ISSN: 2573-9565

Review Article

Journal of Clinical Review & Case Reports

Eating Disorders: Analysis and Therapy Based on Personality Organization

Noga Levin Keini[1*], Dr. Anat Shalev[2]

AshkelonAcademic College, Israel.

***Corresponding Author**

Noga Levin Keini, AshkelonAcademic College, Israel.

Submitted: 2024, Feb 08; **Accepted**: 2024, Feb 15; **Published**: 2024, Mar 01

Citation: Levin Keini, N. & Shalev, A. (2024). Eating Disorders: Analysis and Therapy Based on Personality Organization. *J Clin Rev Case Rep, 9*(3), 01-08.

Abstract

Eating disorders are generally described as being associated with body image, involving an attempt to reduce bodily dimensions to the maximum extent. The disorders are characterized by fasts that last for a period of one or two days, minimal food intake, vomiting and bulimic consumption. The present article proposes that the customary categorization according to symptomatic evidence is inadequate and that a more accurate classification would be based on the sufferer's level of personality organization. Such a division would enable therapy to be optimally matched to each patient [1], greatly assisting therapists in choosing and planning treatment for the individual sufferer.

Keywords: Eating disorders, Anorexia nervosa, Personality organisation, Bulimia Nervosa, Neurotics, Borderline.

1.Introduction

Eating disorders are generally described as being associated with body image, expressing typically a desire to slim or alter the body form. It is customary to classify the disorders according to their characteristic symptoms [2].

• Anorexia nervosa–reduction of food intake to a minimum.

• Bulimia nervosa–eating binges alongside vomiting.

In recent years there has been a greatly increased awareness of the fact that eating disorders stem from severe mental states and that the mental symptom is the result of extreme problems [3,4]. Although the US classification system for psychiatric disorders (DSM-5: APA, 2013) as well as the European classification system ICD-10 (World Health Organization) currently offer a broader and deeper view of evidence-based eating disorders, criticism exists over the fact that their classifications do not succeed in capturing all that is encountered by clinicians in sessions with their patients, these disorders still being considered difficult to treat.

In light of the above, the present article proposes that categorization of eating disorders based on symptomatic evidence is inadequate and that they are better classified according to the level of the sufferer's personality organization [5]. This claim is made in view of the fact that such a division could help determine more appropriate therapy for the sufferer [6].

Categorization according to the level of personality organization would be in accordance with the division proposed by Kernberg [1], who referred to three levels: neurotic, borderline and psychotic. Kernberg's categories are associated with the personality development process, and are distinguished principally by the nature of the defence mechanisms the individual activates in the face of unconscious anxieties, the nature of the early internalized relationship with the object, and the extent to which the sufferer's reality testing has been affected [7].

In our view, an eating disorder is a type of organizational symptom that allows anxieties to be concentrated around it on the conscious level. It thus serves as a defence mechanism against unbearable mental states. For example, unconscious fears of annihilation or emptiness can be manifested consciously in a fear of obesity or in the perception of place and space in the world (Becher, 2002). Observation of a patient suffering from an eating disorder in terms of the personality organization level is intended to help in identifying the etiological aspect of the disorder and the factors responsible for its development. It would thus simplify the determination of appropriate therapy [8].

Eating Disorders against the Background of Neurotic Personality Organization–"Slim is Beautiful"

According to the Kernberg distribution, neurotic individuals generally succeed in coping with deep-seated distress and anxieties. They are equipped with ego forces and an ability to control and regulate urges, conduct relationships, and perform sound reality testing. Nevertheless, their defence mechanisms may be manifested in symptoms that lead to distress and non-adaptive behaviours [7].

Accordingly, patients suffering from eating disorders based on neurotic personality organization are not only generally typified by sound reality testing, but in most cases will also understand the physiological and emotional risks inherent in this kind of disorder [9]. However, it is perhaps precisely why, in their case, an inner conflict arises between attainment of the perfect body and the desire to remain healthy [10]. From the symptomatic point of view the clinical picture associated with them will be reduced food intake, prolonged fasts, and attacks of binge eating followed by the occasional vomiting. There could also be uncontrollable munching, leading to weight gain. Such patients are also characterized by a need for strenuous physical activity alongside strict eating rules, including "permissible" and "forbidden" foods. Symptoms in this class of individuals appear according to varying levels of stringency. Their moods are generally good, with displays of vitality and cheerfulness. Their suffering is, at the same time, intense, their cheery façade often serving as a defence against a tendency to depression that is camouflaged by their eating dysfunction. Typically, these patients suffer from low self-confidence, a damaged body image, social anxiety, and a need to meet the social criteria so often portrayed in the media [11].

