-economic status, and they can manifest at any age with no child, adolescent, or adult being immune. In addition to their ambiguity, complexity, and indiscriminant nature, eating disorders are beyond dangerous; they can be deadly. These diseases have the highest mortality rate of any psychiatric disorder due to the myriad medical complications and the high risk of suicide. With such complex and dangerous disorders multiple varying treatments should be used to guide those suffering through the healing process. Identifying the level of treatment can be the first step in the healing process. Outpatient therapy may be the first approach and if this fails to achieve positive results, inpatient or residential treatment may soon be recommended. Although the course of treatment can appear parallel, the therapeutic strategies differ due to age, acuity level, length of stay, and level of participation. A child under ten years of age requires treatment with a more simplistic approach to best suit her cognitive ability. An adolescent will require a different method due to her maturational level along with her changing, and still developing body. An adult, though able to synthesize more knowledge, has a wholly different set of thoughts and concerns, such as a career, life partner, possible children, etc. Therapy must be conducted creatively and uniquely with an eye to the age of the individual in order to provide the best possible care and most favorable outcome. Treatment Methods Should Include: Psychotherapy Traditionally known as talk therapy, this involves one-on-one counseling with a therapist. This is designed to understand the causes and thought processes of the eating disorder then help the patient learn new skills and techniques to cope with painful emotions and stressors of life. As cited in ANAD statistics data, 50 percent of those meeting the criteria for an eating disorder also meet the criteria for depression. The individual learns the importance of mindfulness, which supports the ability to increase awareness of the thoughts, sensations and emotions as they are being experienced. An individual practicing mindfulness, experiences the compulsion to purge; she will then have the ability to acknowledge the thought as separate from the desired action and choose to respond differently in the face of that thought. Awareness increases the ability to see the space between thoughts and action, providing more opportunities for choice in response. Nutritional Counseling Regardless of whether a person is struggling with anorexia, bulimia or binge eating disorder, affiliation with a registered dietitian RD is an extremely crucial component of recovery. It is not enough to stop an eating disorder; a person needs to learn how to establish a healthy relationship with food. The RD can create a sustainable meal plan that helps the individual maintain a healthy weight that is right for her body. In time, this food plan will be referred to as good eating habits or positive eating lifestyle, simply to remove the formulaic nature of the word diet or plan. Psycho-education is part of this counseling practice, especially if the person has damaged her body as a result of malnutrition. The RD helps her to recognize how the restricting, bingeing, or purging behaviors negatively coincide with her physical body. The goal is for the individual in recovery to develop an intentional relationship with food, in effort to experience hunger and satiety cues based on physical needs, not emotional triggers. Expressive Therapy As much as talk therapy is essential, it is additionally powerful and influential when joined with expressive therapy treatment. Too much of the disorder is contained within the body itself. Therapeutic modalities such as art, dance, and even yoga, are designed to promote emotional and physical healing. These endeavors are not concerned with tangible outcomes; instead, the value is in the process. The truth is that words often prove inadequate when trying to convey buried emotions. These therapies allow a hurting or wounded individual to communicate her internal experience without words. The therapies allow her to reconnect with her physical body and internal being. When an eating disorder is active, the body is the enemy. Through movement, she can rediscover the value, beauty and strength of her body. Since expressive therapies are rarely engaged in alone, the person has

the wherewithal to reconnect relationally. In a dance movement or yoga class , participants might chat or even laugh while connecting to her peers as they move together. As complex as an eating disorder is, the treatment options must be intentional and designed to meet the needs of the individual. The effort is to treat the person, not just the symptoms. With a blend of creative treatment approaches, the individual will have the best chance of recovery. As the Eating Disorder Program Coordinator, Amy facilitates supervision for Eating Disorder Specialists, offers support through training to TK staff, and provides education on eating disorders to the community. As such, she provided support at the milieu level for all residents. She transitioned to Eating Disorder Specialist in , supporting healing in present moment experiences for residents who struggled with eating disorders and body image. These are not necessarily the views of Eating Disorder Hope, but an effort to offer discussion of various issues by different concerned individuals. We at Eating Disorder Hope understand that eating disorders result from a combination of environmental and genetic factors. If you or a loved one are suffering from an eating disorder, please know that there is hope for you, and seek immediate professional help.

