A Consuming Crisis
Ilana H. Damian, PhD

One of the biggest challenges a therapist confronts is working with the borderline patient who also suffers from eating disorders. This challenge becomes exceedingly difficult when working within a managed care system which allows a limited number of sessions.

The interactive nature of the multi-axial system helps us to diagnose the clinical syndrome: Axis I, eating disorders; and Axis II, borderline personality. The proper diagnosis allows the therapist to delineate the treatment plan which makes the therapeutic experience more productive and less frustrating for both the therapist and the client.

The *DSM-IV* describes the borderline as an underlying character structure marked by a cluster of long-standing, ingrained traits which result in the maladaptive patterns of perceiving, behaving and relating to others. Symptoms may include depression, mania, anxiety, substance abuse and eating disorders.

> "Confronting borderlines about their weight loss may elicit angry responses and attempts to quit therapy. The therapist may be seen as the 'bad mother,' who is controlling and critical'

The *DSM-IV* divides eating disorders into three categories:

1. Anorexia nervosa
2. Bulimia nervosa
3. Obesity with psychological factors affecting medical conditions, when there is evidence that psychological factors are of importance in the etiology of obesity.

(Simple obesity is included in the *International classification of Diseases* as a general medical condition and does not appear in the *DSM-IV* because it has not been established that it is consistently associated with a psychological or behavioral syndrome)

Mutual Feelings

The first clue that the therapist s working with a borderline is a negative and positive countertransference, anger and hatred; wishing the patient would look for another therapist and then feelings of unusual fondness. The borderline's "aura" seem to linger with therapists, not just between patients but also after-hours. The countertransference signals to therapists the nature of the containing and absorbing function they are required to perform.

Borderlines are developmentally arrested in the rapprochement phase (6-25 months). Theodore Milton makes the observation that the borderline's fragmented sense of identity and difficulty in maintaining stable relationships reflects the fragmentation of the stable unit in contemporary society. Social influences either set in place or further embed those deficiencies in psychic cohesion which lie in the heart of the disorder.

Confronting borderlines about their weight loss my elicit angry responses and attempts to quit therapy. The therapist may be seen as the "bad mother," who is controlling and critical. Khoum recommends supportive therapy with the borderline, which I have found to be very useful. As long as borderlines se the therapist as the "good mother" they are motivated to work through their issues and weight-loss occurs.

Binge eating has the alluring powers of a drug. The obese person regresses to early stages of development and the ego is not strong enough to make conscious decisions pertaining to food selection. Unless the patient gets involved with 12-step meetings such as Overeaters Anonymous, prognosis is poor.

Compulsive eating is an addiction to food. The “drugs” of food addiction are sugar, refined carbohydrates, and white flours.

Refined carbohydrates and white flour are 20 percent as potent as refined sugar in their mood-altering properties. These substances increase the transmission of dopamine, norepinephrine, and serotonin. As synapses become flooded with these neurotransmitters, a feeling of euphoria results and craving is stimulated. One actually becomes intoxicated.

This chemical reaction is similar to the effects of alcohol on the alcoholic. It is not uncommon to see a recovering alcoholic become obese. The physical response is followed by hyperexcitabliilty and the a feeling of low, followed by shame and guilt Often I hear the statement, “I need a piece of cake just to glue myself back together, “

Compulsive eating is an attempt to nourish ourselves physically. It medicates fear, anger, loneliness, and depression. It is a symptom of our need for emotional nourishment and fulfilling relationships.

Rebuilding the Self

Central to the borderline syndrome is the lack of a core sense of identity When describing themselves, borderlines typically paint a confused or contradictory self-portrait. A useful treatment modality seems to be to give a name to the fragmented ego state. On a three-by-five card, the patient is invited to name the different saboteurs, which include:

- the indulger, master rationalize
- the critic, perfectionist
- the rebel
- the victim
- the martyr
- the procrastinator.

It is also important to identify the part of the personality that is healthy and functional. Naming the different parts of the personality enables the to get in touch with their intrapsychic conflicts.

At a later phase of therapy, patients will start using charts, listening to hypnosis recordings, setting behavioral goals, and using the conscious guide to eating. This includes the following guidelines

Eat when you are hungry
Relax before you start eating by taking three deep breaths. Often what you thing is hunger is tension.
Eat only sitting at a table. Giving yourself a specific place to enjoy your food replaces eating unconsciously while standing or working. Do not eat in the car.
No television allowed while eating. When you eat, you must be fully aware of your food in order to get the most satisfaction from the smallest amount.
Eat without distractions, such as anxiety or conversation.
Eat with enjoyment, pleasure, and gusto.
Slow down by using a small fork, chopsticks or by eating with the non-dominate hand.
Stop eating when you are satisfied, even if there is food on your plate.
Drink six to eight glasses of water per day
Stop eating after 8 pm.
Brush and floss your teeth after your last meal.
Reach for your mate instead of your plate.

Another key issue is distinguishing between psychological hunger and physiological hunger. It is helpful for the patient to rate their hunger on a scale of one to ten, with one being very hungry, five being comfortable, and ten being stuffed.
The target in obtaining ideal weight is focusing on love, joy, and abundance. Because dieting is often associated with deprivation, obtaining and maintaining and ideal weight must be a result of a

change in lifestyle. Educating the patient that abundance and love do not come from food alone, but rather from relationships, dance, exercise, reading, meditation, and music, is a crucial component of therapy.
I encourage my patients to repeat Pythagoras' affirmation, "choose what is best for you and soon habit will render it easy."