Underlying the disorder is the aspiration to conform to a particular ideal of beauty and, to this end, alter the figure [12]. A tendency is often observed in the families of these girls towards gratification of others, which at times has a definitive impact on the girls. By and large, these individuals do not suffer from any significant psychiatric malfunction, reactive depression or neurotic anxieties of any kind.

2. The Conflict Inherent in a Neurotic Disorder

The conflict inherent in a neurotic disorder is easy to detect even during the initial intake stages. Following a psycho-educational explanation on the risks involved in the disorder, such as cardiac injury, reduced fertility, bone impairment and mood disruption, the girls are observed to experience anxiety and an attempt to deny the possible consequences with respect to their bodies. Despite this, denial in most cases is not the dominant factor here, but rather depression, deriving from the realization that practically speaking it is not possible to arrive at the desired result, in terms of weight and figure, in a state of health. Depression also sets in from the girls' resigning themselves to the fact that there is no control over weight and figure, being genetic attributes. In developing an eating disorder, the girl is in fact denying any understanding of the figure she has inherited and her ability to change it to only a very limited extent–denial serving as a factor in protecting her from depression based on a recognition of the facts. As a defence mechanism, however, denial is not sufficiently effective and in itself becomes the cause of distress. Denial of reality in this group can be regarded initially as distorted reality testing; however, insight gradually makes inroads and a rapid breakdown of the denial mechanism may be observed.

The mantra colouring the inner experience of the patient in this group is "I am not good, pretty or attractive enough", translating to "I am not slim enough". The concept of slimness is invariably viewed as positive and esteemed, whereas fulness of figure is viewed as negative and worthy of scorn. A sharp dichotomy commonly observed among girls of this group is beautiful-slim vs. ugly-fat, or attractive-slim vs. repulsive-fat. Holding this dichotomy necessitates a paradoxical, dialectic attitude that allows an understanding of the fact that contradictions can exist side by side [13].

Therapy for groups suffering from neurotic personality organization would focus on self-acceptance, necessitating support in large measures to boost self-confidence, as well as the definition of personal values to enable the individual to cope with frustration. In administering therapy, an attempt would be made to deal with the depression that goes hand in hand with the dialectic attitude with which the girl must cope. On commencing therapy, a considerable difficulty must be addressed around the matter of weight gain, involving a strong desire to remain at home and out of sight. The neurotic individual can muster her own strengths–ego forces that are in no way negligible–as well as her cognitive abilities. Rational explanations can help her to adopt more reasonable conduct with respect to her eating habits. During the therapeutic process many patients experience depression and learn to accept it as part of the human condition. As therapy progresses, the patient will let herself sink into a depression and lament over having to forfeit everything she perceived as the ideal body, but without fearing an overall breakdown. In general, in the absence of therapy, an eating disorder based on neurotic personality organization could continue for a long period of time, and even worsen. It should be noted that individuals in this group are generally cooperative and their prognosis is positive. Most of them attain a good balance while processing and holding the depression arising from their condition.

Most treatment and rehabilitation programs are geared to this group.

3. Eating Disorders Based on Psychotic Personality Organization–"I have to because I simply have to"

According to Kernberg [1], patients with a level of psychotic personality organization tend to use denial and idealization as defence mechanisms, hindering them in their performance of integration between the different parts of their personality. They tend to project internal content, anxieties and conflicts on concrete events in the real world, and based on their experience in maintaining such severe content they express it in overt behaviour. That is why this population has been observed to suffer from deficient reality testing and object relations that are barely expressed to differentiate between inside and outside–namely, between the person himself and other representations of human objects. These individuals will mostly find it difficult to lead a normal life and maintain sound, steady relationships. In patients belonging to this group, adherence to the symptom is observed, alongside a lack of reality testing. The eating disorder with them is generally accompanied by significant psychiatric morbidity, and at times full-blown psychosis is observed even after recovery.

Patients with psychotic personality organization observe eating patterns that do not always square with the concept of weight loss. They will at times state that they "simply have to" refrain from eating, or that they are "not allowed" to eat. They might also impose a limit on certain foods because they are "forbidden". Some of these forbidden foods are indeed fattening, but it is not about gaining weight that the patients appear to be anxious. For example, a patient can avoid carbohydrates of all types, but make an exception with chocolate, since it may be perceived as safe. Eating foods that are forbidden is viewed as an unacceptable act. The inner emotion experienced by patients from this group is one of existential anxiety that is threatening and all-consuming, alongside a loss of control and horror of uncertainty. Any change from the set pattern of eating is perceived as leading to mental breakdown. A patient might, for example, suffer a mental breakdown if the store is out of the cheese that she is used to eating every morning. There is thus a great deal of rigidity regarding eating patterns, causing anxiety together with unfounded thoughts about undergoing a breakdown.