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Chapter 4 : Psychodynamic Technique in the Treatment of the Eating Disorders - Google Books

Introduction. Given the recent changes to the diagnostic criteria of eating and feeding disorders in the DSM-5, specifically the addition of Binge Eating Disorder (BED), I aimed to examine the current research supporting effective psychodynamic treatment of eating disorders (EDs) and how DSM-5 modifications will affect diagnosis, treatment, and awareness of EDs.

Investigators evaluated two new treatment strategies and compared the outcomes to a treatment as normal group. They found that even after the conclusion of therapy, the new approaches fostered continued weight gains. Nevertheless, despite the generally postive outcomes, one quarter of the study participants did not experience rapid improvements. Study findings are published in the journal Lancet. Psychotherapy has been recognized as the treatment of choice for anorexia nervosa and in Germany, is covered by health insurance. However, to date there have been no large-scale clinical studies that examine the efficacy of different treatment methods on a comparative basis, constituting a glaring research gap considering the severity of the disease. Anorexia nervosa is known as a particularly deadly illness. To date, no convincing studies on specific therapy programs have been available in adults. Furthermore, randomized controlled studies comparing promising therapy methods are rare. Around 1 percent of the population has anorexia nervosa, with the disorder primarily affecting girls and young women. Patients with anorexia are very underweight due to their long-term food restriction and, in many cases, their urge to over-exercise. Self-induced vomiting, the use of laxatives, diuretics or appetite suppressants exacerbate the weight loss. Patients with anorexia have an intense fear of gaining weight and their perception of their own figure is distorted. They often have other mental disorders such as depression , anxiety and compulsive disorders. Treatment by experienced psychotherapists in cooperation with family physicians is recommended although the efficacy of different therapy approaches had not been studied. The current study, which accompanied adult women over a period of 22 months 10 months of therapy, 12 months of follow-up observation now allows scientific conclusions to be drawn about the efficacy of different types of psychotherapy for the first time. Three groups of either 82 or 80 patients each underwent a different method of outpatient psychotherapy. For the specific therapies, treatment manuals were developed in conjunction with international eating disorder experts. The therapy comprises 40 outpatient individual therapy sessions over a period of 10 months. For all patients, specially trained psychotherapists conducted the therapy with the patients. Around one-third of the patients had to be admitted for inpatient treatment temporarily due to their poor state of health. Approximately one-quarter of the patients discontinued their participation before the trial had ended. Three psychotherapy methods were compared: Focal psychodynamic therapy addresses the way negative associations of relationships and disturbances affect the way patients process emotions. The working relationship between the therapist and the patient plays a key role in this method. The patients are specifically prepared for everyday life after conclusion of the therapy. Cognitive-behavioral therapy has two focuses: Standard psychotherapy was conducted as optimized treatment as usual by experienced psychotherapists selected by the patients themselves. The patients also visited their respective study center five times during the study. The patients with anorexia in all three groups had made significant weight gains after the end of therapy and at a month follow-up visit. Their BMI had increased by 1. Researchers believe the specific therapies give adult patients a realistic chance of recovery or long-term improvement. However, great challenges for the prevention and early treatment of anorexia nervosa remain.

Chapter 5 : CBT, Psychdynamic Psychotherapy Found Effective for Anorexia

This volume is written by the most prominent contributors to the current understanding and treatment of anorexia, bulimia, and obesity. It details the techniques that can resolve these patients' strong defenses against the acknowledgment of their underlying conflicts, and it provides an understanding of the psychodynamic structure of the various personality disorders that are masked by eating.

This chapter provides a very simplistic summary of three main philosophical approaches to the treatment of eating disorders. Medical treatment and treatment with drugs that are used to affect mental functioning are both discussed in other chapters and not included here. However, it is important to note that medication, medical stabilization, and ongoing medical monitoring and treatment are necessary in conjunction with all approaches. Depending on how clinicians view the nature of eating disorders, they will most likely approach treatment from one or more of the following perspectives: Admittedly, patients may not know whether a certain theory or treatment approach is suitable for them, and they may need to rely on instinct when choosing a therapist. Many patients know when a certain approach is not appropriate for them. For example, I often have patients elect to go into individual treatment with me or choose my treatment program over others because they have previously tried and do not want a Twelve Step or addiction- based approach. Getting a referral from a trustworthy individual is one way to find an appropriate professional or treatment program. Within the psychodynamic realm there are many theories on the development of psychological disorders in general and on the sources and origins of eating disorders in particular. Describing each psychodynamic theory and the resulting treatment approach, such as object relations or self-psychology, is beyond the scope of this book. The common feature of all psychodynamic theories is the belief that without addressing and resolving the underlying cause for disordered behaviors, they may subside for a time but will all too often return. The early pioneering and still relevant work of Hilde Bruch on treating eating disorders made it clear that using behavior modification techniques to get people to gain weight may accomplish short-term improvement but not much in the long run. Like Bruch, therapists with a psychodynamic perspective believe that the essential treatment for full eating disorder recovery involves understanding and treating the cause, adaptive function, or purpose that the eating disorder serves. Please note that this does not necessarily mean "analysis," or going back in time to uncover past events, although some clinicians take this approach. My own psychodynamic view holds that in human development when needs are not met, adaptive functions arise. These adaptive functions serve as substitutes for developmental deficits that protect against the resulting anger, frustration, and pain. The problem is that the adaptive functions can never be internalized. They can never fully replace what was originally needed and furthermore they have consequences that threaten long-term health and functioning. For example, an individual who never learned the ability to self-soothe may use food as a means of comfort and thus binge eat when she is upset. Binge eating will never help her internalize the ability to soothe herself and will most likely lead to negative consequences such as weight gain or social withdrawal. Understanding and working through the adaptive functions of eating disorder behaviors is important in helping patients internalize the ability to attain and maintain recovery. In all of the psychodynamic theories, eating disorder symptoms are seen as expressions of a struggling inner self that uses the disordered eating and weight control behaviors as a way of communicating or expressing underlying issues. The symptoms are viewed as useful for the patient, and attempts to directly try to take them away are avoided. In a strict psychodynamic approach, the premise is that, when the underlying issues are able to be expressed, worked through, and resolved, the disordered eating behaviors will no longer be necessary. Whatever the particular psychodynamic theory, the essential goal of this treatment approach is to help patients understand the connections between their pasts, their personalities, and their personal relationships and how all this relates to their eating disorders. The problem with a solely psychodynamic approach to treating eating disorders is twofold. First, many times patients are in such a state of starvation, depression, or compulsivity