The control conflict experienced by a patient in this group may be described as one that focuses on the issue of the "foreign self" (Rossi & Fongi, 2012). The reference is to the part that is internalized in the person's memory and belief system with respect to himself. This part "speaks to him" from within. Patients do not necessarily report on hearing external voices, but do refer to voices from within, instructing them not to eat, and at times to even harm themselves. The voices are demeaning and censorious, warning them of acute suffering if they do not comply.

From the psychodynamic point of view, an eating disorder based on psychotic personality organization originates in symbiosis, manifested in a difficulty in acquiring a separateness in relationships. Sufferers also find it difficult to distinguish between their own thoughts and the voices they hear from others. Their implacable attitude towards the question of "forbidden foods" may be understood as a mechanism that kicks in so as to achieve a separateness and a sense of control over a world that so threatens to take chaotic command of the individual's self.

The acute anxiety that is a part of life for the anorexic girl casts a pall over the therapeutic environment. The anxiety experienced by the patient is projected on to the therapist, and vice versa. The patient's family members also report considerable suffering and the need to "tread on eggshells" where it comes to the patient's demands of them.

An eating disorder in the case of this group is particularly difficult. An objection to any change could be extreme, being expressed even in suicidal terms. The experience of self is so precarious, it is as though the patient is being held up entirely by strong external "scaffolding" and sturdy defences, which if compromised, can cause her breakdown.

In such cases hospitalization, even forced, can be alleviating, for "someone is making a decision for me; I don't have to bear responsibility for facing the threatening inner element". In therapy an attempt is made to help the patient strengthen her healthy parts and identify the inner voices. The key target with respect to the inner voices would be to expose them and arrive at an understanding that a voice heard by the patient in the past was internalized by her as though it was her own. An attempt is also made to help the patient understand that the voice bears no logic and that there is no point in arguing with it. At times the voice may be likened to a recording that repeats itself over and over again. The patient would be helped to control the intensity of the voices she hears in the recording and lower their volume. She would then learn that the voices were not really her own and that the choice of whether to obey them or not could be hers. In cognitive terms, the patient will learn that it is precisely a disregard of the narrative repeated by the voices that will be instrumental in lowering the level of anxiety. Clearly, in this group medicinal treatment geared to the psychotic side of their personality would be highly effective (Bloch, 2006).

It may thus be stated that therapy for patients suffering from psychotic personality organization is similar to cognitive therapy commonly administered to OCD patients. This is based on the fact that patients with a compulsive disorder are subjected to repeated therapy by tranquillization, achieved by lowering the level of anxiety with respect to the anxious state, provided the patient succeeds in acquiring an insight into her condition. In such a situation the patient can lower the volume of her thoughts and the voices she hears. Another aim in working with patients from this group could be improvement in cognitive flexibility and formulation of various possibilities for managing a range of situations. The "thoughts monster", nurtured repeatedly by compulsive behaviour, could thus be defanged.

4. Eating Disorders Based on Borderline Personality Organization–The Me/Not Me Experience

Individuals with borderline personality organization possess typically primitive defence mechanisms, principally split and dissociation [1]. Their ego forces are unstable. Their reality testing is sound, although it tends to be affected adversely by situations where self-intuition is required and where interpersonal relations remain ambiguous. Accordingly, attempts at establishing contact could lead them to intensely emotional reactions, including displays of tempestuous behaviour.

Frequently, those belonging to this group find it difficult to discern where they themselves end and where others begin. In cases of eating disorders among individuals with borderline personality organization, their reality testing is unstable while their insight regarding their precarious state of health is highly fluid. Thus, it appears at times that they have a complete understanding of the fact that a person cannot exist without food, whereas they exhibit a denial of this understanding where it involves their own condition. Biological rules do not apply to them; they will cope. Patients in this group do not generally show signs of fear regarding bodily injuries that they could sustain due to their eating patterns, flouting the possibility of a resultant death or, alternatively, actually welcoming death [7]. Their conduct is chronically dangerous, indeed, suicidal, the drive towards ending their lives being intense and ever-present.