that psychotherapy cannot effectively take place. Therefore, starvation, tendency toward suicide, compulsive binge eating and purging, or serious medical abnormalities may need to be addressed before psychodynamic work can be effective. Second, patients can spend years doing psychodynamic therapy gaining insight while still engaging in destructive symptomatic behaviors. To continue this kind of therapy for too long without symptom change seems unnecessary and unfair. Psychodynamic therapy can offer a lot to eating disordered individuals and may be an important factor in treatment, but a strict psychodynamic approach alone - with no discussion of the eating- and weight-related behaviors - has not been shown to be effective in achieving high rates of full recovery. At some point, dealing directly with the disordered behaviors is important. The most well-known and studied technique or treatment approach currently used to challenge, manage, and transform specific food and weight-related behaviors is known as cognitive behavioral therapy. Cognitive distortions in the thinking of eating disordered patients that influence behavior are well recognized. A disturbed or distorted body image, paranoia about food itself being fattening, and binges being blamed on the fact that one cookie has already destroyed a perfect day of dieting are common unrealistic assumptions and distortions. Cognitive distortions are held sacred by patients who rely on them as guidelines for behavior in order to gain a sense of safety, control, identity, and containment. Cognitive distortions have to be challenged in an educational and empathetic way in order to avoid unnecessary power struggles. Patients will need to know that their behaviors are ultimately their choice but that currently they are choosing to act on false, incorrect, or misleading information and faulty assumptions. Cognitive behavioral therapy CBT was originally developed in the late s by Aaron Beck as a technique for treating depression. The essence of cognitive behavioral therapy is that feelings and behaviors are created by cognitions thoughts. Common cognitive distortions can be put into categories such as all-or-nothing thinking, overgeneralizing, assuming, magnifying or minimizing, magical thinking, and personalizing. Those familiar with eating disorders will recognize the same or similar cognitive distortions repeatedly being expressed by eating disordered individuals seen in treatment. Disordered eating or weight-related behaviors such as obsessive weighing, use of laxatives, restricting all sugar, and binge eating after one forbidden food item passes the lips, all arise from a set of beliefs, attitudes, and assumptions about the meaning of eating and body weight. If not addressed, the distortions and symptomatic behaviors are likely to persist or return. They provide a sense of safety and control. All-or-nothing thinking provides a strict system of rules for an individual to follow when she has no self-trust in making decisions. Karen, a twenty-two-year-old bulimic, does not know how much fat she can eat without gaining weight so she makes a simple rule and allows herself none. Eating, exercise, and weight become factors that make the person feel special and unique. They enable patients to replace reality with a system that supports their behaviors. Eating disorder patients use their rules and beliefs rather than reality to guide their behaviors. As long as John holds the belief that, "If I stop taking laxatives I will get fat," it is difficult to get him to discontinue his behavior. They help provide an explanation or justification of behaviors to other people. Cognitive distortions help people explain or justify their behavior to others. Stacey, a forty-five-year-old anorexic, would always complain, "If I eat more I feel bloated and miserable. Magical thinking allows patients to believe and try to convince others to believe that electrolyte problems, heart failure, and death are things that happen to other people who are worse off. Treating patients with cognitive behavioral therapy is considered by many top professionals in the field of eating disorders to be the "gold standard" of treatment, especially for bulimia nervosa. At the April International Eating Disorder Conference, several researchers such as Christopher Fairburn and Tim Walsh presented findings reiterating that cognitive behavioral therapy combined with medication produces better results than psychodynamic therapy combined with medication, either of these modalities combined with a placebo, or medication alone. Even though these findings are promising, the researchers themselves concede that the results show only that in these studies, one approach works better than others tried, and not that we have found a form of treatment that will help most patients. Many patients are not helped by the cognitive behavioral approach, and we are not sure which ones will be. More research needs to be done. A prudent course of action in treating eating disordered patients would be to utilize cognitive

behavioral therapy at least as a part of an integrated multidimensional approach. Alcoholism is considered an addiction, and alcoholics are considered powerless over alcohol because they have a disease that causes their bodies to react in an abnormal and addictive way to the consumption of alcohol. The Twelve Step program of Alcoholics Anonymous AA was designed to treat the disease of alcoholism based on this principle. In this model, food is often referred to as a drug over which those with eating disorders are powerless. The Twelve Step program of Overeaters Anonymous was originally designed to help people who felt out of control with their overconsumption of food: The original treatment approach involved abstaining from certain foods considered binge foods or addictive foods, namely sugar and white flour, and following the Twelve Steps of OA which are as follows: We admitted we were powerless over food - that our lives had become unmanageable. Came to believe that a Power greater than ourselves could restore us to sanity. Made a decision to turn our will and our lives over to the care of God as we understood Him. Made a searching and fearless moral inventory of ourselves. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs. Were entirely ready to have God remove all these defects of character. Humbly asked Him to remove our shortcomings. Made a list of all persons we had harmed, and became willing to make amends to them all. Made direct amends to such people wherever possible, except when to do so would injure them or others. Continued to take personal inventory and when we were wrong, promptly admitted it. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out. Having had a spiritual awakening as the result of these steps, we tried to carry this message to compulsive overeaters and to practice these principles in all our affairs. The addiction analogy and abstinence approach make some sense in relationship to its original application to compulsive overeating. It was reasoned that if addiction to alcohol causes binge drinking, then addiction to certain foods could cause binge eating; therefore, abstinence from those foods should be the goal. This analogy and supposition is debatable. To this day we have found no scientific proof of a person being addicted to a certain food, much less masses of people to the same food. Nor has there been any proof that an addiction or Twelve Step approach is successful in treating eating disorders. The analogy that followed - that compulsive overeating was fundamentally the same illness as bulimia nervosa and anorexia nervosa and thus all were addictions - made a leap based on faith, or hope, or desperation. In an effort to find a way to treat the growing number and severity of eating disorder cases, the OA approach began to be loosely applied to all forms of eating disorders. The use of the addiction model was readily adopted due to the lack of guidelines for treatment and the similarities that eating disorder symptoms seemed to have with other addictions Hat-sukami Twelve Step recovery programs sprung up everywhere as a model that could be immediately adapted for use with eating disorder "addictions. The American Psychiatric Association APA recognized a problem with Twelve Step treatment for anorexia nervosa and treatment for bulimia nervosa, in their treatment guidelines established in February The guidelines suggest that for bulimia nervosa Twelve Step programs such as OA may be helpful as an adjunct to other treatment and for subsequent relapse prevention. Although the use of a common language can be a basic factor as to further therapeutic cooperation, it may be at the same time a diagnostic trap by which some more essential, challenging, or threatening elements of the problem and hence the related treatment are avoided. What essential or challenging elements might be avoided? One of the criticisms of the addiction or disease model is the idea that people can never be recovered. Eating disorders are thought to be lifelong diseases that can be controlled into a state of remission by working through the Twelve Steps and maintaining abstinence on a daily basis. According to this viewpoint, eating disordered individuals can be "in recovery" or "recovering" but never "recovered. A "recovering" bulimic is supposed to continue referring to herself as a bulimic and continue attending Twelve Step meetings indefinitely with the goal of remaining abstinent from sugar, flour, or other binge or trigger foods or bingeing itself. Labeling eating disorders as addictions may not only be a diagnostic trap but also a self-fulfilling prophecy. There are other problems applying the abstinence model for use with anorexics and bulimics. For example, the last thing one wants to promote in an anorexic is abstinence from food, whatever that food might be. Anorexics are already

masters at abstinence.

Chapter 6 : Psychodynamic approach - Eating Disorders Glossary

Psychodynamic Technique in the Treatment of the Eating Disorders is a sophisticated text for the experienced clinician who is trained in psychoanalytic theory. Although the volume is a collection of independent pieces by 10 contributors, the bulk of the writing is by the editors themselves, thus.