From the psychodynamic viewpoint, the death drive can be understood as a way of validating the absence of existence and the inner meaning with which they live. Their behaviour can be extremely unpredictable and impulsive, being accompanied by severance from people and dissociation to the point of identity disorder. In many cases one encounters significant early trauma, mostly sexual, in childhood. Most sufferers report negligence and mental or sexual abuse in their early years; indeed, their personality develops against a traumatic and unstable background. Their attachment figures were alternately affectionate and hurtful, exploitative or abusive (Franzi, 1933). Such patients grow up with a "language confusion", finding it difficult to understand when others love them and when they exploit them for their own ends. They carry this behavioural pattern with them into future relationships. Thus, every contact they make is tinged with extreme intensity at first, but with hope advancing to suspicion and ultimately to injury to themselves. This haphazard pattern is re-enacted with respect to their bodies as well. Their bodies are attractive and repulsive at the same time: their attractiveness serves as a means to establish contact; their repulsiveness is a means of defence against the hurt that is inherent in every relationship.

Dissociation develops among girls in this group at an early age, constituting a mechanism for severance based on trauma and injury. The young girl learns to effect a split between her bodily sensations and her emotional experiences. Subsequently, the severance mechanism leads to a condition in which pain is represented differently in the mind. These patients are able to hurt themselves cruelly at times, without feeling pain or distress: there are times when pain and distress even bring them relief. As part of the eating disorder, these patients make their digestive system available to them in a reality that is painful to unbearable. They experience vomiting, diarrhoea, fasts and dizziness without these phenomena causing them any particular disturbance, the mental pain being vastly greater than the physical discomfort. As stated, patients in this group tend towards self-infliction, practising this both by slashing the skin and pursuing idiosyncratic eating patterns. They will try to push their body to its ultimate limit, since it is only there that they will experience something meaningful apart from mere existence. Alongside subsistence, threats of suicide are part of their arsenal, aimed at arousing concern among the people around them with respect to their health. Their indulgence in self-infliction is also oriented to obtaining a sense of existence.

Within this internal chaos and the unconsolidated experience of self, the eating disorder serves as an organizational anchor with respect to the personality. The symptoms serve as steadying defence mechanisms, for they involve behaviour that one can identify with, alongside clear desires that are articulated. Patients from this group find it difficult to accept the presence of benevolent others and therefore feel unloved. When a patient from this group expresses her wish to die, her immediate surroundings are distraught. Stating a desire to be slim, on the other hand, is less rattling to others, who find this fact easier to swallow.

An eating disorder in this group serves, in effect, only as a smokescreen for the death urge. Underlying the disorder is emptiness, a sense of nonexistence, which the disorder validates and to which it provides a concrete answer. Deep within their souls there is profound depression, together with a vast void. They seek to eat nothing, but the unsteady condition that typifies them makes it difficult for them to persevere and they often succumb. The experience of fullness becomes invasive, akin to a foreign object penetrating their body and assuming control over them [14].

Dissociation takes place at times in the therapeutic relationship as well, so that it is experienced as psycho-aggressive, as though the therapist and patient are strangers to each other. The patient's relationship with the therapist is always extremely ambivalent and fraught with suspicion. Interpretations are swept aside, often out of hand and belligerently. Any breakdown in empathy on the part of the therapist could lead to threats of suicide by the patient. Displays of neediness are extremely common, while the thirst for dependency is also very strong. Further, because of the ambivalence and suspiciousness on the part of the patients, it is very difficult to meet their needs. The ambivalent relationships that typify the girls in this group reflect the patterns of interaction that governed their early childhood–girls who so wanted love and did not know when they would find it, if at all [15].

Persevering with therapy in this group is agonizingly difficult, for both therapist and patient. The patients test the limits of therapy and stretch them to the extent that the therapist is forced to abandon treatment. These patients are known in the field of eating disorders as being chronic examples, with a condition that is severe and prolonged. They find it very difficult to heal or even improve, in contrast to the neurotic group or even the psychotic group, who succeed in achieving remission for extended periods of time.

Therapy is long and intense, and makes an attempt at holding the areas of early depression and the accompanying experience of emptiness. Nevertheless, the symptoms continue to endanger the patients, and they need occasional hospitalization, strict behavioural therapy, and even forced feeding. Most of the patients in this group will drop out without completing their therapy. For them, forced feeding is experienced as a re-enactment of the rape and abuse they suffered in childhood. Their prognosis is not at all optimistic (Gur, 2015).

5. Clinical Implications–Neurotic level of Personality Organization

In the neurotic level of personality organization, there usually is an ability to cope with deeper emotional stresses. These patients have ego strength, control of their impulses, ability to manage interpersonal relationships and intact reality judgment. Nevertheless, their defenses might on occasion acquire a symptomatic form and appearance alongside their maladaptive functioning. Because their reality testing is preserved, these patients understand the physical physiological and emotional threats inherent to eating disorders. This understanding and their inability to accept the knowledge that acquiring the "perfect body" entails a threat to the self and severe injury to the body

and mind, arouses both anxiety and considerable conflict. The latter comprises, on the one hand the drive to be thin which is equivalent to being beautiful, while on the other hand the wish to remain healthy and without damaging their physiological well-being.