Involving family therapy Including psychopharmacological interventions The search identified 6 articles that met the inclusion and exclusion criteria, one pilot study, and one naturalistic study. I placed emphasis on studies that involved psychodynamic treatment modalities. The collection of peer reviewed journal articles enabled me to compare psychodynamic treatment techniques with alternative treatment approaches. I paid special attention to recent writings to capture the most up-to-date thinking on knowledge, prevalence, and treatment of EDs. Conclusions Through this systematic literature review, I closely examined eight research studies conducted in the past ten years and organized these findings and my evaluations in Table 1. Though psychodynamic psychotherapy for EDs has not been sufficiently studied in RCTs, findings show that active dynamic interventions, especially interpersonal psychotherapy, may be useful for EDs. My research showed that interpersonal psychotherapy was the most prominent psychodynamic approach to EDs, as it is a more structured, manualized form of typical practice that evaluates the development of ED symptoms in the context of relationships Thompson-Brenner et al. A few of the studies I reviewed in Table 1 showed no significant difference between CBT and psychodynamic therapies for the treatment of BN, anorexia nervosa, and BED, which suggests that research focusing on the integration of CBT and psychodynamic treatment approaches may prove fruitful to symptom remission and better treatment outcome. Many of the studies I reviewed discussed the development of a more structured and symptom-focused version of psychodynamic psychotherapy Poulsen et al. The Murphy et al. The preliminary findings of their study indicated that some EDs could be treated effectively using an integrative approach. The present data suggest that more structured and manualized forms of psychodynamic interventions may be clinically useful in the treatment of EDs, especially BED. Limitations of the present review include the use of published data only, extraction and preparation by a single author, possible publication bias, and broad inclusion and exclusion criteria. My thorough review of the current research highlighted relevant and promising data that I hope will spark a larger conversation regarding the efficacy of psychodynamic treatment modalities for the treatment of EDs, as well as other complex comorbid conditions. Identifying efficacious treatments for patients with EDs represents a critical future direction in the field of clinical psychology. A systematic review of the efficacy of psychodynamic treatments for DSM-5 eating disorders. Long-term efficacy of psychological treatments for binge eating disorder. The British Journal of Psychiatry, 3 , Three psychotherapies for anorexia nervosa: American Journal of Psychiatry, 4 , Preferred reporting items for systematic reviews and meta-analyses: International Journal of Surgery, 8 5 , Integrated psychodynamic therapy for bulimia nervosa and binge eating disorder: European Eating Disorders Review, 13 6 , A randomized controlled trial of psychoanalytic psychotherapy or cognitive-behavioral therapy for bulimia nervosa. American Journal of Psychiatry, 1 , Attachment scales predict outcome in a randomized controlled trial of two group therapies for binge eating disorder: An aptitude by treatment interaction. Psychotherapy Research, 16 1 , A naturalistic study of psychotherapy for bulimia nervosa, part 2: The Journal of nervous and mental disease, 9 , Empirical support for psychodynamic psychotherapy for eating disorders. Bridging the gap between science and practice pp. Psychological treatments of binge eating disorder. Archives of general psychiatry, 67 1 , Focal psychodynamic therapy, cognitive behaviour therapy, and optimised treatment as usual in outpatients with anorexia nervosa ANTOP study: The Lancet, , You Might Also Like:

Chapter 7 : Treatment Approaches for Eating Disorder Recovery

Families of eating disorder patients do typically present for treatment with high levels of conflict and tension. The conflicted parent-child relationship, however, is most likely the result of the eating disorder rather than the cause.

Sitemap Why an ED glossary? This comprehensive glossary has been created to give parents a quick reference tool that explains, in simple lay language, the terms used in the research, management and treatment of eating disorders. It is designed to empower parents by helping them understand a very complex range of illnesses in order to converse with their treatment providers, ask the right questions, understand the answers, and ultimately plan and execute the most effective course of treatment. Many of the terms are broad and may be employed in other areas of medicine or mental health; the definitions provided here apply specifically to their meaning within the context of eating disorders. Additional source references are provided for those wishing to delve deeper. The definitions are designed to inform and explain the terms factually according to the best evidence available. They do not seek to advise you on any course of treatment; that should remain the domain of your treatment providers. To protect the quality of information, the glossary cannot be edited by readers. However, we openly solicit comments, corrections or modifications on existing material as well as your suggestions for additional terms on the vast subject of eating disorders. Send your suggestions and comments to glossary feast-ed. A non-profit organization founded in , F. The organization is run by a board of directors, almost all of whom are parents of sufferers, and it is guided by a Professional Advisory Panel of eating disorders experts from the United States, France, United Kingdom and Australia. Eating disorders are biologically based mental illness and fully treatable with a combination of nutritional, medical, and therapeutic supports. Parents do not cause eating disorders, and patients do not choose eating disorders. Blaming and marginalizing parents in the eating disorder treatment process causes harm and suffering. When available, patients should receive evidence-based treatment. Families should be supported in seeking the most appropriate treatment in the least restrictive environment possible. When the family is supported, the patient is supported. Parents have unique abilities to offer other parents support, information, and the wisdom of experience. We welcome you to visit F. The belief is that if behaviors are discontinued without addressing the underlying motives that are driving them, that relapse will occur. The psychodynamic model does not address nutritional issues, food-related symptoms or behavioral rituals of the eating disorder. Natenshon, "When your child has an eating disorder" Eating Disorders Glossary from a page on the F. T site, click the "go back" button in your internet browser to return to that page; if not, we welcome you to visit the FEAST home page for a wealth of information on evidence-based treatment for eating disorders, support for parents and families, the latest eating disorders research, a forum for parents and caregivers, useful books, etc.