It is possible, already during the initial intake, to identify the level of neurotic conflicts associated with the eating disturbances. In this group, it is appropriate to provide psycho-educational explanation regarding the dangers to cardiac health, fertility, and the skeletal and bone structure. In response to such information and explanations we frequently encounter denial in these patients regarding their physical condition, but mostly the most prevalent response is depression.

This depression derives mainly from the need to apprehend and accept the absence of control over genetic, congenital factors regarding the structure of their bodies. They apparently never will be skinny! The eating disturbance then serves as a repudiation and denial of the acceptance of this fact. This arouses terror, and it then serves as a defense against depression.

In therapy, to guard themselves from the negative influences of anorexia, the patient belonging to this group will need to accept themselves, even though they do not meet their extreme aspirations and criteria of being thin, skinny, and hence successful, beautiful and deserving of admiration. It is necessary to teach them via the therapy, to distinguish and separate between the terms thin and the term ideal. It is also worthwhile to practice much compassion towards herself. The treatment in this group will focus frequently on self-acceptance and acceptance of whom the patient currently is, strengthening their self-confidence and social self-confidence and defining their personal values. This will enhance and enable coping with their acceptance and forgoing of being thin and ideal.
In the early stages of the initial treatment, it appears in general, that patients stubbornly attempt to avoid the depressive position that derives from the dialectic understanding that the skinny and thin body structure is not that of their own! It will never be both thin and healthy! These patients initially report in treatment on the tremendous difficulty that they encounter when increasing their weight. They tend to isolate themselves in their homes or cloak themselves with large baggy clothes in their attempts to hide their bodies. But because of the higher level of their personality organization, and their strengths, they generally succeed in employing their resources: Both their ego strengths and their cognitive abilities.

We should expect that patients in this group will experience depressive episodes and that they will learn to accept them as part of the spectrum of human experience. They should be enabled to mourn the loss of the aspired for, idealized, perfectly looking body rather than a good, adequate, and worthy one.

We may add that most of these patients, in their treatments, cooperate and collaborate with an empathic approach to their difficulties and depression and their prognosis is relatively goo Implications: Patients with eating disturbances having a background psychotic level of personality organization.

6. Clinical Implications-Psychotic Level of Personality Organization

According to Kernberg's conceptualization, people having a psychotic level of personality organization, tend to employ denial and idealization as defense mechanisms. In this group there is a serious difficulty in establishing an integration between the various parts of the personality. Their attempts to contain powerful intense emotional content, manifests frequently in behavior that manifests concretely. Consequently, there are understandably, implications concerning reality testing and or their ability to distinguish between themselves and representations of other human objects.

Patients with an eating disturbance and a psychotic background, will be attached to their symptoms together with the loss of their capacity for reality testing. The eating disturbance in this group is often accompanied by significant comorbid psychiatric illness, and at times, after recovery or remission from the eating disorder, the psychosis manifests.

The basis for the disturbance in this group is existential annihilation anxiety, while facing loss of control or uncertainty. The basic experience of these patient is the terror they experience towards eating, and any change in their established eating pattern may lead to overall mental decompensation.

Consequently, treatment that includes a nutritional program, may create a situation of adherence to "correct" eating nutritional behavior, but this will be accompanied by unbearable rigidity. These kinds of patients may decompensate mentally if for example an item they are used to routinely eating, is absent eg. cheese, from their breakfast. They are unable to tolerate an alternative or replacement.

In such a situation, an acute anxiety attack may be triggered, and it may include ideas of reference in which the patient experiences her world as coming apart. In such situations, instead of the original symptoms, other symptoms will manifest, reflecting the need for anchoring via rigid control over other templates. The internal conflict regarding control may be described as a conflict that focuses around a "foreign self" (Rosso & Fonagy). This concerns part-objects that were internalized into the system of memories and beliefs that the person has, concerning himself. These are part-objects that "speak to him" from inside. These patients will not necessarily report hearing sounds from the outside but will report on "many voices" from within that command them "not to eat" or to eat only in a certain way. These voices threaten them, and sometimes command them to injure themselves. The voices admonish, humiliate, and threaten that if they are not obeyed by the patients, they will be hurt even more. From a dynamic viewpoint, the eating disturbance in this group appears with the background of a symbiosis and difficulty to attain separation in relationships. The patient reports on occasion of a difficulty to distinguish and separate between their own thoughts and those of others. The rigid behavioral mechanism can be understood as an attempt to attain separateness and control of

the world, emanating from a chaotic experience of the self being overpowered by external forces. But the powerful anxiety that accompanies this experience acts on the symbiotic environment of the patient and forces the figures in the environment to surrender to the rigid demands of the disturbance. This may be illustrated by the need to purchase products from a particular company or to store the food only in one way and no other.