Chapter 8 : Feminist Psychodynamic Psychotherapy, Part 2: A Perspective from Practice - Eating Disorder

Addictions and eating disorders are similar in that they involve ingesting (or refusing to ingest, and thereby causing the same effect) substances that alter the brain and body chemistry and result in intrapsychic, physiological and social consequences.

Yet, feminist psychodynamic psychotherapy does not stop here. That is, the crucial objective of identifying and owning split-off self-states and bad objects that wreak such havoc in living life to the fullest is only the start of easing the inner anguish and bodily tensions caused by such insidious forces. Clinical case studies demonstrate how often ruptures and breakdowns in the therapeutic process are brought about by these pathological entities. The patient is assisted by repeatedly working over the common defense of projecting and evacuating bad objects into others. A temporary reprieve from angst occurs when one can psychologically deposit that feeling into another, but there are also consequences. The person who is subject to forceful negative projections may become angry, beleaguered, confused, or simply worn out by what is experienced as personal attack. An important relationship can then easily break down. Psychotherapists practicing with a feminist orientation have always paid particular attention to the role of the mother in fostering development and regulating autonomy and dependency. Infant researchers have concluded that those multiple, tiny disruptions that occur between a mother and her child and the adequate repair that happens in milliseconds between them sets the stage for later resiliency and growth. In the treatment of eating problems, simply knowing psychotherapy will be fraught with disruptions because the patient may keep secrets, move slowly, not follow advice, or act self destructively, and because the therapist will be caught off guard, have flaws, and inadvertently make errors of commission and omission, suggests that the need to repair disruption is essential for forward movement. These articles have offered concrete, cutting-edge tools to assist clinicians in this undertaking. Many young clinicians who treat eating disorders with manualized techniques they learned during residency or graduate training are often shocked in workshops to learn how neatly feminist psychodynamic concepts overlap with what they are already doing and that they have already unknowingly incorporated a technique they may have taken for granted into their practice. Like many of our patients, other psychiatric symptoms remitted while eating problems did not budge until her patient found new ways to transform disagreeable passions into healthier activities e. With eating disorder patients, clinicians appropriate this approach and call it by many new names e. For the feminist psychodynamic psychotherapist, the treatment hour is an essential but insufficient room wherein the individual safely experiences empathy for oneself and others, bears misfortune and trauma, and ultimately transcends the eating disorder symptoms by finding new purpose and meaning in life. Small wonder that many therapeutic traditions now converge in prescribing exercises such as journaling, meditation, prayer, and ongoing self-analysis. All share the same goal of improved self-regulatory functioning in the quest for greater vitality and perspicacity in making decisions and taking ownership for them. Evolving and Transforming Psychodynamic Psychotherapy Western and non-Western scholars and psychotherapists are currently augmenting and transforming the ways that feminist psychodynamic psychotherapy is practiced. These voices will increasingly be integrated into the treatment of eating disorders because they emphasize facets of subjectivity, self- creation, ethics, and cultural responsibility snuffed out when an eating and body image problem takes hold of an individual life. The role of the therapist as witness will remain central regardless of tweaks to and enlargements of feminist theory and its multidisciplinary contributors. You also help me to hear me, those thoughts I am actually saying to myself. A Book about Self Esteem. My Life on the Road. A Spirit of Inquiry: Doing Psychoanalysis in Tehran. Beyond doer and done to: An intersubjective view of thirdness. The Bonds of Love: Psychoanalysis, Feminism, and the Problem of Domination. Shadow of the Other: Intersubjectivity and Gender in Psychoanalysis. Beebe B, Lachmann, FM. Infant Research and Adult Treatment: The Problem of the Passions: Feminism, Psychoanalysis, and Social Theory. New York University Press, In Lacan and Addiction: Karnac, , pp 93 â€”

The Unconscious and the Modern Subject.

Chapter 9 : The Psychodynamic Treatment of Eating Disorders and Compulsions (Book Review)

Psychodynamic therapy is the kind of talk therapy many people imagine when they think of psychological treatment for www.nxgvision.com's because the image of the psychiatrist and patient probing the.

By Jim Haggerty, M. In its brief form, a psychodynamic approach enables the client to examine unresolved conflicts and symptoms that arise from past dysfunctional relationships and manifest themselves in the need and desire to abuse substances. Several different approaches to brief psychodynamic psychotherapy have evolved from psychoanalytic theory and have been clinically applied to a wide range of psychological disorders. There is a body of research that generally supports the efficacy of these approaches. Psychodynamic therapy is the oldest of the modern therapies. As such, it is based in a highly developed and multifaceted theory of human development and interaction. This chapter demonstrates how rich it is for adaptation and further evolution by contemporary therapists for specific purposes. The material presented in this chapter provides a quick glance at the usefulness and the complex nature of this type of therapy. History of Psychodynamic Therapy The theory supporting psychodynamic therapy originated in and is informed by psychoanalytic theory. There are four major schools of psychoanalytic theory, each of which has influenced psychodynamic therapy. The four schools are: Freudian psychology is based on the theories first formulated by Sigmund Freud in the early part of this century and is sometimes referred to as the drive or structural model. Defense mechanisms are constructions of the ego that operate to minimize pain and to maintain psychic equilibrium. The superego, formed during latency between age 5 and puberty , operates to control id drives through guilt. Ego Psychology derives from Freudian psychology. Its proponents focus their work on enhancing and maintaining ego function in accordance with the demands of reality. Object Relations psychology was first articulated by several British analysts, among them Melanie Klein, W. Winnicott, and Harry Guntrip. According to this theory, human beings are always shaped in relation to the significant others surrounding them. Our struggles and goals in life focus on maintaining relations with others, while at the same time differentiating ourselves from others. The internal representations of self and others acquired in childhood are later played out in adult relations. Individuals repeat old object relationships in an effort to master them and become freed from them. Self Psychology was founded by Heinz Kohut, M. The self is perceived in relation to the establishment of boundaries and the differentiations of self from others or the lack of boundaries and differentiations. Each of the four schools of psychoanalytic theory presents discrete theories of personality formation, psychopathology formation, and change; techniques by which to conduct therapy; and indications and contraindications for therapy. Psychodynamic therapy is distinguished from psychoanalysis in several particulars, including the fact that psychodynamic therapy need not include all analytic techniques and is not conducted by psychoanalytically trained analysts. Psychodynamic therapy is also conducted over a shorter period of time and with less frequency than psychoanalysis. Introduction to Brief Psychodynamic Therapy The healing and change process envisioned in long-term psychodynamic therapy typically requires at least 2 years of sessions. Practitioners of brief psychodynamic therapy believe that some changes can happen through a more rapid process or that an initial short intervention will start an ongoing process of change that does not need the constant involvement of the therapist. A central concept in brief therapy is that there should be one major focus for the therapy rather than the more traditional psychoanalytic practice of allowing the client to associate freely and discuss unconnected issues. In brief therapy, the central focus is developed during the initial evaluation process, occurring during the first session or two. This focus must be agreed on by the client and therapist. The central focus singles out the most important issues and thus creates a structure and identifies a goal for the treatment. In brief therapy, the therapist is expected to be fairly active in keeping the session focused on the main issue. Having a clear focus makes it possible to do interpretive work in a relatively short time because the therapist only addresses the circumscribed problem area. The number of professionals who practice an exclusive form of psychodynamic therapy today is a small

percentage of psychotherapists.