Therapists treating such patients with psychotic backgrounds, will frequently find themselves affected and experiencing anxiety that was projected onto and into them as they are invaded by the anxieties of the patients, and this evolves with a back and forth. Not infrequently we will witness how the patient's anxieties pervade and overtake their homes, because any minor digression from the strict rules, leads to anxiety attacks and rage. Sometimes the patient will request to define her home as a "sterile space", in which only she is permitted to enter and to prepare her meals. We found that these patients who make these requests, wish will all their hearts to separate themselves from parental symbiotic figures but find themselves nevertheless in a deep and severe symbiosis with the members of their home. This symbiosis is accompanied mostly by mutual severe hostility.
Treating a patient with an eating disorder, and a background personality with a psychotic organization, is exhausting and particularly difficult as it is confusing and intractable. The patient's difficulty to collaborate and cooperate is challenging. The resistance to any change is strong and may lead to suicidality. The experience of the self is so undermined that there is a sense that they are held together by "external scaffolding". The defenses are most rigid and there is a sense that all might collapse if the patient forgoes them.

In these cases, hospitalization may alleviate the severe internal conflicts. "Someone else decides for me and I am relieved of the responsibility".

In treatment, we will try to help the patient to strengthen her healthy attributes, to identify the internal voices, to build more flexible and adaptive defense mechanisms. A central therapeutic aim will be the externalization of the threatening voices, which entails attaining understanding that they are the voices expressed by someone from the patient's past that have been internalized as if they are the current voice of the therapist. We will try to help the patient understand that the voice is not speaking rationally, with logic and consequently it is pointless to argue with it. We will talk about how the voices repeat themselves endlessly, that they do not transform for the better, and that it is up to her choice if to obey them or not. In such a treatment we will be aided by cognitive and behavioral elements in a way similar to the treatment of OCD. The working assumption is that the patient needs to learn to reduce their anxiety of becoming anxious, which is created by their compulsive behavior associated with eating. Reduction of the volume of threatening, irrational thoughts, deficient of logic, helps the patients to develop a capacity to think more rationally and weaken the "monster of thoughts" that is fed by the compulsive behavior.

7. Clinical Implications: Borderline Personality Organization

The group that has Borderline Personality Organization is also characterized with defense mechanisms that are considered "primitive". The most prominent of them are splitting and disassociation. The ego strength of patients of this group are not sufficiently stable and will manifest variably in various life situations. Reality testing is mostly intact while it is vulnerable in situations wherein integration of the self is necessary, or in tense situations that involve interpersonal relationships. Consequently, attempts to establish relationships with these patients is likely to lead to stormy behavioral responses. Very often in such groups the difficulty becomes apparent that patients encounter difficulty in distinguishing where they end and where the other begins. They also have difficulty in identifying whether a mental behavioral pattern of behavior is theirs or whether it is that of another person. Questions of "whom am I really?" frequently arise.

In eating disorders with a background of borderline personality disorder, reality testing is unstable. Consequently, their insight and self-awareness regarding their dire states of health, are fluid. A patient at this level is aware that the disturbance is a threat to their life and potentially fatal, but the denial of this understanding towards themselves, enables them more easily to disregard the danger. The laws of physics and biology are not valid for them. Frequent vomiting, high dosages of a diarrhetic, will not damage their "invincible" bodies. They display almost no fear of any bodily damage. They deny death or alternately accept it with open arms. Some even report that death is a reasonable solution for them. In this way, their behavior becomes chronically dangerous and suicidal, and the death instinct is prominent and very powerful.

From a dynamic viewpoint their suicidal tendencies are understandable as manifestations of the experience of a lack of meaningful existence and internal significance, in the light of which they live.

The behavior of this group of patients tends to be impulsive and unpredictable. Sometimes their behavior will be accompanied by absences and disassociations to the extent of appearing to be a dissociative identity disturbance. In the background of these patients, we often discover significant early trauma. On occasion this involves a background of sexual trauma and sometimes abuse or severe neglect. Attachment figures of these patients were alternately good and bad, on the one hand supportive, loving and soothing while on the other hand, abusive and exploitative. In Ferenczi's terms (1933) these patients development contained a background "confusion of tongues". They could never determine whether the other was loving or exploitative. This early pattern of attachment accompanied them in their future relationships. In this manner all experiences of relationships were colored with powerful intensities of hope, suspicion and finally inevitable injury and exploitation.

This same confusing pattern is reactivated in these patients, in relation to their own bodies. Their bodies are supposed to be

both seductive and repulsive: Seduction is perceived as a means of creating relationships and repulsion is a defense mechanism, protecting them from certain injury within the relationship. As part of the disassociation in the personality, there can be an almost complete separation between the wish to live and the wish to die. Between the intense hate towards the body and sexuality and the need to externalize sexuality and to be aided by it.

The dissociation develops at an early age and appears as a defense mechanism of disconnection consequent to trauma and severe injury. The patient as a child learnt to disconnect their bodily sensations from their emotional experiences. Only the mental dissociation from the physical pain enabled them to survive the abuse and the pain. These patients are thus able to survive cruel pain and especially without feeling any anguish from the pain.
As part of the eating disturbance, they inflict extreme pain on their digestive systems. This pain would be intolerable to anyone else not having their disturbance. They are also able to tolerate fasting and dizziness or chronic pain without this being particularly disturbing to them. Their mental-emotional pain is much greater than their physical pain, and the latter becomes unfelt.

Patients in this group lead themselves repeatedly to the edge. They succeed in manipulating their environment to receive acknowledgment of their existence and they sometimes injure themselves secretly, for years, to attain some degree and sense of feeling.

Within the internal chaos, with the crumbling experience of self, the eating disturbance creates an anchor that organizes their personality. The symptoms of the disturbance serve as a stabilizing defense mechanism. This is so, since they comprise behavior that can be adhered to and in their experiences that transform from unformulated to formulated experiences.

For example: A patient experiencing emptiness is unable to love or be loved, imagines that they will be loved more if they are thin. But, more that once during treatment it transpires paradoxically, that the need to be acknowledged as an individual who is worthy, loved and appreciated, is a bottomless pit. The patient has difficulty in containing love and acceptance and has a general difficulty in acknowledging the presence of a benevolent other towards her. The trauma seared inside her makes her suspicious towards the other and even aggressive, both towards the other and towards herself. Because of the difficulty to separate between herself and the injury, she identifies with the aggressive parts and injures herself systematically and permanently.

This patient's wish to die is considered strange and unacceptable to her environment, though her wish to be thin sometimes appears as an attempt to integrate socially. In this manner, the eating disturbance camouflages her impulse to die.

From the outset, in the initial intake meeting, it is possible to identify their deep depression and the terrifying emptiness that pervades their beings. Their ambition is usually to be a perfect anorectic, such as those who eat nothing! But their mental instability makes it difficult for them to persist in this way. Quite often, the strong need to feel something and to fill themselves will lead them to attacks of bulimia, in attempts to fill the intolerable emptiness. But since they do not really succeed in feeling full, the feelings of fullness from the self-engorgement becomes an invasive experience, as if something foreign invaded and seized control of their bodies. Hence, the uncontrolled need to vomit out the "foreign invader". After the vomiting, the emptiness provides some temporary alleviation and then once again turns into an intolerable emptiness once again and the process repeats itself.

8. Treatment

Because of the characteristic dissociation in the therapeutic relationships with patients of this group, we will sometimes feel as if we are working with different figures in the same person, alternately conciliatory and then aggressive. Pursuing love and attacking it in parallel. These patients' relationships with the therapist are typically strongly ambivalent. The relationships are similar to the early ambivalent attachment relationships. The child that so much wanted love and security, but never knew or knows whether she will receive them or that she will experience rejection and abuse.

Holding and managing such treatments are challenging both for the therapist and for the patients. Frequently patients test the limits and stretch them to the extent that they are uncontainable and so patients are ejected and leave the treatment. The treatment frequently feels as if it is an inevitable inescapable picture of the future that recurs endlessly without any possibility of stopping or eluding it. Repetition and recapitulation of the aggressive past relationships encumbers attempts to create trust towards any therapist or any kind of treatment.

Patients of this group are known in the world of eating disturbances as chronic patients whose illness is difficult and long-term. They have difficulty in recovering and even improving for short periods. In contrast, patients with a neurotic personality organization and even psychotic personality organization may have long remissions. Consequently, a long-term treatment is required that enables patients to continue to hold on to their eating disturbances and thereby prevent a decompensation of their defenses and consequent psychotic episodes. The treatment must provide the patient with containment of their depression. The early areas of emptiness may eventually undergo development of the personality and acquire some emotional alleviation.

That withstanding, in eating disturbances of this severity the symptoms continue to threaten the lives of the patients and the anxiety for the lives of these patients spreads to the treatment and colors it. It must be remembered that for some of these patients, forced feeding comprises a repetition of the experiences of rape that they experienced in the past and consequently the treatment itself is experienced as traumatic.

Consequently, the treatment of this group is very challenging for the therapist. It is difficult to contain simultaneously the threat to their lives because of the continued symptomology together

with the knowledge that they should maintain their defense mechanisms, thereby avoiding a breakdown into possible psychosis. This therapeutic situation often creates an impossible situation for the therapist.

Discussion and Conclusion

Any treatment of an eating disorder must be suited specifically to the patient. There is no one-size-fits-all solution to the various types of disorders [16]. This article seeks to extend the scope of observation of the disorder and proposes that maximum attention be paid to the personality organization of the patient.

Information on the patient's personality and mode of development can shed light on her condition, enabling prediction of her prognosis and the degree of cooperation that can be expected of her.

Patients with neurotic personality organization can also be helped with therapy that is not geared specifically to them, thanks to their relative resilience in responding to treatment. However, patients with borderline or psychotic personality organization, whose reality testing is not sound, will require more specific therapy as they have great difficulty in cooperating with the therapist as a result of their overwhelming anxiety.

As described herein, an eating disorder based on psychotic personality organization constitutes a defence mechanism in the face of a breakdown, focusing the distorted thought processes and reality testing on a specific organizational framework that comprises control over eating habits and bodily needs. In contrast, those with borderline personality organization tend to adopt the eating disorder symptoms for the purpose of organizing their personality, typified by a feeling of emptiness and an absence of meaning. In such cases the symptoms contribute to feelings of significance and belonging, quickly becoming a "safe haven" for the patient. In contrast, any other contact will be experienced as temporary, involving feelings of impending abandonment. Therefore, this group generally requires prolonged therapy in which demands are made of the therapist himself by way of survival in the face of thoughts of constant abandonment during the therapeutic sessions. Therapy in the case of this group is invariably complex.

References

1. Kernberg, O. (1967). Borderline personality organization. Journal of the American PsychoanalyticAssociation, 15(3), 641-685.
2. Keel, P.K. (2017). Eating disorders. Oxford University Press.
3. Carter, J.C., Bewell, C., Blackmore, E., & Woodside, D.B. (2006). The impact of childhood sexual abuse in anorexia nervosa. Child Abuse & Neglect, 30(3), 257-269.
4. Culbert, K.M., Racine, S E., & Klump, K. L. (2015). Research Review: What we have learned about the causes of eating disorders–a synthesis of sociocultural, psychological, and biological research. Journal of Child Psychology and Psychiatry, 56(11), 1141-1164.
5. Polivy, J., & Herman, C.P. (2002). Causes of eating disorders. Annual Review of Psychology, 53(1), 187-213.
6. Murphy, R., Straebler, S., Basden, S., Cooper, Z., & Fairburn, C.G. (2012). Interpersonal psychotherapy for eating disorders. Clinical Psychology & Psychotherapy, 19(2), 150-158.
7. Kernberg, O.F., & Caligor, E. (2005). A psychoanalytic theory of personality disorders. Guilford Press.
8. Kernberg, O.F. (1993). Severe personality disorders: Psychotherapeutic strategies. Yale University Press.
9. Sullivan, P.F. (2002). Course and outcome of anorexia nervosa and bulimia nervosa. In Eating disorders and obesity: A comprehensive handbook (2 ed., pp. 226-232).
10. Juli, M.R. (2019). The "imperfect beauty" in eating disorders. Psychiatria Danubina, 31(3), 447-451.
11. Fairburn, C.G., & Cooper, Z. (2011). ating disorders, DSM–5 and clinical reality. The British journal of psychiatry. 198(1), 8-10.
12. Cassin, S.E., & Von Ranson, K.M. (2005). Personality and eating disorders: a decade in review. Clinical psychology review, 25(7), 895-916.
13. Zysberg, L., & Rubanov, A. (2010). Emotional intelligence and emotional eating patterns: a new insight into the antecedents of eating disorders?. Journal of nutrition education and behavior, 42(5), 345-348.
14. Coleman, S.E., & Caswell, N. (2020). Diabetes and eating disorders: an exploration of 'Diabulimia'. BMC psychology, 8(1), 1-7.
15. Herpertz-Dahlmann, B. (2015). Adolescent eating disorders: update on definitions, symptomatology, epidemiology, and comorbidity. Child and Adolescent Psychiatric Clinics, 24(1), 177-196.
16. Safer, D.L., Telch, C.F., & Chen, E.Y. (2009). Dialectical behavior therapy for binge eating and bulimia. Guilford Press.